Appendix A1: Summary of evidence from surveillance

2019 surveillance of [alcohol-use disorders: prevention](#) (2010) NICE guideline PH24

Please note for the 2019 surveillance of this topic, recommendations 1 to 3 were not in scope for the surveillance process due to them being national policy, which are not within NICE's current remit.

Summary of evidence from surveillance

Studies identified in searches are summarised from the information presented in their abstracts.

Feedback from topic experts who advised us on the approach to this surveillance review, was considered alongside the evidence to reach a view on the need to update each section of the guideline.

Surveillance evidence summary	Intelligence gathering	Impact statement
Recommendation 4: licensing		
2014 surveillance In previous [surveillance](#) of this guideline, one systematic review (1) (53 studies) suggested that	An expert highlighted that Directors of Public Health should be added under who should take action as they are now a responsible authority under the Licensing act 2003.	Local licensing policies Published evidence on local licensing policies indicates that they are effective in reducing alcohol-related hospital admissions and may have

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environmental factors of licensed premises, such as loud music, may be associated with increases in risky drinking, intoxication, and violence. However, results were reported without statistical data such as measures of effect sizes, p values or indicators of the size of the data pool.		effects on violent and sexual assaults, although effects may diminish over time. This evidence is generally in line with current recommendations, which suggests using local crime and trauma data to map alcohol-related problems to develop a licensing policy.
2019 surveillance		New evidence is unlikely to change guideline recommendations.
Local licensing policies		
One natural experiment estimated (2) the impact of new local alcohol licensing policies in England on hospital admissions and crime using Home Office licensing data (2007-2012). Outcomes considered were alcohol-related hospital admissions, violent and sexual crimes, and antisocial behaviour from 2009-2015. Local alcohol policies were associated with a non-statistically significant reduction in alcohol-related hospital admissions of 6.3% and a 4.6% reduction in violent crimes, especially up to 2013. There was weak evidence of a statistically non-significant 8.4% reduction in sexual crimes up 2013 and insufficient evidence of an effect on antisocial behaviour as a result of a change in reporting.		Compliance checks
		Published evidence on compliance checks indicates that only premises directly impacted by the compliance check or in close proximity are affected by the compliance check, and that the impact diminishes over time. Compliance checks and sanctions are currently recommended and as such no change to the guideline is anticipated.
		New evidence is unlikely to change guideline recommendations.
One observational study (3) looked at the effects of UK licensing policies aimed at restricting its spatial and temporal alcohol availability, including cumulative impact zones, on alcohol-related crime		Mystery shoppers
		Published evidence from the US and the Netherlands on mystery shoppers indicates that sales to underage people occur, but that immediate feedback and monthly management reports may decrease underage sales. Mystery

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(284 lower tier local authorities). From 2009 to 2013, alcohol-related violent and sexual crimes and public order offences rates reduced faster in areas with more 'intense' policies compared with 'passive' areas. However, post-2013, the recorded rates increase. One cost-benefit analysis (4) of a multi-component intervention (increasing community and liquor licensees' awareness, police activity, and feedback) analysed the effects typically associated with alcohol-related violence. There was no effect on alcohol-related assaults, but a 64% reduction in alcohol-related sexual assaults in the experimental relative to control communities, which was equivalent to 5 fewer alcohol-related sexual assaults, with a net social benefit of AUD$3,938,218. One observational study (5) evaluated whether differences in the presence or absence of cumulative impact zones and the intensity of licensing enforcement (including regulating the availability of alcohol and modifying the drinking environment) were associated with alcohol-related hospital admissions in England. Results suggest that greater reductions in alcohol-related admission rates occurred in areas with more intense alcohol licensing policies in the 2007-2015 period. A statistically significant additional 5% reduction in alcohol-related admissions (p=0.006)		shoppers are currently recommended and as such no change to guideline recommendations is anticipated. New evidence is unlikely to change guideline recommendations. We do not plan to include Directors of Public Health in the list of who should take action, as local authorities are already included, and this would encompass all relevant personnel.

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was seen in 2015 in local areas with the most intensive policies compared with what would have been expected had these areas had no active licensing policy.		
One study (6) examined associations between liquor licences (including general licences, on-premise licences, club licences, and liquor stores) and alcohol consumption at 20-years (n=988) and 22-years (n=893), and whether changes in the licences between time points influenced alcohol consumption (n=665). At 20-years only general licences were associated with alcohol consumption (p=0.037), but by 22-years, all licences types were positively associated with alcohol consumption (p<0.05). Each increase in liquor stores over time increased alcohol consumption by 8% (p=0.030), and for each additional club licence the alcohol consumption increased by 6% (p=0.007).		
One study (7) implemented the multi-component Drink Less Enjoy More in Liverpool in 2013. The intervention aimed to: increase awareness of legislation preventing sales of alcohol to drunks; support bar staff compliance with the law; provide a strong deterrence to selling alcohol to drunks; and promote responsible drinking among nightlife users. Pre-intervention only 16% of bar servers refused to serve the intoxicated actors, which increased to 74% post-intervention. There was a		

Surveillance evidence summary	Intelligence gathering	Impact statement
significant reduction in the proportion of alcohol test purchases leading to a sale of alcohol to a pseudo-intoxicated actor (from 84% to 26%) post-intervention. One study (8) aimed to analyse the effect of the Responsible Beverage Service (RBS) programme on police-recorded assaults after the dissemination of the programme in 237 Swedish municipalities from 1996-2009. Each single component extension of the programme was associated with a significant 3.1% reduction in assaults, although this effect was seen mainly in smaller municipalities. The presence of a community coalition steering group component had a significant effect on assaults. No significant effect was found for RBS training or supervision of on-licensed premises. ### Compliance checks One study (9) examined whether the effects of compliance checks diffuse to neighbouring establishments using data from the Complying with the Minimum Drinking Age trial, which included more than 2,000 compliance checks conducted at more than 900 alcohol establishments. There was a decrease in the likelihood of establishments selling alcohol to underage youth after they had been checked by law enforcement, but these effects quickly		

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decayed over time. Establishments that had a close establishment (within 125 m) checked in the past 90 days were also less likely to sell alcohol to young-appearing buyers, but the effect of compliance checks on other establishments decayed rapidly with increasing distance. **Mystery shoppers** One study (10) of a mystery shopping procedure, transfers of alcohol between young adult buyers and minors, were staged in 109 Dutch cafes and bars to measure vendors' compliance with secondary supply. Results found that 29% of the vendors disallowed the secondary supply of alcohol to minors (32 of 109 attempts), 37% of the vendor asked for the identification document (ID) of the minor. However, 20% of the minors were served even after the ID of the minor was requested. One cluster randomised cross-over trial (11) studied the effects of a mystery shopper intervention with immediate feedback and monthly management reports to reinforce age verification in 16 communities in 4 US states (N = 557). Fixed effects multi-level logistic regressions indicated that the intervention led to a significant two-fold increase in the odds of age verification.		

Surveillance evidence summary	Intelligence gathering	Impact statement

Recommendation 5: resources for screening and brief interventions

Surveillance evidence summary	Intelligence gathering	Impact statement
2014 surveillance In previous surveillance of this guideline one systematic review (12) of quantitative and qualitative studies assessing health professionals' attitudes towards patients with substance misuse disorders was found. Generally, health professionals had negative attitudes towards patients with substance misuse disorders. Education and training had a positive impact on health professionals' attitudes, but most health professionals did not feel they have the specific knowledge or skills in caring for this population. **2019 surveillance** One systematic review (13) of implementation strategies that focus on screening and brief interventions uptake (29 studies) was found. Strategies had no overall impact on patients' reported alcohol consumption, but did significantly improve screening and brief intervention delivery. Multi-faceted strategies involving professional and/or organisational and/or patient-orientated strategies, seemed to have the strongest effects on patients' alcohol consumption (P<0.05), compared with professional-orientated strategies	One expert heighted that recommendation 5 states: Commissioners should ensure a local joint alcohol needs assessment is carried out in accordance with 'World class commissioning' and 'Signs for improvement'. However, World class commissioning and Signs for improvement have been superseded by the Alcohol, Drugs and Tobacco Commissioning Support Pack (https://www.gov.uk/government/publications/alcohol-drugs-and-tobacco-commissioning-support-pack) and the Alcohol Challenging services, Leadership, Results (CLeaR) System Improvement Tool (www.gov.uk/local-alcohol-services-and-systems-improvement-tool) A topic expert highlighted that models of care has been superseded by NICE CG115 and NICE Care Pathways. The 2017 Drug Strategy also provides guidance on alcohol services (https://www.gov.uk/government/publications/drug-strategy-2017). The expert also stated that estimates for the number of dependent drinkers in need of treatment has recently been revised but no target for local numbers in treatment have been agreed.	Published evidence indicates that training of providers and strategies to aid implementation can improve delivery of screening and brief interventions, and improve healthcare professionals' attitudes towards people with alcohol use disorders. This is consistent with areas covered by the recommendation, such as support and training provision for screening and brief interventions. **New evidence is unlikely to change guideline recommendations.** Topic expert feedback highlighted that there are some references to outdated commissioning information within recommendation 5. An editorial amendment will be made to recommendation 5 to refresh out of date links to 'World class commissioning' and 'Signs for improvement'. The recommendation wording is suggested to read: 'Commissioners should ensure a local joint alcohol needs assessment is carried out in accordance with Alcohol, Drugs and Tobacco Commissioning Support Pack and the Local alcohol services

Surveillance evidence summary	Intelligence gathering	Impact statement
alone. Combining professional with patient-orientated screening and brief intervention implementation strategies had the highest impact (P<0.05), and involving other staff besides physicians was effective for screening (P<0.05). One cluster randomised controlled trial (RCT) (14) of a provider training package (1-day workshop and 4 feedback and coaching sessions) in addition to rolling out screening and brief intervention, versus rolling out screening and brief intervention without the provider training (10 sites; n=878 patients) was found. The study found that intervention site providers consistently demonstrated enhanced motivational interviewing skills compared with control providers, and intervention patients had an 8% reduction in Alcohol Use Disorders Identification Test (AUDIT) hazardous drinking relative to controls over the course of the year after injury, particularly among patients without traumatic brain injury.	An expert said there are concerns about the commissioning [or rather lack of commissioning] of services and the effect that the lack of resources has on the delivery of services.	systems Improvement Tool.' See Editorial and factual corrections below. Topic expert feedback also indicated that there is a lack of resources to fulfil the requirements of the recommendations in this guideline. Whilst budget constraints are a factor that may impact implementation, the guideline is intended to be cost-effective and offer a return on investment. It is acknowledged, however, that the changing budgetary landscape will affect commissioning decisions.

Recommendation 6: supporting children and young people aged 10 to 15 years

Recommendation 7: screening young people aged 16 and 17 years

2014 surveillance	Topic expert feedback suggested that there is an overlap between recommendations 6 and 7 in PH24, and recommendations 1.3.7.1 to 1.3.7.4 in NICE	New published evidence indicates that an AUDIT-C threshold of 3 may be helpful in identifying at-risk alcohol use in adolescents, whilst an AUDIT

Surveillance evidence summary	Intelligence gathering	Impact statement
In previous surveillance of this guideline, no studies relevant to this section of the guideline were identified. **2019 surveillance** One cross-sectional survey (15) to determine the AUDIT and AUDIT-C cut-off values for identifying alcohol misuse in adolescents aged 10-18 years in emergency departments was found (n=5377). The study found that AUDIT-C with a score of 3 was more effective for identifying at-risk alcohol use, heavy episodic use and alcohol abuse. AUDIT with a score of 7 was more effective in identifying alcohol dependence.	guideline CG115. In particular, both guidelines cover initial assessment, however views were mixed on whether the guidelines are complementary or at odds. Furthermore, NICE guideline PH24 recommendation 6 does not recommend using AUDIT in the 10 to 15 age group whereas CG115, in the context of treatment, does. Another topic expert felt that recommendation 6 strays into support and management of alcohol problems in children – which is the focus of CG115; whereas the focus should be limited to identifying children at-risk of alcohol problems. Experts also advised that there is a lack of clarity on how to lower the AUDIT screening threshold for young people (see also PH24 recommendation 9). In particular, PH24 recommends assessment of alcohol use is conducted using common assessment framework for this cohort whereas CG115 1.3.7.1 recommends that if alcohol misuse is identified as a potential problem in any children and young people aged 10 -17 years, an initial brief assessment should be conducted to assess severity and duration of alcohol misuse – this recommendation goes on to say that the standard adult threshold on the AUDIT for referral and intervention should be lowered for young people aged 10–16 years because of the more harmful effects of a given level of alcohol consumption in this population) but it does not specify what thresholds should be used.	score of 7 was more effective in identifying alcohol dependence. This evidence was in an emergency department setting and it is unclear if this can be extrapolated to other settings. However, this new evidence could be used to provide greater clarity on screening thresholds in young people and could possibly alter the recommendation, which does not currently specify screening thresholds in young people aged 10-17 years. Some topic experts suggested that there might be an overlap between recommendations 6 and 7 within PH24 and recommendations 1.3.7.1 to 1.3.7.4 in CG115. However, other experts identified a clear distinction between the 2 guidelines, with PH24 focused on prevention and CG115 on treatment. The guidelines are intended to be complimentary but with different settings, and as such no change is deemed necessary in either guideline to address this. A topic expert highlighted that recommendation 7 does not mention that clinicians may wish to modify AUDIT thresholds in young people, although this is advised later on in recommendation 9 (adults). An editorial amendment will be made to recommendation 7 to add 'use professional judgement as to whether to revise the AUDIT scores downwards when screening people under the age of 18'. See Editorial and factual corrections below.

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	PH24 recommendation 7 does specifically mention using AUDIT but only in the 16 to 17 age group – it indicates that a validated screening tool should be used with 16-17 year olds but doesn't mention that clinicians may wish to modify the thresholds used to determine appropriate responses to the AUDIT score. This is mentioned later in the guidance (PH24) within recommendation 9 – screening adults – but it would be more helpful if this was actually specified in this section.	New evidence may change guideline recommendations.

Recommendation 8: extended brief interventions with young people aged 16 and 17 years

2014 surveillance In previous surveillance of this guideline one RCT (16) assessed the effectiveness of a brief motivational intervention in young people aged 14–21 years (n=853) presenting to the paediatric emergency department who screened positive for high risk or dependent drinking. Overall, compared with the assessed control group, people in the intervention group had no significant difference in trying to cut back on drinking (73.3% versus 64.9% respectively, p=0.065); however, a statistically significant difference was seen in trying to quit drinking (40.5% versus 27.8% respectively, p=0.007) and in trying to be careful	No topic expert feedback was relevant to this section.	The published evidence across the surveillance review time points suggests that extended brief interventions and motivational interviewing may be effective in reducing drinking, drinking related violence and depressive symptoms in young people and adolescents. However, the evidence base was generally limited by heterogeneity in outcomes, populations and settings, which hinders interpretation. Furthermore, studies in people aged 16 to 17 was not available. Despite these limitations, the evidence appears to be in line with the guideline that recommends arranging extended brief interventions for young people. This issue will be revisited at the next surveillance time point.

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when drinking (80.5% versus 71.3%, p=0.03). When the results were stratified by age, none of the outcomes were statistically significantly different between intervention and control groups for those aged 14–17 years (n=57). For those aged 18–21 years (n=359), all outcomes were significantly different: tried to cut back on drinking (73.9% versus 63.0%, p=0.028); tried to quit drinking (41.5% versus 26.9%, p=0.004); tried to be careful when drinking (81.7% versus 69.2%). One systematic review (17) assessed the effects of treatments to reduce alcohol use in young people, and to compare individual treatments with family-based approaches. The review included 16 studies: about two-thirds of studies were of individual treatments and the remaining third assessed family interventions. All studies included young people aged under 19 years. All tested interventions reduced alcohol use (overall Hedges g=−0.62, 95% CI −0.83 to −0.40); however, the effects were not always significant. The intervention with the largest effect size was cognitive behavioural therapy integrated with 12 steps (−1.91 (95% CI −2.37 to −1.61). One systematic review (18) of RCTs assessed brief interventions delivered to young people in the emergency department for reducing harmful and hazardous use of alcohol and other drugs. The authors noted that the evidence was inconsistent		New evidence is unlikely to change guideline recommendations. Note that PH24 did not make any recommendations on brief interventions in people aged 16-17 years. For new evidence of brief interventions in this age group see the section on 'Areas not covered' in the guideline below.

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and limited by variation in outcomes reporting and study quality. **2019 surveillance** One systematic review (19) of motivational interviewing delivered in a brief intervention during an emergency care contact was found (6 trials, n=1,433 participants aged 13-25). The review found that motivational interviewing was as effective as control interventions. Two trials found significantly reduced alcohol use in the motivational interviewing groups. One trial found that motivational interviewing may be most effective in young people with high-volume alcohol consumption. One RCT (20) of a drinking-motive-tailored intervention for adolescents hospitalised following alcohol intoxication, compared with a non-motive-tailored intervention was found (n=254 adolescents). All adolescents reported lower alcohol use at the four-week follow-up irrespective of intervention. There was a significant interaction effect between time and intervention for girls in terms of drinking frequency (F = 7.770, p < 0.01) and binge drinking (F = 7.0005, p < 0.05) but not for boys.		

Surveillance evidence summary	Intelligence gathering	Impact statement
Recommendation 9: screening adults		
2014 surveillance In previous surveillance of this guideline 2 studies were identified. One systematic review and meta-analysis (21) of 8 randomised trials (n=2340) of brief interventions to evaluate the effects of asking questions about drinking behaviour found that answering questions on drinking did not significantly reduce total weekly drinking, (−13.71 g ethanol, 95% CI 0.17 to −27.60 g, p=0.582; 8 studies), daily drinking (−0.25 g ethanol, 95% CI 3.36 to −3.86 g, p=0.57; 6 studies), or AUDIT scores (−1.01, 95%. CI 0.12 to 1.91, p=0.09; 4 studies). One cluster randomised trial (22) (n=3609) in 16 primary healthcare practices in Sweden compared universal screening with consultation-based early identification in the detection of risky drinking (a form of targeted screening). In the original intended analysis of results, no significant differences were seen between the 2 intervention periods. However, universal screening may detect risky drinking at an earlier stage than consultation-based screening. **2019 surveillance**	Experts advised that the recommendation does not provide clarity on screening thresholds for older people, people from different ethnic minority groups and the lesbian, gay and bisexual community (LGBT) community. Experts provided a number of references which were incorporated in the 2019 surveillance summary as appropriate.	The published evidence across the surveillance review time points suggests that 2 questions can identify patients at-risk of alcohol misuse, but the 10 item AUDIT identification tool was found to be the most effective single tool in primary care. Published evidence from 1 study also suggests that universal screening may detect risky drinking at an earlier stage than consultation-based screening. Simply asking about drinking did not change drinking behaviour. This evidence is in line with the recommendation to carry out alcohol screening as an integral part of current practice, and to use a validated tool such as AUDIT. **New evidence is unlikely to change guideline recommendations.** Recommendation 9 will be editorially amended to remove the bullet point which says: 'Use professional judgement as to whether to revise the AUDIT scores downwards when screening… younger people (under the age of 18)'. This information will be included in recommendation 7, which covers screening young people aged 16

Surveillance evidence summary	Intelligence gathering	Impact statement
One meta-analysis (23) of brief screening consisting of one or 2 questions, used alone or in combination with longer tests, was found (17 studies). After adjustments, diagnostic accuracy of a single-question approach had a sensitivity of 54.5% and a specificity of 87.3% using meta-analytic weighting. Two questions had a sensitivity of 87.2% and specificity of 79.8%. The 10-item AUDIT questionnaire was found to be the most accurate single tool for identifying alcohol use disorders, followed by the 4-item Cut Annoyed Guilty Eye (CAGE) questionnaire. There were several studies focused on combined screening and brief interventions, which are discussed under recommendation 10 below.		and 17 years old. See Editorial and factual corrections below.

Recommendation 10: brief intervention for adults

2014 surveillance Brief advice in primary care In previous surveillance of this guideline one meta-analysis (24) of 13 studies (n=4,140 participants) of brief intervention for reduction of alcohol use delivered in primary care by healthcare staff other than doctors. Meta-analysis	Topic expert feedback indicated that the guideline should not be advising every setting to deliver alcohol screening and brief intervention, but only those settings where research shows an intervention is effective. A topic expert also highlighted that older drinkers are a group that may need focused attention.	Brief advice in primary care Although there were some mixed findings, overall the evidence from 8 studies suggests that screening and brief alcohol interventions in primary care may be effective and cost-effective. One meta-analysis indicated that interventions may be especially effective in reducing hazardous or harmful drinking in middle-aged male drinkers.

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was possible for 7 studies (n=2210), which showed a non-statistically significant reduction of 1.73 standard drinks per week (95% CI −0.03 to 3.50, p=0.054). One study appeared to contribute disproportionate heterogeneity, and exclusion of this study resulted in a slightly smaller effect size, but the reduction in mean number of drinks was now statistically significant (mean difference=1.36, 95% CI 0.30 to 2.43, p=0.012). One pragmatic randomised trial (25) of 3 brief interventions in 34 primary care practice clusters in England to reduce harmful and hazardous drinking was identified (n=756). At baseline, 622 (82%) people screened positive for hazardous or harmful drinking. The majority of patients (99% or more) received the booklet and brief intervention. However, only 57% (n=143) of those allocated to brief lifestyle counselling attended the subsequent session. The proportion of participants who screened negative on AUDIT was increased at 6 months compared with baseline in all groups, but the difference between groups was not significant. In an update of the modelling used in the development of NICE PH24, one study (26) modelled the cost-effectiveness of screening and brief intervention to prevent alcohol use disorders in primary care. For screening at registration at a general practice, about 2.5 million people would have screening each year, with a steady		This evidence complements the recommendations in NICE PH24, which recommends primary care as a setting for brief intervention. Brief interventions in emergency departments The published evidence from 9 studies found mixed effects for brief interventions in the emergency department, although the studies were heterogeneous in terms of populations, outcomes and types of brief intervention. Telephone brief intervention after discharge was shown to have some effects in reducing alcohol-related injuries up to 12 months, but did not show significant effects for other outcomes. An intervention in young adult participants with risky driving and hazardous drinking found some effects at 6 and 9 months, but not at 12 months. Two further systematic reviews failed to show an effect. Overall, the evidence showed mixed results, although interpretation is complicated by the evidence being heterogeneous. Screening and brief intervention in sexual health clinics Published evidence from 3 studies suggests that brief interventions delivered in sexual health clinics may be acceptable to patients in this setting but may not be effective in reducing drinking or unprotected sex. Evidence from a UK HTA also indicates that universal screening and brief

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distribution over time and an annual cost of about £10 million. After 10 years, 33–40% of hazardous and harmful drinkers would have received an intervention. For screening at the next general practice appointment, about 35 million people would be screened in the first year, so most of the cost of the programme (£700 million overall) would accrue in the first few years. After 10 years, 71–89% of hazardous or harmful drinkers would have received an intervention. **Brief intervention in emergency departments** One RCT (27) assessed a brief intervention to reduce the risk of all injuries, alcohol-related injuries, and serious injuries in adults admitted to an urban emergency department in the USA. Generally, no statistically significant effect was seen for injury outcomes at 6 months or between 6 and 12 months – although black participants receiving the brief intervention had a higher risk of any injury in the second 6-month period (28 injuries) than black participants in the control group (14 injuries, RR=1.92, 95% CI 1.05 to 3.53). However, because the number of injuries was fairly low, this finding may be due to chance, and alcohol-related injuries did not show a corresponding increase. **Screening and brief intervention in sexual health clinics**		intervention in sexual health clinics might not be effective or a cost-effective use of resources. This HTA of brief intervention also included an offer of an alcohol health worker follow-up, so was actually broader than simple screening and brief intervention. This evidence could change guideline recommendations which currently do not limit or specify which settings should be providing brief intervention. **Brief interventions for people admitted to hospital (for reasons unrelated to alcohol-use)** The published evidence from a Cochrane review suggests that brief interventions delivered in a hospital setting may be effective in reducing alcohol consumption at 6 and 9 months, but by 12 months the effects were not maintained. The review also found a reduction in deaths at 12 months, but suggested that further research was warranted to determine the optimal content of interventions and identify populations in whom interventions work best. Another review found no effects but was unable to pool data. This evidence is broadly in line with the guideline as PH24 does not limit the setting for brief interventions. However, it may be warranted to update the guideline to strengthen the wording around the delivery of brief advice specifically in inpatient settings. This may be particularly important to

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On study (28) of screening and brief intervention delivered by a nurse in a sexual health clinic in Australia. Effectiveness was measured by participants' recall of the intervention and change in self-reported drinking behaviour or reduction in consumption at 3 months. People aged 16 years and older were asked whether they wished to participate in a survey about alcohol whilst they waited to see clinic staff. Follow-up was completed by 66 people in the intervention group and 67 people in the control group. Overall, 31% of people reduced their drinking to a level at which their drinking was no longer categorised as harmful or hazardous. AUDIT score reduced significantly from baseline in the intervention (-3.3, 95% CI -2.1 to -4.8, $p<0.001$) and the control (-2.2, 95% CI -1.06 to -3.4, $p<0.01$) groups, but the difference between groups was not significant. The advice was acceptable to 53 (80%) participants in the intervention group and to 46 (70%) participants in the control group.		ensure concordance with PHE's CQUIN 9, preventing ill health by risky behaviours – alcohol and tobacco (see Health Matters), which applies to community, mental health and acute providers and covers adult inpatients who are admitted for at least 1 night (excluding maternity).
Brief interventions for people admitted to hospital (for reasons unrelated to alcohol-use)		Brief interventions delivered by community pharmacists
One Cochrane review (29) of brief interventions to reduce alcohol use disorders in people aged 16 years and over who were admitted to hospital for reasons other than alcohol treatment. In 8 studies (n=2196), brief intervention significantly reduced		The published evidence from 1 RCT suggests that brief interventions delivered by community pharmacists are not effective in reducing alcohol use. The trial was conducted in the UK and may be sufficient to indicate that brief interventions are not effective when delivered by pharmacists. As such, this could change guideline recommendations which currently do not limit which settings should be providing brief intervention.
		Brief interventions in the judicial system
		The published evidence from 2 reviews highlights that there is a lack of research for brief interventions in a judicial setting; however, 1 study found a benefit of brief interventions in this setting, providing some indication that brief interventions may be effective in this setting.
		Brief interventions in women

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alcohol consumption in grams of ethanol per week compared with control at 6 months (mean difference=−69.43 g, 95% CI −128.14 to −10.72 g, p=0.02) and at 9 months (mean difference=−182.88 g, 95% CI −360.00 to −5.76 g, p=0.043), but not at 12 months. The studies reporting outcomes at 6 months had significant heterogeneity, so a sensitivity analysis was done, excluding 1 non-blinded study that included additional follow-up care. After sensitivity analysis, the result at 6 months was not significant. In 3 studies (n=1318) in which mean alcohol consumption per week was measured by change in score from baseline, no significant differences were recorded compared with control. One systematic review (30) of any alcohol intervention, including brief interventions, for people admitted to hospital for reasons other than alcohol-use was identified (22 studies). The review was unable to pool results in a meta-analysis, but narratively found that there was no evidence of effect for most interventions, including brief interventions. **2019 surveillance** There were 24 systematic reviews, 1 health technology assessment and 26 RCTs of brief interventions in adults. To avoid double-counting RCTs that are included within the reviews, only		suggests that brief interventions may be effective in women, particularly pregnant women and college students. Brief interventions in military personnel A systematic review found that self-administered web-based interventions, involving personalised feedback over a number of sessions, and system-level electronic clinical reminders may be effective. Brief interventions in older adults Published evidence from 1 systematic review suggests that brief interventions may be effective in older adults with greater effect delivered by more intensive therapies. A topic expert also highlighted that older drinkers are a group that may need focused attention. Brief interventions/motivational interventions in higher education Published evidence from 3 systematic reviews suggests that brief interventions and motivational interventions may reduce alcohol consumption compared with control in higher education students. This evidence supports NICE PH24, which recommends delivering brief intervention to adults in higher education settings.

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the systematic reviews are summarised, with only a brief overview of RCTs at the end of this section. The exceptions are the RCTs conducted in community pharmacy (1 RCT), occupational health (1 RCT) and sexual health (1 RCT) settings, all of which were not covered by systematic reviews. ## Brief interventions in primary care One Cochrane review (31) assessing the effectiveness of a screening and brief alcohol intervention to reduce excessive alcohol consumption in hazardous or harmful drinkers in general practice or emergency care settings was found (69 studies; n=33,642 participants). 'Brief intervention' was defined typically as a conversation of 5-15 minutes in duration with a doctor or 20 to 30 minutes with a nurse and delivered in 5 or fewer sessions of brief intervention or brief lifestyle counselling with a total duration of less than 60 minutes. Digital interventions were excluded. Results indicated that participants who received brief intervention consumed less alcohol than minimal or no intervention participants after one year (mean difference (MD) -20 g/week, 95% confidence interval (CI) -28 to -12), and both men and women reduced alcohol consumption after receiving a brief intervention. However, brief alcohol interventions had little impact on drinking days per		## Brief interventions in people with comorbid mental health conditions The published evidence from 1 review indicates brief interventions may have some effects in people with comorbid mental health conditions, but the review was inconclusive. Currently PH24 suggests offering brief interventions to all adults identified via screening as consuming hazardous or harmful amounts of alcohol. This new evidence does not appear to contradict current recommendations. ## Brief interventions in occupational health The published evidence from 1 RCT suggests that brief interventions delivered in occupational health may not be effective in reducing drinking. This evidence could change guideline recommendations which currently do not limit which settings should be providing brief interventions. ## Nurses delivering brief interventions The published evidence from 1 review suggests that brief interventions delivered by nurses are effective and may be more effective than those delivered by physicians. This evidence is in line with recommendations in NICE PH24, which recommends trained professionals should deliver the advice.

Surveillance evidence summary	Intelligence gathering	Impact statement
week, frequency of binges per week, or drinking intensity. Longer counselling duration had little additional effect. A review (32) of systematic reviews and meta-analyses of the effectiveness of brief alcohol intervention in primary healthcare was found (24 systematic reviews). Results found that brief interventions were effective for addressing hazardous and harmful drinking in primary healthcare, particularly in middle-aged, male drinkers. The effectiveness was unclear in older and younger drinkers, women, minority ethnic groups, and dependent/comorbid drinkers. On review of systematic reviews and meta-analyses (33) of brief interventions delivered in primary health care to non-alcoholic adult drinkers was found (7 studies). The review of reviews found that 5 studies reported a decrease in alcohol consumption and 4 showed a decrease in the number of participants who consumed alcohol above the established risk level. Brief interventions with multiple contacts or follow-up sessions were found to be the most effective. One systematic review (34) of cost-effectiveness analyses (22 studies) of screening and brief intervention programmes in primary care found that almost all studies reported screening and brief intervention programmes to be cost-effective, although there was significant heterogeneity		**Brief interventions in adults – summary of the overall evidence base** When the guideline was developed there was limited evidence on brief interventions for some settings and in different populations. The committee extrapolated evidence of effect from settings and populations to those where there was no clear evidence. There is new published evidence on brief interventions in various settings and delivered by different practitioners and to different populations. The published evidence from 1 systematic review indicates that the effectiveness of a brief intervention is not modified by the setting or practitioner delivering the intervention (note, the abstract does not clarify the settings in this instance), but did note that practitioners affected the effectiveness of brief interventions with interventions delivered by nurses being the most effective in reducing quantity of alcohol consumed. This correlates with another review which found that nurse-delivered brief interventions were more effective than physician-delivered interventions. However, evidence from other systematic reviews and RCTs conducted in specific settings appear to indicate that brief interventions are effective in specific settings, notably primary care, but may be ineffective in other settings, notably sexual health

Surveillance evidence summary	Intelligence gathering	Impact statement
across studies. There was no clear evidence that either the duration of the intervention or the delivery staff used had a substantial impact on this result.		clinics and community pharmacies. Likewise, there appear to be specific populations, such as pregnant women and older adults who may benefit from brief interventions.

Brief interventions in the emergency department

On systematic review (35) of screening and brief intervention in the emergency department was found in patients aged 12-70 years of age (35 studies). The review found that 13 studies reported significant differences between control and brief intervention groups in terms of number of drink days and number of units per drink day. Sixteen studies showed a reduction of alcohol consumption in both the brief intervention and control groups; of which 7 studies did not identify a significant effect for brief intervention for the main outcome, whilst 9 studies found some significant effects of brief intervention for subgroups.

One realist review (36) of brief interventions in emergency departments was found (36 studies). The review found 4 mechanisms: engagement in/retention of brief intervention materials; increased awareness into consequences of drinking; resolving ambivalence; and increased empowerment to use skills for change. The contexts that impacted mechanisms were: emotional state; severity of alcohol use; injury

During the current surveillance review, topic expert feedback highlighted new evidence on settings and indicated that it may be warranted for the guideline to be updated so that it did not recommend that all settings should be delivering brief interventions, but only those settings where it has been proven to be effective.

Given this new evidence and advice from experts, the guideline recommendation on brief interventions for adults may need updating to clarify the settings or populations where alcohol brief interventions are shown to be effective. It will also be important for the committee to consider the barriers to implementation or other factors that can explain the lack of effectiveness in specific settings.

It should be noted that the current surveillance review used the definition of a brief alcohol intervention from abstracts in the included studies. It was not always possible to discern if the brief interventions included within the studies encompassed very brief intervention, brief intervention, and extended brief intervention as

Surveillance evidence summary	Intelligence gathering	Impact statement
attributed to alcohol use; and baseline stage of change.		defined within Behaviour change: individual approaches (NICE guideline PH49).
One systematic review of (37) brief interventions in emergency departments was found (23 RCTs; n=15,173 participants). For injury studies at 6-month follow-up, an effect in favour of brief intervention over control was found (SMD = -0.10; 95% CI -0.17 to -0.02). For pooled non-injury specific studies, small benefits of brief intervention were found at 5-months or less follow-up, at 6-month follow-up, and at 12-month follow-up (SMD = -0.08; 95% CI -0.15 to -0.01).		New evidence may change guideline recommendations.
One systematic review (38) of brief interventions in emergency departments was found (34 studies). The review found that all studies reported a significant reduction in alcohol consumption at 3 months following the brief intervention, with some studies finding significant differences between the brief intervention and control groups, and other studies finding no between groups differences but significant decreases in both arms. At 6 and 12 months follow-up the majority of studies did not find significant between group differences in terms of decreases in alcohol consumption, although people who received a brief intervention were significantly less likely to have an alcohol-related injury at 6 or 12 months post-intervention than individuals who did not receive a brief intervention.		

Surveillance evidence summary	Intelligence gathering	Impact statement
One systematic review (39) of ultra-brief interventions in adults and adolescents in emergency departments was found (13 studies). The review found that at 3 months 6 studies showed a significant reduction in the quantity of alcohol consumed with an intermediate effect size (d = -0.40), and a small effect size at 12 months (d = -0.15). At 3 months 2 studies showed a significant reduction in binge drinking with a small effect size (d = -0.12) and a small effect size 12 months (d = -0.09). No studies showed an effect on emergency department visits or frequency of alcohol consumption. One systematic review (40) of brief interventions delivered in emergency departments to young adults ages 18-24 was found (4 trials; n=618 participants). The review found that 2 studies showed motivational interview was significantly associated with a reduction in alcohol use whilst 2 studies showed no effect. The successful interventions were found to be either delivered at a distance from the event or to include booster sessions. The benefits were sustained over 12 months. One systematic review (41) of brief interventions delivered in emergency departments was found (28 studies; n=14,456 patients). The review found that 6 out of 9 comparisons showed small		

Surveillance evidence summary	Intelligence gathering	Impact statement
significant effects in favour of brief intervention. No significant moderators of effect were found. One systematic review (42) of brief interventions delivered in emergency departments was found (7 studies). The review found that onsite brief intervention was effective compared with control, but there was no evidence it was effective when compared to active control conditions. Referral to post-discharge brief interventions was not found to be effective when used alone or in addition to onsite brief intervention. ### Brief interventions delivered in sexual health clinics One UK HTA (43) including an RCT and cost-effectiveness analysis of universal screening and brief intervention, versus a control arm leaflet on lifestyle and health, in adults in sexual health clinics in London was identified (n=802 participants). The brief intervention was delivered by the treating clinician and included feedback on the consequences of excessive drinking, a discussion of whether the participant's clinic attendance was alcohol-related, written information on health and alcohol, and an offer of an appointment with an alcohol health worker. The trial found that there was no significant difference in the adjusted mean difference in alcohol consumption after 6 months, or rates of		

Surveillance evidence summary	Intelligence gathering	Impact statement
unprotected sex, between the intervention and control groups. The brief intervention was found to cost on average £12.60 per person to deliver and was not deemed a cost-effective use of resources. One RCT (44) of brief intervention versus leaflet control group in adults attending sexual health clinics was found (n=802 participants). The trial found a small non-significant reduction in alcohol consumption at 6 months with brief intervention compared with control group (p=0.053), likewise there was no significant difference in unprotected sex or costs between the groups. ## Brief interventions delivered by community pharmacists One RCT (45) of brief interventions delivered by community pharmacists in the UK versus leaflet only controls to reduce hazardous or harmful drinking was found (n=407 adult participants). The trial found that at 3 months follow-up there was no difference in AUDIT scores for brief intervention versus leaflet participants. The control leaflet group had improved scores for alcohol dependence (p=0.014) and health status scores (0.013). ## Brief interventions in the judicial system A systematic review (46) of brief alcohol interventions in at different stages of the UK		

Surveillance evidence summary	Intelligence gathering	Impact statement
criminal justice system was found (number of studies not reported). The review highlighted that there is a lack of evidence of the effectiveness of brief intervention in the various stages of the criminal justice system, primarily due to the lack of follow-up data. A systematic review (47) of brief intervention and extended brief intervention for incarcerated people was found (9 studies; 6 brief intervention and 3 extended brief intervention). The review found that 3 of the studies of brief intervention found significant reductions in alcohol use as did all of the studies of extended brief intervention. The authors noted that the studies used different measures of alcohol use which limits interpretation. ### Brief interventions in women A systematic review (48) of brief alcohol interventions in women (36 studies) was found. This review identified what was described as 'promising results' of brief interventions for women, especially pregnant women and female college students, in different forms of application (face-to-face, by computer or telephone), but results were less clear in primary care (effect sizes not reported in the abstract). In general, the results indicated a decrease in both in the number		

Surveillance evidence summary	Intelligence gathering	Impact statement
of days of consumption and the number of doses of alcohol. ### Brief interventions in military personnel A systematic review (49) of brief alcohol interventions in military personnel was found (10 studies). The review found some evidence that self-administered web-based interventions, involving personalised feedback over a number of sessions, and system-level electronic clinical reminders may be effective. The delivery of interventions by a clinician during motivational interviews was found to be most effective for those with post-traumatic stress disorder symptoms. ### Older adults One systematic review (50) of interventions to reduce or prevent alcohol misuse in older adults (55+ years) was found (13 studies). The review found an overall intervention effect for 3-month and 6-month outcomes combined (SMD = -0.18; 95% CI -0.28 to -0.07) and 12 month outcomes (SMD = -0.16; 95% CI -0.32 to -0.01). Three studies suggested more intensive interventions with personalised feedback, physician advice, educational materials, follow-up could be most effective. However, more simple interventions including brief intervention, leaflets, alcohol assessments with advice to reduce drinking could also have a positive effect.		

Surveillance evidence summary	Intelligence gathering	Impact statement
Brief interventions/motivational interventions in higher education One individual participant-level meta-analysis (51) of brief motivational interventions in college students was found (17 trials; n=6,713 participants). The review found that estimates of the effectiveness of brief interventions were very small and not statistically significant for any of the outcomes. Post hoc analysis found a small, statistically significant reduction in alcohol problems with individual motivational intervention with personalised feedback. Both the short-term and long-term results were reportedly similar. One systematic review (52) of alcohol interventions for college students, including brief intervention and motivational interventions, was found (49 studies). The review found that interventions decreased drinking (n=34), reduced alcohol problems or consequences (n=8), and decreased peer perception of alcohol use (n=4). The most effective interventions included a brief, personalised consultation with a trained facilitator. One systematic review (53) of single session alcohol interventions for heavy drinking college students was found (73 studies). Brief interventions were found to significantly reduce alcohol use among heavy drinking college students compared with comparison conditions		

Surveillance evidence summary	Intelligence gathering	Impact statement
(overall mean effect size of g=0.18; 95% CI 0.12 to 0.24). Studies using motivational enhancement therapy/motivational interviewing elements reported larger effects than those using psychoeducational therapy interventions.		

Brief interventions among people with comorbid mental health conditions

One systematic review (54) of brief intervention for alcohol among adults with risky alcohol consumption and comorbid mental health conditions was found (17 RCTs). Compared with a minimally active control, brief intervention had mixed effects, a significant reduction in alcohol consumption in 4/9 RCTs in common mental disorders and 2/5 RCTs in severe mental illness. Compared with an active comparator, brief intervention also demonstrated mixed results. The authors noted considerable heterogeneity in study populations, brief intervention delivery mode and intensity, outcome measures and risk of bias.

Brief interventions in occupational health

An RCT (55) of brief intervention (informative advice using motivational approach, with 10-minute average duration) compared with control group (informational booklets) in participants (n=787 participants) consulting their occupational doctor was found. Participants in the brief intervention group had a lower AUDIT score

Surveillance evidence summary	Intelligence gathering	Impact statement
(p=0.01), a higher reduction in reported consumptions (p=0.04). The control group reduced their AUDIT scores below hazardous levels by 44.8% compared to 51.6% in the brief intervention group (p=0.15).		

Brief interventions delivered by nurses

A systematic review (56) of brief alcohol interventions delivered by nurses was found (11 trials). The review found that 5 trials reported a statistically significant reduction in alcohol consumption at 6-12 month follow-up in the intervention group, and 2 trials found that brief intervention delivered by nurses were as effective as those delivered by physicians.

Settings of brief intervention

A systematic review (57) of the effectiveness of brief intervention across different settings (52 trials; n=29,891 participants) found that neither the setting nor content appeared to significantly moderate intervention effectiveness (settings and content are not specified in the abstract). However, the type of provider influenced results, with interventions delivered by nurses being the most effective in reducing quantity (d=-0.23, 95% CI -0.33 to -0.13) but not frequency of alcohol consumption. All groups had statistically significant mean effects, although brief intervention was the most effective in reducing

Surveillance evidence summary	Intelligence gathering	Impact statement
quantity consumed (d=-0.20, 95% CI -0.30 to -0.09). Effects were maintained at the first and last assessment time using stratified sensitivity analysis. ## Overview of RCT level evidence on brief intervention There were an additional 22 RCTs (25,58,67–76,59,77,78,60–66) on brief intervention across a range of settings such as emergency department, primary care, and hospital inpatients. The populations, follow-ups and outcomes of the trials varied greatly. Likewise, the results differed with some studies showing positive effects of brief intervention in specific settings and populations, but others finding no effect.		

Recommendation 11: extended brief interventions for adults

2014 surveillance Primary care One systematic review and meta-analysis (79) to evaluate screening followed by behavioural counselling for alcohol use disorders in primary care included 23 RCTs of at least 6 months' duration in adults or young people identified by	A topic expert highlighted that 'older drinkers are a group that may need focused attention'.	Primary care The published evidence suggests that extended brief, multi-contact or stepped care interventions delivered in primary care may be effective in reducing alcohol consumption, but the advantage over brief interventions is not statistically significant in older adults. One study found stepped care to be cost-effective compared with 5

Surveillance evidence summary	Intelligence gathering	Impact statement
screening in primary care and reporting behavioural or health outcomes. Extended multi-contact interventions were statistically significantly associated with a reduction in alcohol consumption at 12 months (mean difference=−2.546 drinks per week, 95% CI −4.767 to −0.325 drinks per week, p=0.025), but brief single contact interventions had no statistically significant effect. Brief single contact interventions (risk difference=0.079, 95% CI 0.039 to 0.120, p<0.001) and very brief intervention (risk difference=0.080, 95% CI 0.019 to 0.141, p=0.01) were effective for achieving recommended drinking levels at 12 months. Both brief multi-contact and extended multi-contact interventions were statistically significantly better than control for reducing heavy drinking episodes at 12 months (risk difference=0.118, 95% CI 0.074 to 0.162), but brief interventions were not. No statistically significant differences in mortality were seen for any type of intervention, and no evidence of direct harms of interventions was noted. **2019 surveillance** Primary care One study (80) of a stepped care intervention versus a minimal intervention in the treatment of older (≥55 years) hazardous alcohol users in		minute brief intervention, but the result was not statistically significant. Young adults The published evidence from 2 reviews, including a Cochrane review, suggests there are no clear benefits of motivational interviewing or extended brief interventions in young people, but college students aged up to 25 showed some improvements. Men who have sex with men The published evidence suggests that motivational interventions may be effective treatment for heavy drinking compared with no treatment. Emergency department The published evidence suggests there is no advantage of extended brief interventions compared with screening and advice in the emergency department setting. Pregnant women The published evidence suggests there is no advantage of brief motivational enhancement therapy compared with usual care in pregnant women. Older adults Published evidence suggests that screening followed by more intensive interventions may be

Surveillance evidence summary	Intelligence gathering	Impact statement
primary care in England and Scotland was found (n=529 patients). The minimal intervention group received a 5-minute brief intervention with the practice or research nurse, whilst those in the stepped care arm initially received a 20-minute session of behavioural change counselling, with referral to step 2 (motivational enhancement therapy) and step 3 (local specialist alcohol services) if needed. The study found that both groups reduced alcohol consumption between baseline and 12 months. The difference between groups in log-transformed average drinks per day at 12 months and 6 months was not statistically significant. The mean Quality adjusted life year (QALY) gains were slightly greater in the stepped care group than in the minimal intervention group, resulting in an incremental cost-effectiveness ratio (ICER) of 1100 per QALY gained, but the result was not statistically significant. Young adults One Cochrane review (81) of motivational interviewing (the majority of trials include sessions of 1 hour or less) for the prevention of alcohol misuse in young adults aged up to 25 years was found (84 trials; n=22,872). The review included studies in young people under 18 but the majority of studies had a mean age of 18 years or older. The review found no clinically meaningful benefits		the most effective and cost-effective interventions for older adults. Interventions with the most promise included stepped care, and patient and provider educational materials. Currently PH24 does not specify which interventions are most effective for older adults. A topic expert also highlighted that 'older drinkers are a group that may need focused attention'. Thus, this new evidence may be something that would enable alcohol services to be better targeted to the needs of older drinkers as a specific subgroup. Extended brief interventions – summary of overall evidence base The published evidence on extended brief interventions seems to indicate that interventions may not be effective in all populations and settings. Currently NICE guideline PH24 recommends offering extended brief interventions to all adults who have not responded to brief structured advice on alcohol, but does not specify or limit to the setting or populations where there may be an effect. Given this new evidence, the guideline recommendations on extended brief interventions for adults may need updating. New evidence may change guideline recommendations.

Surveillance evidence summary	Intelligence gathering	Impact statement
of motivational interviewing interventions for preventing alcohol use, misuse or alcohol-related problems in young adults. There was no clear relationship between the duration of the intervention and effect size. One systematic review (82) of motivational interviewing interventions for reducing alcohol consumption among college students was found (13 studies). The review found that motivational interviewing interventions were effective in reducing alcohol consumption among college students, compared to alternative interventions or no intervention. The potential moderators of motivational interviewing intervention effectiveness were practitioner's adherence to motivational interviewing techniques and individual's drinking motivations. An RCT (83) of a 10-minute brief intervention, a 50-minute brief intervention, or an attention-control group aimed at reducing alcohol use and alcohol-related negative consequences among college student drinkers was found. Participants in both active conditions statistically significantly reduced their alcohol consumption, as compared to the control group participants, but there were no statistically significant differences in alcohol-related negative consequences. Men who have sex with men		

Surveillance evidence summary	Intelligence gathering	Impact statement
One systematic review (84) of interventions to reduce heavy drinking and/or alcohol-related problems among men who have sex with men was found (5 RCTs, n=1,022 participants). The review found preliminary support for the use of motivational interviewing/motivational enhancement-based interventions, and hybrid motivational interviewing and cognitive behavioural therapy treatments for heavy drinking over no treatment. However, the authors deemed that more research is needed. **Emergency Departments** One RCT (85) of extended brief interventions (up to 6 counselling sessions) compared with usual care which included screening and advice on alternative services (n=267 participants) was found. The trial found no statistically significant difference between groups in the Severity of Alcohol Dependence Questionnaire, alcohol consumption and readiness to change. However, all secondary outcome measures improved, on average, in both arms. **Pregnant women** One RCT (86) of usual care or up to 5 face-to-face brief motivational enhancement sessions lasting 10-30 minutes each in pregnant women was found (n=251 included women). The trial found that, compared with usual care, women receiving the		

Surveillance evidence summary	Intelligence gathering	Impact statement
brief motivational enhancement sessions had a non-statistically significant reduction in odds of using any alcohol (p=0.08) and a non-statistically significant consumption of fewer drinks per day (p=0.07). The authors noted that missing data hampered the analysis. **Older adults** One systematic review (50) of interventions to reduce or prevent alcohol misuse in older adults (55+ years) was found (13 studies). The review found an overall intervention effect for 3-month and 6-month outcomes combined (SMD = -0.18; 95% CI -0.28 to -0.07) and 12 month outcomes (SMD = -0.16; 95% CI -0.32 to -0.01). Three studies suggested more intensive interventions with personalised feedback, physician advice, educational materials, follow-up could be most effective. However, more simple interventions including brief interventions, leaflets, alcohol assessments with advice to reduce drinking could also have a positive effect. Three publications (87–89) of a cluster RCT of a patient and provider educational material intervention in older adults classified as at-risk drinkers (Project SHARE) was found (31 primary care providers, n=106 older adults). The trial found that at 12 months, the intervention was statistically significantly associated with an		

Surveillance evidence summary	Intelligence gathering	Impact statement
increase in alcohol-related discussions with physicians (23% vs. 13%; p <0.01) and reductions in at-risk drinking (56% vs. 67%; p<0.01), alcohol consumption (-2.19 drinks per week; p<0.01), physician visits (-1.14 visits; p=0.03), and emergency department visits (16% vs. 25%; p 0.01). The average variable costs per patient were $31 for screening and $79 for intervention. The authors deemed that the costs had been off-set by lower health care utilization. Discussing alcohol risk with a physician, making a drinking agreement, and/or self-reporting the use of a drinking diary were associated with lower odds of at-risk drinking at follow-up. There was a statistically significant effect on health related quality of life (HRQL) but this was not deemed clinically meaningful. One pragmatic RCT (90) and cost-effectiveness of opportunistic screening and stepped care intervention for older adults (55+ years) scoring 8 or more on AUDIT was found. The control group was identification followed by 5-minute brief intervention session. The intervention group was identification followed by 'stepped care', which was an initial 20-minutes of behavioural change counselling, with step 2 being 3 sessions of Motivational Enhancement Therapy and Step 3 being referral to local alcohol services. The trial found that at 12 months both groups reduced		

Surveillance evidence summary	Intelligence gathering	Impact statement
alcohol consumption, with a small non-statistically significant difference between groups. There were no statistically significant differences between the groups on secondary outcomes. The economic analysis indicated that the stepped care intervention had a greater probability of being more cost-effective than brief intervention.		

Recommendation 12: referral

2014 surveillance In previous surveillance of this guideline there were no studies relevant to this section of the guideline. **2019 surveillance** One study (80) of a stepped care intervention versus a minimal intervention in the treatment of older hazardous alcohol users in primary care was found. The minimal intervention group received a 5-minute brief intervention with the practice or research nurse, whilst those in the stepped care arm initially received a 20-minute session of behavioural change counselling, with referral to step 2 (motivational enhancement therapy) and step 3 (local specialist alcohol services) if	No topic expert feedback was relevant to this section.	The published evidence suggests that stepped care, including an onward referral component, was cost-effective compared with 5 minute brief intervention in older adults. This evidence is consistent with the recommendation in NICE PH24 to offer referral for those who have failed to benefit from extended advice and wish to receive further help. New evidence is unlikely to change guideline recommendations.

Surveillance evidence summary	Intelligence gathering	Impact statement
indicated. Both groups reduced alcohol consumption between baseline and 12 months. The difference between groups in log-transformed average drinks per day (ADD) at 12 months and 6 months was not statistically significant. At month 6 the stepped care group had a lower ADD, but again the difference was not statistically significant. The mean QALY gains were slightly greater in the stepped care group than in the minimal intervention group, with a mean difference of 0.0058 (95% CI -0.0018 to 0.0133), generating an ICER of 1100 per QALY gained. From an economic perspective the minimal intervention was dominated by stepped care but, as would be expected given the effectiveness results, the difference was small and not statistically significant.

One pragmatic RCT (90) and cost-effectiveness of opportunistic screening and stepped care intervention for older adults (55+ years) scoring 8 or more on AUDIT was found. The control group was identification followed by 5-minute brief intervention session. The intervention group was identification followed by 'stepped care', which was an initial 20-minutes of behavioural change counselling, with step 2 being 3 sessions of Motivational Enhancement Therapy and Step 3 being referral to local alcohol services. The trial found that at 12 months both groups reduced | | |

Surveillance evidence summary	Intelligence gathering	Impact statement
alcohol consumption, with a small non-statistically significant difference between groups. There were no statistically significant differences between the groups on secondary outcomes. The economic analysis indicated that the stepped care intervention had a greater probability of being more cost-effective than brief intervention.		

Areas not covered in the guideline

2014 surveillance Social norms interventions In previous surveillance of this guideline one Cochrane review (91) of RCTs that assessed social norms interventions compared with control, alcohol education leaflet, or other non-normative feedback intervention (22 studies; n=7275). For studies with a follow-up of up to 3 months, web feedback was associated with a statistically significant effect on alcohol-related problems (standardised mean difference [SMD]=−0.31, 95% CI −0.59 to −0.20, p=0.03; 3 studies, n=278) and on binge drinking (SMD=−0.47, 95% CI −0.92 to −0.03, p=0.04; 1 study, n=80). However, mailed feedback, individual face-to-face and group face-to-face interventions did not statistically significantly affect alcohol-related problems or		Social norms interventions The published evidence suggests that social norms interventions may not be clinically effective in reducing quantity of drinking and effects on binge drinking seem to be inconsistent, and there was heterogeneity across studies. As such, this evidence is unlikely to impact on NICE guideline PH24. This will be revisited at subsequent surveillance time points to see if the evidence base has extended. New evidence is unlikely to change guideline recommendations.

Surveillance evidence summary	Intelligence gathering	Impact statement
binge drinking. In 14 studies assessing quantity of alcohol consumption (n=1,663), no statistically significant effect was seen for any type of intervention. For studies with a follow-up of 4–16 months, alcohol-related problems were statistically significantly affected by web feedback (SMD=−0.26, 95% CI −0.45 to −0.07, p=0.009; 3 studies, n=415) and by individual face-to-face interventions (SMD=−0.24, 95% CI −0.42 to −0.07, p=0.005; 5 studies, n=533), but not by mailed feedback. In 9 studies (n=1158), quantity of drinking or binge drinking were not statistically significantly affected by interventions using mailed feedback, web feedback or individual face-to-face feedback. **2019 surveillance** Social norms interventions One Cochrane review (92) of social norms interventions among university and college students (70 studies; n=44,958 participants) was found. The review found some small and statistically significant results across a range of outcomes. There was a statistically significant decrease of 1.28 points in the 69-point alcohol problems scale score for individual face-to face contact, but no effects for web or mailed		Email boosters to maintain effects of brief interventions The published evidence suggests there is no effect of email boosters on maintaining the effects of brief interventions. This evidence is unlikely to affect NICE PH24. This will be revisited at subsequent surveillance to see if the evidence base has extended. New evidence is unlikely to change guideline recommendations. Sport settings The published evidence suggests that interventions to reduce alcohol misuse and related harms in sport settings may be effective in reducing risky alcohol drinking and alcohol-related-harm. Currently PH24 does not specify sport settings as a focus for intervention. However, the authors suggested that further research was warranted, particularly around barriers to implementation, sustainability of change, and costs. As such it appears too soon to recommend interventions in a sport setting and changes to PH24 seem premature. This topic will be revisited at subsequent surveillance to see if the evidence base has extended.

Surveillance evidence summary	Intelligence gathering	Impact statement
interventions at 4 months. There was statistically significant decrease of 0.17 drinking days per week, from a baseline of 2.74 days per week for individual face-to-face contact, but not group face-to-face contact or marketing campaigns. There was a statistically significant reduction of 0.9 drinks consumed each week, from a baseline of 13.7 drinks per week, for all settings pooled. But overall the authors concluded that the effect sizes were too small to be meaningful, and that there was heterogeneity across studies which may have impacted upon results. **Sports** One RCT (93) of a 4-month multi-faceted intervention to reduce alcohol misuse and related harms among amateur sports people in Ireland versus no intervention was found (number of participants not reported in abstract). The trial found no evidence of effect for the primary outcomes or AUDIT scores. There was a statistically significant difference in the median number of alcohol-related harms reported by intervention group players compared with control group players at post-intervention (0 versus 3; p=0.005).One cluster RCT (94) of an alcohol management intervention to reduce risky alcohol consumption and the risk of alcohol-related harm among community football club members was found (88 football clubs; n=1,411 club members).		New evidence is unlikely to change guideline recommendations. **Mailed personalised feedback** The published evidence suggests there is no effect of personalised mailed feedback for problem drinking following an emergency department visit. This evidence is unlikely to impact NICE PH24. New evidence is unlikely to change guideline recommendations. **Telephone interventions** The published evidence from 1 RCT suggests there is no effect of telephone based alcohol brief interventions compared with scripted home fire and safety calls (control) or screening and brief intervention for alcohol misuse. Currently PH24 does not recommend telephone brief advice and based on this trial changes to PH24 do not appear warranted. This will be revisited at subsequent surveillance to see if the evidence base has extended or changed direction of effectiveness.

Surveillance evidence summary	Intelligence gathering	Impact statement
Following the intervention, a statistically significantly lower proportion of intervention club members reported a statistically significant reduction in a number of outcomes, including risky alcohol consumption at the club (Intervention: 19%; control: 24%; p=0.05), risk of alcohol-related harm (Intervention: 38%; control: 45%; p<0.01), and possible alcohol dependence (Intervention: 1%; control: 4%; p<0.01). One RCT (95) of a multi-strategy intervention to improve the implementation of responsible alcohol management practices by sports clubs was found (87 football clubs). The 2-year multi-strategy intervention included a number of components, including project officer support, funding, accreditation rewards, observational audit feedback, and training and support from state sporting organisations. The trial found that post-intervention 88% of intervention clubs reported implementing '13 or more' of 16 responsible alcohol management practices, compared with 65% of control groups (p=0.04. All of the intervention components were considered highly useful. ### Mailed personalised feedback One RCT (96) of a mailed personalised feedback intervention versus no feedback for problem drinking emergency department patients scoring 8		New evidence is unlikely to change guideline recommendations ### Brief and very brief interventions for young people The published evidence suggests there is limited effectiveness of brief interventions in young people at 6 months follow-up. There was preliminary evidence that self-affirmation based interventions may reduce alcohol consumption, but the study was small, and it was unclear how long the intervention effects were maintained. Currently PH24 does not recommend brief or very brief interventions to young people, as the evidence base was limited for under 16s at the time of guideline development, with some data suggesting adverse effects. Therefore, the committee did not feel able to recommend brief interventions for people aged 16-17 years old at the time of guideline development. This new evidence does not provide a clear benefit of brief or very brief interventions in this age group and as such it is unlikely to change recommendations within PH24.

Surveillance evidence summary	Intelligence gathering	Impact statement
or more on AUDIT was found. The review found that the intervention had no effect on alcohol consumption, whilst findings regarding alcohol-related injuries and repeat emergency department presentations were inconclusive. Telephone interventions One RCT (97,98) of a 3-session telephone brief motivational intervention, compared with a 3-call scripted home fire and safety calls, to reduce alcohol misuse in the emergency department was found (n=730 patients). The initial results at 12 months were encouraging,(98) but the final trial(97) found that there were no benefits of telephone brief motivational intervention versus control in terms of maximum number of drinks at one time in the past 30 days, frequency of binge alcohol use during the previous 30 days, and typical alcohol use in the past 30 days, alcohol-impaired driving, alcohol-related injuries, or alcohol-related negative consequences. One RCT (99) of a telephone based brief intervention plus screening and brief intervention versus screening and brief intervention alone in heavy drinkers was found (n=146 participants). The trial found that both groups reduced the average number of drinks per day and number of drinking days with no statistically significant between group differences.		New evidence is unlikely to change guideline recommendations

Surveillance evidence summary	Intelligence gathering	Impact statement
Brief and very brief interventions for young people One RCT (100) of a very brief intervention based on self-affirmation theory, compared with a distractor task, to reduce alcohol consumption in adolescents (n=67) was found. The trial found that the very brief intervention produced a statistically significant decrease in alcohol consumption, of 2.48 fewer grams of pure alcohol per day than the distractor task at the end of the study. One RCT (101) of a brief motivational intervention (single session with telephone booster 6 weeks later), compared with written material, to reduce drinking within paediatric emergency departments in patients under 18 years old was found (n=316). The trial found that both groups reduced number of alcohol drinks consumed and alcohol-related problems but the differences in mean changes between intervention and control were similar after 6 months for all outcomes.		

Research recommendations

RR2. Which screening tool should be considered as the 'gold standard' for assessing the drinking behaviour of those under the age of 18?

Surveillance evidence summary	Intelligence gathering	Impact statement
One cross-sectional survey (15) to determine the AUDIT and AUDIT-C cut-off values for identifying alcohol misuse in adolescents aged 10-18 years was found (n=5377). The study found that AUDIT-C with a score of 3 was more effective for identifying at-risk alcohol use, heavy episodic use and alcohol abuse. AUDIT with a score of 7 was more effective in identifying alcohol dependence.	Topic expert feedback highlighted that this guideline does not recommend using AUDIT in this age group whereas CG115 does.	New published evidence indicates that an AUDIT-C threshold of 3 may be helpful in identifying at-risk alcohol use in adolescents, whilst an AUDIT score of 7 was more effective at identifying alcohol dependence. This new evidence could be used to provide greater clarity on screening thresholds in young people and could possibly alter recommendations 6 and 7. However, it does not fully address the issue of which is the gold standard tool for assessing drinking behaviour in under 18s and so does not fully address the research recommendation. This research recommendation will be considered again at the next surveillance point.

RR3. Are brief interventions effective and cost-effective in reducing alcohol use among various subgroups of the population, such as: those under 16 and over 65; people from some black and minority ethnic groups; pregnant women attending antenatal care?

There has been a large amount of evidence published on brief intervention in various settings and delivered by different practitioners and to different populations, particularly adult populations. The published evidence for brief intervention in adults is summarised in full under recommendation 10 above, and not repeated here for brevity.	A topic expert highlighted that 'older drinkers are a group that may need focused attention.'	There is new published evidence available for brief interventions in women, military personnel, people with comorbid mental health conditions, and young adults or college students. The evidence in the various subpopulations is mixed but as a body of evidence it could change guideline recommendation 10. However, the evidence does not cover all subpopulations, such as black and minority ethnic groups and so does not fully address the research recommendation.

Surveillance evidence summary	Intelligence gathering	Impact statement
		This research recommendation will be considered again at the next surveillance point.

RR4. Are screening and brief alcohol interventions effective and cost-effective in: medical settings outside primary care and emergency departments (for example, in district hospitals or mental health settings); non-medical settings (for example, on criminal justice or social services premises, in pharmacies or in the workplace); voluntary sector organisations?

There has been a large amount of evidence published on brief intervention in various settings and delivered by different practitioners and to different populations, particularly adult populations. The published evidence for brief intervention in adults is summarised in full under recommendation 10 above, and not repeated here for brevity.	Topic expert feedback indicated that the guideline should not be advising every setting to deliver alcohol screening and brief intervention, but only those settings where research shows it is effective.	There is new published evidence available for brief interventions delivered in occupational health, emergency department, hospital inpatient settings, sexual health clinics, and judicial settings. The evidence in the various settings is generally mixed but as a body of evidence it could change guideline recommendation 10. However, the evidence does not cover all settings, such as social service settings, and so does not fully address the research recommendation. This research recommendation will be considered again at the next surveillance point.

RR5. What factors (conditions and components) ensure a brief intervention is effective in promoting low-risk alcohol consumption?

No relevant studies identified.	No feedback was provided.	No relevant published evidence identified. This research recommendation will be considered again at the next surveillance point.

Surveillance evidence summary	Intelligence gathering	Impact statement
RR6. To what extent are local services responding to the needs of children affected either by parental alcohol misuse or their own drinking – and which interventions are effective in helping these families?		
No relevant studies identified.	No feedback was provided.	No relevant published evidence identified. This research recommendation will be considered again at the next surveillance point.

Editorial and factual corrections

Editorial

During surveillance we identified the following areas that require editorial amendment:

- Recommendation 5 will be amended to refresh out of date links to 'World class commissioning' and 'Signs for improvement'. The new recommendation wording is suggested to read: 'Commissioners should ensure a local joint alcohol needs assessment is carried out in accordance with Alcohol, Drugs and Tobacco Commissioning Support Pack and the Local alcohol services systems Improvement Tool.

- Recommendation 7 will be amended to add: 'Use professional judgement as to whether to revise the AUDIT scores downwards when screening people under the age of 18'.

- Recommendation 9 will be amended to remove the bullet point which says: 'Use professional judgement as to whether to revise the AUDIT scores downwards when screening… younger people (under the age of 18)'.

NICE National Institute for
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