NICE National Institute for Health and Care Excellence

Surveillance proposal consultation document

2019 surveillance of alcohol-use disorders (NICE guidelines PH24 and CG115)

Surveillance proposal

We propose to update the guideline on Alcohol-use disorders: prevention (NICE guideline PH24). The update will focus on alcohol screening children and young people aged 10 to 15 years, and 16 and 17 years (recommendations 6 and 7), and brief advice and extended brief advice in adults in various settings and populations (recommendations 10 and 11).

We propose to not update the guideline on Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE guideline CG115).

Please note, recommendations 1 to 3 within PH24 were excluded from the 2019 surveillance process as they are national policy recommendations, which are not within NICE's current remit.

Section of the NICE guideline PH24, recommendations 4-12	New evidence identified	Impact
Recommendations for practice		
Recommendation 4: licensing	Yes	No
Recommendation 5: resources for screening and brief interventions	Yes	No
Recommendation 6: supporting children and young people aged 10 to 15 years,	Yes	Yes
Recommendation 7: screening young people aged 16 and 17 years	Yes	Yes
Recommendation 8: extended brief interventions with young people aged 16 and 17 years	Yes	No
Recommendation 9: screening adults	Yes	No
Recommendation 10: brief advice for adults	Yes	Yes
Recommendation 11: extended brief interventions for adults	Yes	Yes

Recommendation 12: referral	Yes	No

Section of the NICE guideline CG115	New evidence identified	Impact
1.1 Principles of care		
1.1.1 Building a trusting relationship	No	No
1.1.2 Working with and supporting families and carers	No	No
1.2 Identification and assessment		
1.2.1 General principles	No	No
1.2.2 Assessment in specialist alcohol services	No	No
1.3 Interventions for alcohol misuse		
1.3.1 General principles for all interventions	No	No
1.3.2 Care coordination and case management	No	No
1.3.3 Interventions for harmful drinking and mild alcohol dependence	Yes	No
1.3.4 Assessment and interventions for assisted alcohol withdrawal	Yes	No
1.3.5 Drug regimens for assisted withdrawal	Yes	No
1.3.6 Interventions for moderate and severe alcohol dependence after successful withdrawal	Yes	No
1.3.7 Special considerations for children and young people who misuse alcohol	Yes	No
1.3.8 Interventions for conditions comorbid with alcohol misuse	Yes	No

Reasons for the proposal

This section provides a summary of the proposals, the areas proposed to be updated and the reasons.

Alcohol-use disorders: prevention (NICE guideline PH24)

We propose to update the NICE guideline PH24 for the following recommendations:

Recommendation 6: supporting children and young people aged 10 to 15 years and Recommendation 7: screening young people aged 16 and 17 years

New published evidence indicates that an AUDIT-C threshold of 3 may be helpful in identifying at-risk alcohol use in young people aged 10 to 17 years, whilst an AUDIT score of 7 was more effective at identifying alcohol dependence. This evidence could be used to provide greater clarity on screening thresholds in young people aged 10 to 17 years and could change the recommendations – currently the guideline advises to use professional judgement as to whether to revise the AUDIT scores downwards when screening younger people (under the age of 18).

Recommendation 10: brief advice for adults

There has been a large amount of new evidence published on brief interventions for adults in various settings and delivered by different practitioners and to different populations. The published evidence indicates that the effectiveness of brief interventions is modified by the setting, practitioner delivering the intervention and population receiving the advice. Topic expert feedback also highlighted that not all settings should be delivering brief interventions, but only those settings where it has been proven to be effective. Given this new evidence, the guideline recommendation on brief advice for adults may need updating.

Recommendation 11: extended brief interventions for adults

New published evidence on extended brief interventions seems to indicate that interventions may not be effective in all populations and settings. Currently the NICE guideline PH24 recommends offering extended brief interventions to all adults who have not responded to brief structured advice, but does not specify the setting or populations to target. Given this new evidence, the guideline recommendations on extended brief interventions for adults may need updating.

For further details and a summary of all evidence identified in the surveillance of NICE guideline PH24, see appendix A1 below.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE guideline CG115)

We propose to not update the NICE guideline CG115. The reason for not updating the guideline at this time is that the new published evidence was not deemed sufficient to change current recommendations and further evidence is needed, particularly around digital interventions for alcohol misuse, and pharmacotherapies for managing mild alcohol dependence, assisted withdrawal, and following successful withdrawal.

For further details and a summary of all evidence identified in the surveillance of CG115, see appendix A2 below.

Overview of 2019 surveillance methods

NICE's surveillance team checked whether recommendations in the following guidelines remain up to date:

- [Alcohol-use disorders: prevention](#) (NICE guideline PH24), recommendations 4-12.

- [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) (NICE guideline CG115).

The surveillance process consisted of:

- Feedback from topic experts via a questionnaire.

- A search for new or updated Cochrane reviews.

- A search for national policy relating to alcohol-use disorders.

- Consideration of evidence from previous surveillance.

- Examining related NICE guidance and quality standards and NIHR signals.

- A search for ongoing research.

- Examining the NICE event tracker for relevant ongoing and published events.

- Literature searches to identify relevant evidence.

- Assessing the new evidence against current recommendations to determine whether or not to update sections of the guideline, or the whole guideline.

- Consulting on the proposal with stakeholders (this document).

For further details about the process and the possible update decisions that are available, see [ensuring that published guidelines are current and accurate](#) in developing NICE guidelines: the manual.

Evidence considered in surveillance

Search and selection strategy

We searched for new evidence related to the whole guideline for [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) (NICE guideline CG115), and for recommendations 4 to 12 within [Alcohol-use disorders: prevention](#) (NICE guideline PH24). Recommendations 1 to 3 within PH24 were excluded from the 2019 surveillance process as they are national policy recommendations, which are not within NICE's current remit.

NICE is currently developing a guideline on [Behaviour change: technology-based interventions](#) which will cover digital interventions for **hazardous drinking** and, as such, digital interventions are not part of the scope of the current PH24 surveillance review. Digital interventions for **harmful drinking** are within scope of the current CG115 surveillance review as they will not be covered by [Behaviour change: technology-based interventions.](#)

Searches were conducted between 10 November 2014 to 14 August 2018 for CG115, and between 5 July 2013 to 7 September 2018 for PH24, which reflected previous surveillance

cut-off periods, and the dates when searches were conducted. However, both searches provided studies that were relevant to both PH24 and CG115.

Alcohol-use disorders: prevention (NICE guideline PH24)

We found 86 studies in a search for all study types for recommendation 4 on licensing, and randomised controlled trials and systematic reviews for recommendations 5-11.

We also included:

- 1 relevant study, which was not identified via literature searches, from a total of 11 studies identified by topic experts

- 15 studies identified by searches conducted in previous surveillance in 2014, including those from comments received during consultation on the previous surveillance review in 2014.

From all sources, we considered 101 studies to be relevant to the guideline.

See appendix A1: summary of evidence from surveillance below for details of all evidence considered, and references.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE guideline CG115)

We found 80 studies in a search for randomised controlled trials and systematic reviews.

We also included:

- 94 studies identified by searches conducted in previous surveillance in 2013 and 2015.

From all sources, we considered 174 studies to be relevant to the guideline.

See appendix A2: summary of evidence from surveillance below for details of all evidence considered, and references.

Selecting relevant studies

Studies were selected in line with the standard surveillance methods, see ensuring that published guidelines are current and accurate in developing NICE guidelines: the manual. However, due to the amount of research available in relation to brief advice for adults (recommendation 10 in PH24), only systematic reviews were summarised in the 2019 evidence summary, with only a brief summary of randomised controlled trial (RCT) level evidence apart from settings not covered by systematic reviews. See appendix A1 and appendix A2: summary of evidence from surveillance below for details of all evidence considered, and references.

Ongoing research

We checked for relevant ongoing research. Of the ongoing studies identified, 3 studies were assessed as having the potential to change recommendations; therefore, we plan to check the publication status regularly, and evaluate the impact of the results on current recommendations as quickly as possible. These studies are:

[Alcohol-use disorders: prevention](#) (NICE guideline PH24)

- [Evaluation of the Communities In Charge of Alcohol (CICA) Programme in Greater Manchester](#). ISRCTN81942890

[Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) (NICE guideline CG115)

- [An online self-help program for parents whose partners abuse alcohol ISRCTN38702517](#)

- [Baclofen in Managing Acute Alcohol Withdrawal](#) NCT03293017

Intelligence gathered during surveillance

Views of topic experts

We considered the views of topic experts, including those who helped to develop the guideline. For this surveillance review, topic experts completed a questionnaire about developments in evidence, policy and services related to alcohol use disorders (NICE guidelines PH24 and CG115).

We sent questionnaires to 21 topic experts. The topic experts were recruited to the NICE Centre for Guidelines Expert Advisors Panel to represent their specialty. The experts completing the questionnaires included representation from PHE, academics with a specialist interest in alcohol and substance misuse, commissioners of drug and alcohol services, and medical professionals involved in treating alcohol misuse.

[Alcohol-use disorders: prevention](#) (NICE guideline PH24)

All 6 of the experts who completed the questionnaires in relation to this guideline felt that the guideline required updating. The main issues raised were changes to how alcohol services are commissioned and delivered, new evidence on brief interventions, and a potential overlap between recommendations 6 and 7 in [alcohol-use disorders: prevention](#) (NICE guideline PH24) and recommendations 1.3.7.1 to 1.3.7.4 in [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) (NICE Guideline CG115). Further clarity was sought from experts on this potential overlap and the view whilst mixed seemed to indicate that the overlap was not an issue as the recommendations complemented one another as PH24 is focused more on prevention, whilst CG115 focusses on treatment. Digital interventions were also raised as a potential update area by topic experts. However, NICE is currently developing a guideline on [Behaviour change: technology-based interventions](#) which will cover digital interventions for hazardous drinking and, as such, digital interventions are not part of the scope of NICE guideline PH24 update plans.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE guideline CG115)

All 7 of the experts who completed the questionnaires in relation to this guideline felt that the guideline required updating. The main issues raised were changes to how alcohol services are commissioned and delivered, new evidence on pharmacotherapies for withdrawal and relapse prevention, and a potential overlap between recommendations 6 and 7 in alcohol-use disorders: prevention (NICE guideline PH24) and recommendations 1.3.7.1 to 1.3.7.4 in Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE Guideline CG115). Further clarity was sought from experts on this potential overlap and the view whilst mixed seemed to indicate that the overlap was not an issue as the recommendations complemented one another as PH24 is focused more on prevention, whilst CG115 focusses on treatment. Comments were also made on a lack of resources affecting the delivery of recommendations, such as the provision of psychological services, as well as comments that licensing updates applied for some drugs.

Equalities

No equalities issues were identified during the surveillance process.

Editorial amendments

Alcohol-use disorders: prevention (NICE guideline PH24)

During surveillance we identified the following editorial changes:

- Recommendation 5 is proposed to be amended 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 systems improvement tool.

- Recommendation 7 is proposed to 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 is proposed to 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)'.

Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (NICE guideline CG115)

During surveillance we identified the following editorial changes:

- Recommendation 1.3.3.2 is proposed to be amended to say: 'Offer behavioural couples therapy for harmful drinkers and people with mild alcohol dependence who have a regular

partner who is willing to participate in treatment, unless there are indicators that a person has experienced, or is a perpetrator of, domestic abuse.'

- Recommendation 1.3.3.2 is proposed to be amended to include the following cross-referral: 'For advice on the use of nalmefene for alcohol dependence see Nalmefene for reducing alcohol consumption in people with alcohol dependence NICE technology appraisal guidance (TA325).'

- Recommendation 1.3.5.3 is proposed to be amended to add: 'Prescribers should be aware of the following legislation and advise patients accordingly: Drugs and driving: blood concentration limits to be set for certain controlled drugs in a new legal offence 2014'.

- Recommendation 1.3.5.11 is proposed to be amended to add: 'Prescribers should also see Addiction to benzodiazepines and codeine July 2011.

- Recommendation 1.3.8.4 is proposed to be amended with a cross reference to Stop smoking interventions and services NICE guideline NG92, which has since replaced PH1.

- Footnote 1 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.'

- Footnote 2 is proposed to be amended to reflect changes in licensing: 'Oral naltrexone is licensed for alcohol dependence. See SPC https://www.medicines.org.uk/emc/product/6073/smpc Prescribers should follow the safety advice around opioids'.

- Footnote 5 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.'

- Footnote 7 is proposed to be amended to reflect changes in licensing: 'Oral naltrexone is licensed for alcohol dependence. See SPC https://www.medicines.org.uk/emc/product/6073/smpc Prescribers should follow the safety advice around opioids'.

- Footnote 12 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. Prescribers should check the licensing status of benzodiazepines in this age group.'

- Footnote 13 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full

responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information. Prescribers should check the licensing status of benzodiazepines in this age group.'

- Footnote 16 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's [Prescribing guidance: prescribing unlicensed medicines](#) for further information.'

- Footnote 17 is proposed to be amended to include [Antisocial personality disorder: prevention and management](#) (CG77). It will also be amended to say: 'Also see NICE guideline [Coexisting severe mental illness and substance misuse: community health and social care services](#) (NG58).'

Overall surveillance proposal

After considering all evidence and other intelligence and the impact on current recommendations, we propose to update the guideline on [Alcohol-use disorders: prevention](#) (NICE guideline PH24). The update will focus on screening children and young people aged 10 to 15 years, and 16 and 17 years (recommendations 6 and 7), and brief advice and extended brief advice in adults in various settings and populations (recommendations 10 and 11).

We propose to not update the guideline on [Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence](#) (NICE guideline CG115).

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 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	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 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

Surveillance evidence summary	Intelligence gathering	Impact statement
data such as measures of effect sizes, p values or indicators of the size of the data pool. **2019 surveillance** 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. 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 (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		to map alcohol-related problems to develop a licensing policy. New evidence is unlikely to change guideline recommendations. 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. 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 shoppers are currently recommended and as such no change to guideline recommendations is anticipated.

Surveillance evidence summary	Intelligence gathering	Impact statement
'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) 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.		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.

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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.		

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		

Surveillance evidence summary	Intelligence gathering	Impact statement
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.		
Recommendation 5: resources for screening and brief interventions		
2014 surveillance	One expert heighted that recommendation 5 states: Commissioners should ensure a local joint alcohol	Published evidence indicates that training of providers and strategies to aid implementation can

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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).	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. 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.	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 is suggested for 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 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

Surveillance evidence summary	Intelligence gathering	Impact statement
One cluster 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 AUDIT hazardous drinking relative to controls over the course of the year after injury, particularly among patients without traumatic brain injury.		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 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	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 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	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 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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.	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]. 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	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.
		New evidence may change guideline recommendations.

Surveillance evidence summary	Intelligence gathering	Impact statement
	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.	

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 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	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. New evidence is unlikely to change guideline recommendations. Note that PH24 did not make any recommendations on brief interventions in people

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		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.

Surveillance evidence summary	Intelligence gathering	Impact statement
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.		

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	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.	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.

Surveillance evidence summary	Intelligence gathering	Impact statement
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** 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	Experts provided a number of references which were incorporated in the 2019 surveillance summary as appropriate.	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 and 17 years old. See Editorial and factual corrections below.

Surveillance evidence summary	Intelligence gathering	Impact statement
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.		

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 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	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. 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		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 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		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 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 delivered by community

Surveillance evidence summary	Intelligence gathering	Impact statement
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. **Brief interventions for people admitted to hospital (for reasons unrelated to alcohol-use)** 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 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		**pharmacists** 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** Published evidence from 1 systematic review 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-

Surveillance evidence summary	Intelligence gathering	Impact statement
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 HTA and 26 RCTs of brief interventions in adults. To avoid double-counting RCTs that are included within the reviews, only 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.		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. 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		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. **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.

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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. Brief interventions in the emergency department		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 as effective as 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 clinics and community pharmacies. Likewise, there appear to be specific populations, such as pregnant women and older adults who may benefit from brief interventions. 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 attributed to alcohol use; and baseline stage of change. 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;		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 defined within Behaviour change: individual approaches (NICE guideline PH49). New evidence may change guideline recommendations.

Surveillance evidence summary	Intelligence gathering	Impact statement
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). 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. 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		

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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.

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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 (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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 (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		

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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	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 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.

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		**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 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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		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
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 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		

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		

Surveillance evidence summary	Intelligence gathering	Impact statement
(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 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 | | |

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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.		

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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	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
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 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.		

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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		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. 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.

Surveillance evidence summary	Intelligence gathering	Impact statement
(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.		New evidence is unlikely to change guideline recommendations.
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 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		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. 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.

Surveillance evidence summary	Intelligence gathering	Impact statement
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). 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),		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 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. 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.

Surveillance evidence summary	Intelligence gathering	Impact statement
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 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.		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. New evidence is unlikely to change guideline recommendations

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.

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

Surveillance evidence summary	Intelligence gathering	Impact statement
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?

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

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

Surveillance evidence summary	Intelligence gathering	Impact statement
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 are proposed to require editorial amendment:

- Recommendation 5 is proposed to 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 is proposed to 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 is proposed to 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)'.

Appendix A2: Summary of evidence from surveillance

2019 surveillance alcohol use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence (CG115)

Summary of evidence 2019 surveillance

Studies identified in searches are summarised from the information presented in their abstracts. Please note, due to the limited information available in abstracts, particularly in relation to which stage of alcohol misuse interventions were aimed at (mild dependence, alcohol withdrawal, or interventions after successful withdrawal), studies for psychological and pharmacological interventions are discussed under the recommendation deemed most likely relevant to the study, but it is acknowledged that they may also be relevant to other recommendations.

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.

Previous surveillance was conducted in 2013 and 2015 but using different methodology which considered the impact of new studies by review question, rather than guideline recommendation. At both of these time points the decision was not to update the guideline. Full details of the previous surveillance are available in full online, so only a brief summary of the impact is included below.

2019 surveillance summary	Intelligence gathering	Impact statement
Recommendation 1.1.1 Building a trusting relationship and providing information		
No studies relevant to this section of the guideline were identified.	A topic expert suggested that the referral pathway between acute hospital trusts and community services is often reported as ineffective, and that frequent feedback from service users that they were not referred by hospital staff or given up to date information on alcohol services. One expert identified a need to check the guideline for stigma terminologies e.g. avoid 'misuse' and 'service user' or caution use as they are apparently seen to be stigmatising by some people.	There was no new published evidence identified at any surveillance time point. A topic expert highlighted that there may be issues with referral pathways but no new evidence was identified on how to address this issue and it is not clear how this issue relates to the recommendations in the guideline. A topic expert highlighted that terms like misuse and service user may be stigmatising to some. However, these are commonly used terms that are easily understood by many people, and other topic experts did not identify this as an issue. Furthermore, there is a risk that changing these terms could cause a lack of clarity and as such no change to the guideline will be made. No new evidence was identified.

2019 surveillance summary	Intelligence gathering	Impact statement
Recommendation section 1.1.2 Working with and supporting families and carers		
No studies relevant to this section of the guideline were identified.	One expert queried whether it would be possible to strengthen statements around facilitating a parent who has problems with alcohol use into treatment.	There was no new published evidence found at any surveillance time point. A topic expert highlighted that there should be a statement around facilitating treatment for parents with alcohol use problems. The guideline already covers support for families and carers and no new evidence was identified to add to this.
		No new evidence was identified.
Recommendation section 1.2.1 General principles (identification and assessment)		
No studies relevant to this section of the guideline were identified. However, a study on Alcohol Use Disorders Identification Test (AUDIT) in children and young people is covered in section 1.3.7 below. Studies related to identification of alcohol misuse in adults (including AUDIT) are included in the Alcohol-use disorders: prevention (NICE guideline PH24), decision matrix in relation to recommendation 9.	One expert stated that community alcohol and drug treatment is now funded through Public Health budgets in local authorities so the guidelines should reflect that if they are intended to cover community services. The expert said it would make sense to look at how alcohol-specific interventions can be delivered within that context. An expert also highlighted that many treatment services are joint drug and alcohol services and there are anecdotal reports that clients with alcohol-use disorders are put off seeking	There was no new evidence identified at any surveillance time point that would impact the recommendations in this section.

A topic expert highlighted that community alcohol and drug services are now funded through Public Health and have established joint drug and alcohol services. Whilst these changes have led to |

2019 surveillance summary	Intelligence gathering	Impact statement
	treatment because they see the service as drug focused, with associated stigmas preventing uptake. One expert expressed concern that offenders with alcohol problems are under treated. This is partly because alcohol concerns are not an issue prisons address, as alcohol is not available in prisons and because of the poor state of the criminal justice system.	considerable changes in localities, it is not anticipated that recommendation 1.2.1 (or the guideline more broadly) would be affected as it outlines principles of practice which should apply in any relevant setting. There was also a concern that offenders with alcohol problems are under treated. No new evidence was identified to address this issue. NICE has produced guidance on the Physical health of people in prison (NICE guideline NG57) and Mental health of adults in contact with the criminal justice system (NICE guideline NG66).
		No new evidence was identified.
Recommendation section 1.2.2 Assessment in specialist alcohol services		
No studies relevant to this section of the guideline were identified.	One expert stated that it is not clear if recommendations 1.2.2.7 and 1.2.2.8 are in line with NICE guidance on Coexisting severe mental illness and substance misuse: community health and social care services (NICE guideline NG58), which states that patients with coexisting severe mental illness and	There was no new evidence at any surveillance time point that would impact the recommendations in this section. A topic expert highlighted that it was unclear if there was concordance

2019 surveillance summary	Intelligence gathering	Impact statement
	alcohol misuse should be treated primarily by mental health service, whilst recommendation 1.2.2.8 within CG115 suggests abstinence from alcohol for 3-4 weeks before considering referring for treatment for a comorbid mental health problem.

The expert also made a point about waiting 3-4 weeks after abstinence from alcohol before referring for specific mental health treatment (see recommendation 1.2.2.8) being unhelpful as it allows Improving Access to Psychological Therapies (IAPT) and other psychological therapy services to not treat those with mental health disorders who have turned to alcohol.

One expert queried whether additional tests for cognitive functioning should be considered, including MOCA and 6CIT. | across NICE guidelines on treating people with mental health conditions and alcohol misuse. We have checked the NICE guideline on coexisting severe mental illness and substance misuse: community health and social care services (NG58), and identified that it should not conflict with CG115 as the focus of NG58 is severe mental illness, so the 2 guidelines are more complimentary. CG115 currently advises that people with a significant comorbid mental health condition should be referred to a psychiatrist, which does not conflict with NG58. However, to ensure readers of CG115 are aware of NG58, footnote 17 within CG115 will be updated to also include a cross reference to NG58.

Topic expert feedback also highlighted that recommendation 1.2.2.8, which suggests waiting 3-4 weeks to see if alcohol abstinence improves mental health problems before treating for mental health, is unhelpful and leads to delays in treatment for mental illness. At the |

2019 surveillance summary	Intelligence gathering	Impact statement
		time of guideline development, the committee noted that treatment for comorbid disorders (in particular depression and anxiety) whilst people are consuming significant levels of alcohol does not appear to be effective. However, the committee did acknowledge that some people with depressive disorders will require immediate treatment and the recommendations were not meant to stand in the way of immediate treatment being provided in such a situation. In reviewing the evidence for comorbid disorders, the committee did not find any treatment strategies or adjustments that should be made because of the comorbid problem and, in view of this, decided to refer to the relevant NICE guidelines. During this surveillance review there was no new evidence found to contradict this.

There was no evidence found for MOCA and 6CIT tests in people with alcohol use disorders which might trigger an update to the recommendations, although |

2019 surveillance summary	Intelligence gathering	Impact statement
		recommendation 1.2.2.11 does already recommend considering brief measures of cognitive functioning.
		No new evidence was identified.
Recommendation section 1.3.1 General principles for all interventions		
No studies relevant to this section of the guideline were identified.	One expert stated that recommendations in this section are not clear or specific on the content of intensive structured community based intervention, and that the lack of clarity leads to people thinking that this only refers to a 3-week, post-detox structured intervention. The expert also stated that some service users would need an intensive structured community based intervention that lasts longer than 3-weeks. An expert also highlighted that in recommendation 1.3.1.1 a reference should be included about trained and competent staff. They went on to add that there is a tendency in some community services to use untrained staff to conduct initial assessments, when it is particularly important to have competent, trained staff at this point as it determines what interventions will be offered.	There was no new evidence identified at any surveillance time point that would impact the recommendations in this section. A topic expert highlighted that there is a lack of clarity on what constitutes an intensive structured community based intervention and a recommended duration of the intervention. The section covers general principles, whereas the detail of specific intervention duration is covered in sections 1.3.3 and 1.3.4 of the guideline. In this respect, the information is provided by the guideline. A topic expert also highlighted that it is important that staff are appropriately trained to carry out initial assessments,

2019 surveillance summary	Intelligence gathering	Impact statement
		whereas in practice untrained staff can sometimes be employed in this role. However, the guideline recommends that staff are trained and this is covered in recommendation 1.3.1.5. The reasons for untrained staff being employed to carry out initial assessment is unclear, although it is anticipated this relates to resource constraints, so there is no impact on the guideline. Footnote 5 is proposed to be amended to the new standard wording for unlicensed medicines, see Editorial and factual corrections below.
		No new evidence was identified.
Recommendation section 1.3.2 Coordination and case management		
2019 surveillance No studies relevant to this section of the guideline were identified during the 2019 surveillance. **2015 and 2013 surveillance**	One expert highlighted that this section does not describe how cases are managed in community treatment. The expert stated that the term 'care coordination' has been used differently in community treatment, and that case management and key work processes have been changing as resources diminish.	**2019 surveillance** There was no new evidence identified that would impact the recommendations in this section. A topic expert highlighted that

2019 surveillance summary	Intelligence gathering	Impact statement
Two studies were identified in the previous surveillance which may be of relevance here, see the 2015 surveillance review for clinical area 2: evaluating the organisation of care for people who misuse alcohol.	The expert went on to add that it would be useful to have guidance which clearly specifies the essentials of case management that alcohol-dependent adults should be offered if there is evidence on this. The expert stated that the term 'care coordination' has a specific meaning in psychiatric services which can lead to confusion between addiction services (which are public health services rather than psychiatric ones) - the terms care coordination and case management have little meaning in modern addiction services.	services have changed since the guideline was written and that the terms care coordination and case management have different meanings in different settings. On reviewing this issue, it is apparent that the recommendations in this section describe the nature and the elements of care coordination and case management. Further details are available in the full-guideline. Whilst language and terminology naturally change the core elements for practice are described in the recommendations. Furthermore, no new evidence has been found to inform changes to guideline language and recommendations.
		No new evidence was identified.
		2015 and 2013 surveillance Previous surveillance concluded that evidence identified at that time point was unlikely to change guideline recommendations as the evidence was in line with the guideline.

2019 surveillance summary	Intelligence gathering	Impact statement
Recommendation section 1.3.3 Interventions for harmful drinking and mild dependence		

2019 surveillance

Psychological interventions

One systematic review (102) of patient centred care interventions for the management of alcohol use disorders was identified (40 studies, n=16,020 patients). The review found that single sessions of motivational interviewing showed no clear benefit on alcohol consumption outcomes, with few studies indicating a benefit of patient centred care versus control. The results for multiple sessions of counselling were mixed, but many studies showed a significant benefit of the patient centred care interventions. Pharmacologically supported patient centred care interventions were also found to be generally effective, with most studies reaching statistical significance.

One pragmatic RCT (103) of 8 x 1 hour sessions delivered over 12 weeks by clinical psychologists of personalised cognitive behavioural therapy, versus usual targeted treatment, in a public health clinic for alcohol use disorders was identified (n=379 participants). The review found that only 25% of participants completed all 12 sessions, with the average being 4.4 sessions. Compared with usual targeted treatment, cognitive behavioural therapy (CBT) had no significant effect on drinking days or consumption, but there was significant reduction in craving (b = -18.97, 95% CI -31.44 to -6.51) and impulsivity (b = -26.65, 95% CI -42.09 to -11.22)

A topic expert noted that alcohol misuse and behavioural couples therapy may be contra-indicated where domestic abuse is an issue, with respect to recommendation 1.3.3.2.

An expert highlighted that the evidence for anti-craving medication is weak.

One expert stated that the recommendations covering pharmacotherapy for alcohol dependence are still appropriate, but need to be updated to include a recommendation for nalmefene for the management of heavy drinking (note: this drug was not licensed for use for this indication when the Guideline was published).

Another expert expressed a need for guidance on interventions with pregnant alcohol users.

One expert highlighted that as resources for delivering alcohol services are decreasing there is an increase of online interventions and that voice over interactive protocol is also being used to increase accessibility.

One expert said that there is increasing use of group interventions for alcohol-use and queried whether evidence is available that can be reviewed. The expert also highlighted that there is now a widespread practice in community services of requiring service users to attend pre-detox/stabilisation groups before they can access detox and queried if there was

2019 surveillance

Psychological interventions

Published evidence suggests that single sessions of motivational interviewing showed no clear benefit, multiple counselling sessions have uncertain effects, but pharmacologically supported patient centred care was found to be effective. Targeted treatment was not found to be superior to CBT. Likewise, female-specific CBT was not found to be superior to gender neutral CBT. Group couples' therapy was found to be significantly less effective than individual couples therapy.

This broad range of evidence is in line with current recommendations which recommend psychological intervention over multiple sessions, and involving a regular partner if willing to participate.

A topic expert highlighted that alcohol dependence can be

2019 surveillance summary	Intelligence gathering	Impact statement
modules. One RCT (104) of 12 outpatient manual-guided sessions of female-specific CBT, versus gender neutral CBT, for alcohol dependant women was identified (n=99 women). The trial found no difference between treatments with women in both groups being satisfied and engaged and reporting significant reductions in drinking. Women in the FS-CBT but not in the gender neutral CBT group reported an increase in percentage of abstainers in their social networks in the year following treatment (0.69% per month, p=0.002). One RCT (105) of group behavioural couples therapy versus standard couples behavioural therapy, plus 12-step-orientated individual behavioural therapy, for people with alcohol use disorders was identified (n=101 patients). The trial found that both alcohol and relationship outcomes were significantly worse with group behavioural couple therapy, compared with standard couple behavioural therapy. One RCT (106) of 12 sessions of conjoint CBT, versus 5 individual CBT sessions plus 7 sessions of blended CBT, for women with alcohol use disorders was identified (n=59 women). The trial found that the percentage of drinking days or percentage of heavy drinking days did not differ in the 12 months following treatment. However, the authors reported a small trend favouring blended CBT, patient preference for individual therapy as part of treatment and that some individual sessions decreased the challenges of scheduling conjoint sessions. One RCT (107) of 12 weeks of network support treatment,	evidence on this. One expert identified that recommendations around psychological therapies, in particular 1.3.3.3 – 1.3.3.5, were generally perceived to be unrealistic and hence undeliverable. The expert went on to say that whilst they might represent the 'council of perfection' they could have the adverse effect if commissioners or providers felt that if they couldn't develop what was recommended they would not provide anything at all.	associated with domestic violence and thus recommendation 1.3.3.2 which suggests couples' therapy should be caveated. Recommendation 1.3.3.2 will be suggested to stakeholders at consultation as an editorial amendment to highlight that domestic abuse should be ruled out before offering couples' therapy. The suggested editorial amendment is outlined in the section below on Editorial and factual corrections. A topic expert also highlighted that the provision of psychological services recommended in the guideline were seen as unrealistic due to resource constraints. There was no new evidence found that would inform a revision to recommendations in the context of financial pressures. 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.

2019 surveillance summary	Intelligence gathering	Impact statement
compared with packaged CBT, in people with alcohol use disorder was identified (n=193 patients). Compared with packaged CBT, network support treatment had better results in terms of both proportion of days abstinent and drinking consequences, and equivalent improvements in 90-day abstinence, drinks per drinking day and heavy drinking days. The effects of network support treatment were mediated by pre-post changes in abstinence self-efficacy, proportion of non-drinkers in the social network and attendance at Alcoholics Anonymous. Acupuncture One meta-analysis (108) of acupuncture for alcohol use disorders was identified (7 studies, n=243 participants).The analysis found that compared with control, acupuncture had a stronger effect on reducing alcohol-related symptoms and behaviours (g = 0.67). The authors suggested that a larger cohort study is required to confirm results One systematic review (109) of acupuncture to reduce alcohol dependency was identified (15 RCTs, n=1,378 participants). The review found that, compared with control, acupuncture reduced alcohol craving (SMD -1.24, 95% CI -1.96 to -0.51); and alcohol withdrawal symptoms (SMD -0.50, 95% CI -0.83 to -0.17). Secondary analyses showed that acupuncture reduced craving compared with sham acupuncture; reduced craving compared with controls in RCTs conducted in Western countries; and reduced craving compared with controls in RCTs with only male participants. Exercise		New evidence is unlikely to change guideline recommendations. Acupuncture Published evidence suggests that acupuncture may have some potential to reduce alcohol craving, however the evidence base is limited and more research is needed. Currently the guideline does not recommend acupuncture. This evidence is not thought to be sufficient to change the guideline recommendations, but this area will be revisited at the next surveillance review to see if the evidence base has expanded and evidence of an effect is clearer. New evidence is unlikely to change guideline recommendations. Exercise Published evidence suggests that exercise has inconsistent effects on

2019 surveillance summary	Intelligence gathering	Impact statement
One systematic review (110) of exercise treatment for alcohol use disorders was identified (21 studies, n=1,204 participants). The review found that exercise did not significantly reduce daily alcohol consumption or the AUDIT total scores. However, exercise significantly reduced depressive symptoms versus control (p=0.006) and improved physical fitness (VO$_2$) (p=0.01). One systematic review (111) of clinical exercise interventions for alcohol use disorders was identified (14 studies). The review found that exercise may have beneficial effects on certain domains of physical functioning but inconsistent effects on anxiety, mood management, craving, and drinking behaviour, although the trend was towards a beneficial effect. Exercise interventions were found to be safe. The authors caveated that results should be interpreted cautiously due to the heterogeneity of the interventions and measures, and methodological flaws. One RCT (112) of exercise (30-45 mins twice weekly running or brisk walking) plus treatment as usual, compared with treatment as usual, in the treatment of alcohol use disorders was identified (n=105 patients). The trial found no significant difference in drinking habits between groups. One RCT (113) of physical activity (group or individual) as an adjunct to outpatient alcohol treatment, versus standard care, in people with alcohol use disorder was identified (n=175 patients). Compared with control, there was no significant difference in excessive drinking in the group exercise group (OR 0.99, p=0.976) or individual exercise group (1.02,		alcohol-related outcomes but may improve mood and depressive symptoms. This evidence is not thought to be sufficient to change the guideline recommendation, but this area will be revisited at the next surveillance review to see if the evidence base has expanded and evidence of an effect is clearer. New evidence is unlikely to change guideline recommendations. Drugs for alcohol dependence A network meta-analysis covering naltrexone, acamprosate, baclofen and topiramate came to the conclusion that there was no high grade evidence for drugs used in alcohol use disorders and that the drugs only showed a low to medium efficacy on alcohol-related outcomes, such as total alcohol consumption, with a high risk of bias. It should be noted that it is unclear from the abstract if all of the included studies were in alcohol dependence, but nalmefene, acamprosate and

2019 surveillance summary	Intelligence gathering	Impact statement
p=0.968). Subgroup analyses found that participants with moderate level physical activity had lower odds for excessive drinking than participants with low level physical activity (OR 0.12, p<0.001). The amount of alcohol consumed in the intervention groups decreased by 4% (p = 0.015) for each increased exercising day. ### Drugs for alcohol dependence One network meta-analysis (114) of nalmefene, naltrexone, acamprosate, baclofen or topiramate for alcohol dependence or alcohol use disorders was found (32 RCTs, n=6,036 participants). The network analysis found that compared with placebo, nalmefene, baclofen and topiramate showed superiority over placebo on total alcohol consumption. No efficacy was observed for naltrexone or acamprosate compared with placebo. Nalmefene and naltrexone had increased withdrawals due to safety reasons. Indirect comparisons found that topiramate was superior to nalmefene, naltrexone and acamprosate on alcohol consumption outcomes, but with a poor adverse event profile. ### Anticonvulsants One Cochrane review (115) of anticonvulsants for alcohol dependence was identified (25 studies, n=2,641 participants).There was moderate-quality evidence that, compared with placebo, anticonvulsants reduced drinks or drinking days (MD -1.49, 95% CI -2.32 to -0.65) and heavy drinking (SMD -0.35, 95% CI -0.51 to -0.19), and there was no difference in withdrawal for medical reasons, but for specific adverse effects the analyses generally favoured placebo.		naltrexone are drugs used in alcohol dependence. This new evidence does not seem sufficient to change current guideline recommendations in section 1.3.3 on interventions for harmful drinking and mild alcohol dependence, as the new evidence does not provide greater clarity on which drugs should be used. The evidence will be revisited at the next surveillance review to see if there is greater clarity on which drugs should be used in alcohol dependence. New evidence is unlikely to change guideline recommendations. ### Anticonvulsants A Cochrane review found that anticonvulsants were superior to placebo, but not to naltrexone, and the authors concluded that the evidence for anticonvulsants for treating alcohol dependence was insufficient. This new evidence does not seem sufficient to change current

2019 surveillance summary	Intelligence gathering	Impact statement
Compared with naltrexone, anticonvulsants did not have an effect on dropout rates, severe relapse rates, or continuous abstinence rates, but anticonvulsants were associated with fewer heavy drinking days (MD -5.21, 95% CI -8.58 to -1.83), more days to severe relapse (MD 11.88, 95% CI 3.29 to 20.46) and lower withdrawal for medical reasons (RR 0.13, 95% CI 0.03 to 0.58).		guideline recommendations in this section of the guideline, as the new evidence does not show a clear benefit of anticonvulsants compared with naltrexone, which is currently recommended in the guideline. The evidence will be revisited at the next surveillance review to see if there is greater clarity on the use of anticonvulsants for alcohol dependence.
Naltrexone		
One RCT (116) (117) of naltrexone versus placebo in young adult heavy drinkers aged 18-25 years old (n=118 adolescents) found that there was no significant difference between placebo and naltrexone for percentage of heavy drinking days and percent days abstinent. Compared with placebo, naltrexone significantly reduced the number of drinks per drinking day (p=0.009) and percentage of drinking days with estimated blood alcohol concentrations of 0.08 g/dL or more (p=0.042). There were no serious adverse events, although sleepiness was more common with naltrexone.		**New evidence is unlikely to change guideline recommendations.**
Nalmefene		**Naltrexone**
Related NICE guidance:		One RCT found that naltrexone was effective in reducing the number of drinking days in young adults aged 18-25 years, but not percent days abstinent or heavy drinking days. This evidence does not conflict with the guideline which currently suggests naltrexone or acamprosate may be used for alcohol dependence. However, footnote 7 is proposed to be amended to reflect changes in naltrexone licensing, see
• Nalmefene for reducing alcohol consumption in people with alcohol dependence NICE technology appraisal guidance (TA325)		
In addition there were 10 studies (114,118–126) concerning nalmefene identified during the 2019 surveillance process.		

Antipsychotics

One systematic review (127) of antipsychotics for alcohol dependence in patients without schizophrenia or bipolar depression was identified (13 double-blind studies, n=1,593 patients). The review included a range of drugs including aripiprazole, olanzapine, quetiapine and tiapride. The review found that none of the antipsychotics improved abstinence or reduced drinking or craving.

One RCT (128) of 12 weeks of 5mg or 2.5mg olanzapine, versus placebo, in the treatment of alcohol dependence was identified (n=129 participants). The trial found that there were reductions in alcohol use and craving and an increase in control over alcohol use across all treatment groups. Dose-response analyses indicated that, compared with placebo, participants in the 5 mg group experienced reduced craving for alcohol and participants in the 2.5 mg group decreased the proportion of drinking days and increased their control over alcohol use. The improved control over alcohol use in the 2.5mg group remained significant 6 months post-treatment. Both the 2.5mg and 5mg doses were equally well tolerated.

Varenicline

One systematic review (129) of varenicline in the treatment of alcohol use disorders in 'heavy drinkers' was identified (8 studies, number of participants not reported). The review found that varenicline reduces alcohol craving as well as reduction of overall alcohol consumption in patients with alcohol use disorders, but not abstinence rates.

One RCT (130) of varenicline (titrated to 2mg/day) versus placebo, in combination with a computerised behavioural intervention, for alcohol dependant participants (smokers and

Editorial and factual corrections below.

New evidence is unlikely to change guideline recommendations.

Nalmefene

There is a NICE guideline covering nalmefene for reducing alcohol consumption in people with alcohol dependence (TA325). We identified 10 studies relating to nalmefene use and these will be passed to the NICE technology appraisals programme for consideration during review of TA325. However, topic expert feedback highlighted that this section of the guideline should be updated to refer to the NICE guideline TA325 nalmefene.

An editorial amendment is proposed to be added to recommendation 1.3.3.2 to cross-refer to information on Nalmefene for reducing alcohol consumption in people with alcohol dependence (2014) NICE technology appraisal guidance 325. An editorial amendment is outlined in the section below on Editorial and factual corrections.

2019 surveillance summary	Intelligence gathering	Impact statement
non-smokers) was identified (n=200). The trial found that, compared with placebo, the varenicline group had significantly lower weekly percent heavy drinking days, drinks per day, drinks per drinking day, and alcohol craving (p<0.05). Adverse events were mild.		New evidence is unlikely to change guideline recommendations.
Other drugs

One RCT (131) of 600mg once daily benfotiamine (a high potency thiamine analogue), versus placebo, in alcohol dependant participants was identified (n=120 non-treatment seeking participants). The trial found that alcohol consumption reduced significantly for both groups and there were no significant adverse events. Compared with placebo, the reductions in total alcohol consumption over 6 months were significantly greater for benfotiamine treated women (p=0.02).

One RCT (132) of 30mg/day mirtazapine versus placebo in male high alcohol consumers, sub-grouped by hereditary alcohol use disorder, was identified (n=59 participants). There was no benefit of mirtazapine in the intention-to-treat analysis but participants with heredity for alcohol use disorder showed a benefit in terms of self-reported drinking with mirtazapine compared with placebo.

One phase II RCT (133) of samidorphan (1, 2.5, or 10 mg/day) versus placebo in adults with alcohol use disorder was identified (n=406 patients). During weeks 5 to 12 there was no statistical difference between samidorphan and placebo groups on the primary outcome of percentage of people with no heavy drinking days. However, compared with placebo, dose-dependent reductions in cumulative rate of heavy | | **Antipsychotics**

One systematic review found that antipsychotics were not effective in reducing alcohol drinking, abstinence or craving in patients without schizophrenia or bipolar depression, whilst 1 RCT found that olanzapine was effective compared with placebo in reducing alcohol use and craving. This evidence is not deemed sufficient to change the guideline recommendations as it does not provide clear evidence to demonstrate a benefit of antipsychotics in alcohol dependence. The evidence will be revisited at the next surveillance review to see if any new evidence provides support for antipsychotics for alcohol dependence. |
| | | New evidence is unlikely to change guideline |

2019 surveillance summary	Intelligence gathering	Impact statement
drinking days were observed for samidorphan 10 mg/day (-41%, p<0.001) and for samidorphan 2.5 and 1 mg (-30% and -32%, p<0.05 for both). Statistical significance was also reached for 10mg samidorphan on alcohol craving, and Patient Global Assessment of Response to Therapy (PGART). **2015 and 2013 surveillance** A total of 24 studies were found during previous surveillance conducted in 2013 and 2015 that covered psychological interventions (see clinical area 5: psychological and psychosocial interventions in previous surveillance), and 29 studies focused on pharmacological treatments for alcohol dependence or harmful alcohol use (see clinical area 6: pharmacological interventions in the previous surveillance review). Note that the methods used for previous surveillance did not separate out studies according to recommendations but instead looked at clinical areas.		recommendations. Varenicline One systematic review found that varenicline did reduce alcohol craving and alcohol consumption but not abstinence rates. It was unclear if any of the included studies were against an active comparator. Currently the guideline recommends naltrexone or acamprosate for alcohol dependence, and this new evidence does not provide an indication if varenicline is superior to these drugs, as such no impact on the guideline is anticipated. The evidence will be revisited at the next surveillance review to see if a more robust evidence base is available. New evidence is unlikely to change guideline recommendations. Other drugs Limited evidence was available for samidorphan, benfotiamine and mirtazapine, which showed benefits

2019 surveillance summary	Intelligence gathering	Impact statement
		of these drugs, compared with placebo, for some alcohol-use outcomes. Currently the guideline recommends naltrexone or acamprosate for alcohol dependence, and this new evidence does not provide an indication if any of these drugs are superior to naltrexone or acamprosate, as such no impact on the guideline is anticipated. Furthermore, samidorphan is currently not licensed in the UK. The evidence will be revisited at the next surveillance review to see if a more robust evidence base is available.
		New evidence is unlikely to change guideline recommendations.
		2015 and 2013 surveillance Previous surveillance concluded that cumulative evidence identified at the 2013 and 2015 surveillance time points was unlikely to change guideline recommendations.

2019 surveillance summary	Intelligence gathering	Impact statement
Recommendation section 1.3.4 Assessment and interventions for assisted alcohol withdrawal		
2019 surveillance Psychosocial interventions One systematic review (134) of psychosocial interventions in inducing or maintaining alcohol abstinence in patients with chronic liver disease was identified (13 studies, n=1,945 participants). The psychosocial interventions included motivational enhancement therapy, CBT, motivational interviewing, supportive therapy, and psycho-education either alone or in combination with another intervention or usual care. All studies of induction of abstinence (10 studies) reported an increase in abstinence among participants in the intervention and control groups. However, an integrated therapy that combined CBT and motivational enhancement therapy with comprehensive medical care, delivered during a period of 2 years, produced a significant increase in abstinence (74% increase in intervention group vs 48% increase in control group, p=0.02). All studies of maintenance of abstinence (3 studies) observed a return to alcohol in the intervention and control groups. However, an integrated therapy that combined medical care with CBT produced a significantly smaller rate of return to alcohol (32.7% in integrated CBT group versus 75% in control group, p=0.03). Treatment setting One systematic review (135) of community detoxification for alcohol dependence was identified (n=20 studies).The review	One expert identified that in relation to recommendation 1.3.4.2 (which recommends offering an intensive community programme following assisted withdrawal in which the service user may attend a day programme lasting between 4 and 7 days per week over a 3-week period), some service users would need an intensive structured community based intervention that lasts longer than 3 weeks (although not necessarily 7 days per week).	**2019 surveillance** Psychosocial interventions Published evidence suggests that psychosocial interventions may have a role in inducing abstinence if they offer combined CBT and motivational enhancement therapy with comprehensive medical care. This is in line with the guideline which recommends offering outpatient-based community assisted withdrawal programmes should consist of a drug regimen and psychosocial support including motivational interviewing (recommendation 1.3.4.3). However, a topic expert highlighted that recommendation 1.3.4.2 may be misinterpreted as meaning therapy should last for a maximum of 3 weeks which might not be sufficient. Recommendation 1.3.4.2 does state that community based programmes should 'vary in intensity according to severity of dependence, available

2019 surveillance summary	Intelligence gathering	Impact statement
found that compared to patients undergoing facility based detoxification, those who underwent community detoxification had better drinking outcomes. Community detoxification was also found to be cheaper than facility based detoxification, had good completion rates, and was reported to be safe. One RCT (136) of treatment for alcohol dependence in primary care, compared with outpatient specialist care, was identified (n=288 participants). The trial found that it was not possible to confirm the non-inferiority of primary care compared with outpatient specialist care for the primary outcomes of change in weekly alcohol consumption. Subgroup analysis found that specialist care was superior to primary care only for patients with high severity of dependence. **2015 and 2013 surveillance** A total of 24 studies were found during previous surveillance conducted in 2013 and 2015 that covered psychological interventions (see clinical area 5: psychological and psychosocial interventions in previous surveillance). Note that the methods used for previous surveillance did not separate out studies according to recommendations but instead looked at clinical areas.		social support and the presence of comorbidities'. Furthermore, 3-weeks was based on the evidence included at the time of guideline development and no new evidence was found to suggest a change in duration for these programmes. As such no change to recommendations is anticipated. New evidence is unlikely to change guideline recommendations. Treatment setting Published evidence suggests that community treatment is more effective for alcohol detox and cheaper than inpatient/facility based detox. Primary care based treatment was found to be non-inferior to outpatient specialist treatment. This is in line with current guideline recommendations which recommends community based detox. New evidence is unlikely to

2019 surveillance summary	Intelligence gathering	Impact statement
		change guideline recommendations.
		2015 and 2013 surveillance Previous surveillance also concluded that cumulative evidence identified at the 2013 and 2015 surveillance time points was unlikely to change guideline recommendations.

Recommendation section 1.3.5 Drug regimens for assisted withdrawal		
2019 surveillance Drug combinations One systematic review (137) of combined pharmacological interventions intended to treat alcohol use disorder was identified (16 studies). The majority of published trials included naltrexone combined with gabapentin, quetiapine, ondansetron, acamprosate, gamma-hydroxybutyrate, sertraline, or escitalopram plus gamma-hydroxybutyrate. There was no significant benefit of combinations over single agents, but the results were limited by low statistical power, and heterogeneity of outcome measures and drug combinations. Drug combination effect sizes were comparable to those observed in single-agent trials. However, the authors noted that the use of drug combinations may be useful to treat	A topic expert highlighted that there is a need to consider the use of other pharmaceutical interventions than just those covered by the guideline for the management of alcohol withdrawal, A topic expert indicated that recommendation 1.3.5.5, which states 'Prescribe for instalment dispensing, with no more than 2 days' medication supplied at any time' does not reflect common practice, especially in more rural areas, as in most areas there is no payment for true 'instalment dispensing' for these drugs. An expert indicated that there is increasing evidence to support using acamprosate/naltrexone earlier, and not wait until detox is completed. An expert indicated that there is no evidence to suggest a fixed dose regime is superior to a symptom-	**2019 surveillance** Drug combinations Published evidence from 1 systematic review suggests that there is no significant benefit of drug combinations over single agents for treating alcohol use disorders, although specific drug combinations may be effective in treating certain symptoms or populations. This new evidence does not seem sufficient to change current guideline recommendations, as the new evidence does not provide greater

2019 surveillance summary	Intelligence gathering	Impact statement
specific symptoms, or subpopulations. **Baclofen** One systematic review (138) of low (30-60mg/day) and high (>60mg/day) dose baclofen, versus placebo, for alcohol dependence was identified (13 RCTs). Compared to placebo, baclofen significantly increased time to lapse (SMD=0.42; 95% CI 0.19 to 0.64), and patients abstinent at the end point (OR=1.93; 95% CI 1.17 to 3.17), but there was no significant difference in percentage days abstinent. Overall, studies with low dose baclofen showed better efficacy than studies with high dose baclofen, and the tolerability of high dose baclofen was worse. Meta-regression analysis showed that the effects of baclofen were greater with high daily alcohol consumption as a starting point. One meta-analysis (139) of baclofen versus placebo for the treatment of alcohol use disorders (14 RCTs, n=1,522 patients) was identified. The review found a small non-significant difference with baclofen compared with placebo for all primary outcomes (SMD=0.22; 95% CI -0.03 to 0.47). One meta-analysis (140) of baclofen versus placebo for reducing harmful drinking, craving and negative mood was identified (12 RCTs). The trial found that compared with placebo, baclofen had a significant effect on abstinence rates when using intention-to-treat analysis (OR=2.67, 95% 1.03 to 6.93; p=0.04). There was no significant effect on other drinking outcomes such as heavy drinking days (p=0.21), or craving (p=0.24). There was substantial heterogeneity across each analysis.	triggered dose for treatment in the community and the recommendation could be revised.	clarity on which drugs should be used for the treatment of alcohol use disorder. Please note, due to abstract level detail it was unclear if all of the included studies within the systematic review were specifically for alcohol withdrawal. However, if the review does include studies for alcohol dependence or relapse prevention, the interpretation of results would not change and there would not be an anticipated impact on the guideline. The evidence will be revisited at the next surveillance review to see if there is greater clarity on combination drugs for the treatment of alcohol use disorders. New evidence is unlikely to change guideline recommendations. **Baclofen** New published evidence from 1 systematic review suggests that baclofen may be more effective than placebo, with low dose (30-60mg/day) baclofen showing better efficacy and safety than high dose

2019 surveillance summary	Intelligence gathering	Impact statement
One RCT (141) of baclofen (50mg/day) versus placebo, plus standard psychosocial treatment, for alcohol dependence was identified (n=64 participants). There were no between group differences for the percentages of heavy drinking and abstinent days. Both arms had a significant reduction in levels of distress, depression and craving, but self-efficacy and social support remained unchanged in both groups. There were no adverse events.		(>60mg/day) baclofen. Meta-regression analysis showed that the effects of baclofen were greater with a starting point of high daily alcohol consumption. Two further meta-analyses and 3 RCTs showed mixed results against placebo. The single trial of baclofen versus an active comparator showed that chlordiazepoxide provided more rapid and more effective control of anxiety and agitation requiring less lorazepam supplementation than baclofen.
One RCT (142) of 12 weeks baclofen (30mg/day or 60mg/day) versus placebo, alongside a structured psychosocial therapy called BRENDA, in alcohol dependant patients was identified (n=69). The trial found that heavy drinking days and drinks per drinking day significantly reduced across all 3 groups, and there were no statistically significant advantages to baclofen. A post hoc analysis found an advantage of baclofen 30mg/day and 60mg/day in patients with comorbid anxiety disorder on time to relapse (p < 0.05). There were no serious adverse events with either dose of balcofen.		
One RCT (143) of oral baclofen 30mg/day versus placebo in adults with chronic hepatitis C and alcohol use disorders was identified (n=180 participants). The trial found that compared with placebo, baclofen did not improve the percentage of days abstinent or the percentage of no heavy drinking. There were also no significant differences between baclofen and placebo participants outcomes.		Given the inconsistent benefits of baclofen compared with placebo, and the fact that chlordiazepoxide provided better outcomes compared with baclofen, the evidence is not deemed sufficient to change current recommendations. The evidence will be revisited at the next surveillance review to see if there is a more robust evidence base.
One RCT (144) of high dose baclofen (180mg/day) versus placebo in alcohol dependant patients was identified (n=320 participants). The trial did not find a statistically significant difference for its primary outcome of the percentage of		New evidence is unlikely to change guideline recommendations.

2019 surveillance summary	Intelligence gathering	Impact statement
abstinent patients during 20 consecutive weeks (baclofen: 11.9%; placebo: 10.5%, p=0.618). A reduction in alcohol consumption was observed from month 1 in both groups, but was not statistically significant between groups (p=0.095). In patients with high drinking risk level at baseline, the reduction in alcohol consumption was greater with a difference at month 6 of 15.6 g/day between groups in favour of baclofen (p=0.089). There was a significant reduction in craving assessed with Obsessive-Compulsive Drinking in the baclofen group (p=0.017). There were no major safety concerns. One RCT (145) of 9 days of 30mg baclofen versus 75mg chlordiazepoxide in participants with uncomplicated alcohol withdrawal syndrome was identified (n=60 participants). Lorazepam was used as rescue medication. The trial found that both baclofen and chlordiazepoxide showed a consistent reduction in the total Clinical Institute Withdrawal Assessment for Alcohol-Revised Scale (CIWA-Ar) scores. However, chlordiazepoxide showed a faster and more effective control of anxiety and agitation requiring less lorazepam supplementation. Both drugs were well tolerated with mild self-limiting adverse events. **Gabapentin** One systematic review of gabapentin for alcohol withdrawal and dependence (146) was identified (10 trials). The review found limited data suggesting that gabapentin can provide benefit in managing mild alcohol withdrawal syndrome, with improvements in sleep, mood and anxiety-related outcomes, although there were 5 suspected seizures in the withdrawal		**Gabapentin** Published evidence suggests that gabapentin may have a benefit in mild alcohol withdrawal and alcohol dependence. Currently gabapentin is not mentioned in the guideline, as the evidence was limited at the time of guideline development. Gabapentin is also currently unlicensed for alcohol withdrawal in the UK. This evidence is not deemed sufficient to change current recommendations. The evidence will be revisited at the next surveillance review to see if there is a more robust evidence base. New evidence is unlikely to change guideline recommendations. **Sodium oxybate** One trial of sodium oxybate sodium oxybate versus oxazepam for alcohol-dependent outpatients with uncomplicated alcohol withdrawal found no difference in effectiveness. Currently recommendation 1.3.6.14

2019 surveillance summary	Intelligence gathering	Impact statement
studies. Studies evaluating gabapentin for alcohol dependence found dose-dependent benefits for complete abstinence, rates of no heavy drinking and alcohol cravings, and gabapentin was well tolerated with no severe adverse reactions. One RCT (147) of gabapentin (900 or 1800 mg/day) versus placebo for alcohol dependence was identified (n=150 patients). The trial found that gabapentin significantly improved the rate of abstinence with 4% abstinence with placebo versus 11% with 900mg and 17% with 1800mg gabapentin (p=0.04 for linear dose effect). Gabapentin also significantly reduced heavy drinking, with 22.45% heavy drinking rate with placebo versus 29.6% with 900mg, and 44.7% with 1800mg gabapentin (p=0.02). The trial found no serious drug-related adverse events. ### Sodium oxybate One RCT (148) of 10 days of sodium oxybate versus oxazepam for alcohol-dependent outpatients with uncomplicated alcohol withdrawal was identified (n=126 patients). The RCT found no difference in the mean total CIWA-Ar score between groups, with both groups having significant reductions from baseline. There were no severe side effects reported with either therapy and both were well tolerated. **2015 and 2013 surveillance** A total of 29 studies focused on pharmacological treatments for alcohol dependence or harmful alcohol use (see clinical		does not recommend sodium oxybate (or Gamma-hydroxybutyric acid (GHB) as it is known in the guideline) as the committee who developed the guideline felt that the harm due to GHB misuse outweighed the benefits. As such, this new evidence is not deemed sufficient to update the guideline. The evidence will be revisited at the next surveillance review to see if there is a more robust evidence base to warrant an update. New evidence is unlikely to change guideline recommendations. ### Other issues Topic exerts highlighted that there is no evidence to suggest that fixed dosing is superior to symptom-triggered dosing in the community. However, the guideline committee came to the conclusion that symptom-triggered assisted withdrawal was only practical in those inpatient settings that

2019 surveillance summary	Intelligence gathering	Impact statement
area 6: pharmacological interventions in the [previous surveillance review](#)). Note that the methods used for previous surveillance did not separate out studies according to recommendations but instead looked at clinical areas.		contained 24-hour medical monitoring and high levels of specially trained staff. No new evidence has been found to contradict this and as such it does not appear warranted to update the guideline. A topic expert suggested that recommendation 1.3.5.5 which advocates only prescribing for instalment dispensing, with no more than 2 days' medication supplied at any time, was not practical in current practice, especially in rural areas. This recommendation is focused on preventing overdose and diversion and it is assumed that rural practices will have policies in place to balance the risks of overdose with dispensing practicalities. Whilst this is an important consideration it is not possible to cover and address all contextual factors within a guideline of this nature. In addition, 4 editorial amendments are proposed. Recommendation 1.3.5.3 is proposed to be amended to add: 'Prescribers should be aware

2019 surveillance summary	Intelligence gathering	Impact statement
		of the following legislation and advise patients accordingly: Drugs and driving: blood concentration limits to be set for certain controlled drugs in a new legal offence 2014'. Recommendation 1.3.5.11 is proposed to be amended to add: 'Prescribers should also see Addiction to benzodiazepines and codeine July 2011. Footnotes 12 and 13 are proposed to be amended with the new standard wording for unlicensed medicines. See Editorial and factual corrections below. **2015 and 2013 surveillance** Previous surveillance also concluded that cumulative evidence identified at the 2013 and 2015 surveillance time points was unlikely to change guideline recommendations.
Recommendation section 1.3.6 Interventions for moderate and severe alcohol dependence after successful withdrawal		
2019 surveillance Disulfiram	One expert stated that there is a need to examine the use of adjunctive medication in preventing relapse, and that gabapentin is being studied for its potential in relapse prevention. However, given concerns in the	**2019 surveillance** Disulfiram

2019 surveillance summary	Intelligence gathering	Impact statement
One meta-analysis (149) of disulfiram for supporting abstinence was identified (22 studies). The analysis found a higher success rate of disulfiram compared to controls. The results were significant across open label studies but when looking at RCTs with blind designs the results were not significant. Disulfiram was also more effective than the control condition when compared to naltrexone and to the no disulfiram group. The authors noted a high degree of heterogeneity across studies. One RCT (150) of 6 months disulfiram versus naltrexone, together with group psycho-education, for relapse prevention in adolescents was identified (n=52 adolescents). The trial found that at the end of the study, relapse occurred at a mean of 93 days with disulfiram compared with 63 days for naltrexone, and 84.61% patients receiving disulfiram remained abstinent compared with 53.85% receiving naltrexone. One RCT (151) of disulfiram versus placebo, with and without adjunctive mailed letters therapy outlining alcohol harms, for the treatment of alcohol dependence was identified (n=109). The trial found no significant differences among treatments in terms of abstinent patients or study dropouts. However, patients with inactive ALDH2 significantly sustained abstinence with the use of disulfiram (p = 0.044). The trial also found that the ratio of abstinence was not related to the severity of alcohol dependence or the degree of alcohol craving. **Naltrexone** One RCT (152) of 6 monthly injections of extended release	UK about its misuse and interactions with opioids, a statement about gabapentin use in treating alcohol misuse would be welcome. One expert stated that the use of pharmacotherapy for relapse prevention continues to be a challenge given associated costs, how services are commissioned, increased number of 3rd sector providers and a lack of prescribing in primary care. One expert identified that recommendation 1.3.6 needs updating as there are now several trials of baclofen and it is being used off-label quite widely. One expert highlighted there is little about recovery interventions in the guideline, and that there is a need to strengthen the use of drugs used to maintain abstinence (prevent relapse) to better support GP prescribing. One expert highlighted that there is a need to update information on naltrexone because it's UK marketing authorisation has been updated. An expert reported that pre- and post-detox the guideline should refer to use of vitamins, as this remains a contentious issue nationally, and clinical practice varies widely as a result of a lack of guidance. One expert said there is some new evidence that Acceptance and Commitment Therapy (ACT) has some impact in preventing alcohol relapse.	Published evidence for disulfiram for relapse prevention showed some benefits compared with naltrexone and controls. However, the effects were uncertain due to heterogeneity across studies and results were more likely to be significant in open label studies than blinded RCTs. This new evidence generally suggests disulfiram may have some benefits in supporting abstinence and is unlikely to change recommendations which cover disulfiram use. New evidence is unlikely to change guideline recommendations. **Naltrexone** Published evidence suggests that naltrexone may be effective in reducing quantity of alcoholic drinks and time to relapse, but mixed effects on other outcomes such as drinking frequency. This evidence is in line with current guideline recommendations which state

2019 surveillance summary	Intelligence gathering	Impact statement
naltrexone versus placebo in prisoners with HIV and alcohol use disorder who were released early was identified (n=100 participants). The trial found no statistically significant difference in time-to-heavy-drinking day between treatment arms overall. In the subgroup of participants aged 20-29 years there was a longer time to first heavy drinking day with naltrexone compared to placebo (24.1 versus 9.5 days; p<0.001). There were no statistically significant differences for other individual drinking outcomes with naltrexone. One systematic review (153) of oral or injectable naltrexone compared to placebo with or without behavioural intervention in women with alcohol use disorder was identified (7 RCTs, 903 women). The review found a trend towards a reduced quantity of drinks (2 trials) and time to relapse (3 trials), but mixed effects on drinking frequency (4 trials). Acamprosate One systematic review and meta-analysis (154) of acamprosate versus placebo and naltrexone to prevent relapse in participants who are alcohol-dependent was identified (22 RCTs, n=5,236 participants). The review found that the risk of returning to any drinking at 6 months was significantly lower for acamprosate (RR=0.83, 95% CI 0.78 to 0.89), but there was no significant difference in risk of participants discontinuing treatment for any reason or due to adverse events for the acamprosate compared to placebo groups. For the naltrexone group, the risk of individuals returning to any drinking at 3 months was significantly reduced (RR=0.92, 95% CI 0.86 to 1.00), as was the risk of individuals		consider offering naltrexone. One expert highlighted that the marketing authorisation for naltrexone has changed. An editorial amendment to footnote 2 within the guideline is proposed to be made to update the UK marketing authorisation for naltrexone, see the section below on Editorial and factual corrections. New evidence is unlikely to change guideline recommendations. Acamprosate Published evidence suggests that acamprosate is effective in preventing relapse and maintaining abstinence. This evidence is in line with current guideline recommendations, which state consider offering acamprosate. New evidence is unlikely to change guideline recommendations. Baclofen

2019 surveillance summary	Intelligence gathering	Impact statement
relapsing to heavy drinking at 3 months (RR=0.85, 95% CI 0.78 to 0.93). There was no significant difference between naltrexone and placebo for the risk of individuals discontinuing treatment for any reason but there was a significantly greater risk of participants discontinuing treatment due to adverse events for naltrexone compared to placebo (RR=1.72, 95% CI=1.10 to 2.70).

One RCT (155) of 24 weeks acamprosate (1,998 mg/d orally) or placebo in maintaining complete abstinence in Japanese patients with alcohol dependence was identified (n=327 participants). The trial found that significantly more patients remained abstinent with acamprosate (47.2%) compared with 36% in the placebo group (p = 0.039). The difference in complete abstinence rates between with acamprosate compared with placebo was 11.3% (95% CI, 0.6%-21.9%).

Baclofen

One meta-analysis (156) of baclofen versus placebo on the maintenance of abstinence and the decrease of craving in alcohol-dependent patients was identified (number of trials and participants not reported in abstract). The review found that baclofen was associated with a significant increase of 179% in the percentage of abstinent patients at the end of the trials, compared with placebo. There was no significant effect of baclofen compared to placebo for secondary outcomes.

One RCT (157) of individually titrated high dose baclofen (30-270mg/day) for the treatment of alcohol dependence was identified (n=93). The trial found that, compared with placebo, statistically significantly more baclofen patients maintained | | New published evidence from 1 meta-analysis and 2 trials suggest that baclofen improves alcohol abstinence compared with placebo, but 1 trial showed no difference compared with placebo. One trial showed that balcofen was superior to benfotiamine (a thiamine supplement). Currently baclofen is not covered in the guideline, and as such it's use is neither recommended nor precluded for moderate and severe alcohol dependence after successful withdrawal. This evidence does not indicate if baclofen is superior or equivalent to drugs already mentioned in this guideline section and therefore evidence is deemed insufficient to change current guideline recommendations. The evidence will be revisited at the next surveillance review to see if there is a more robust evidence base to warrant a statement on the use of baclofen after successful withdrawal.

New evidence is unlikely to change guideline |

2019 surveillance summary	Intelligence gathering	Impact statement
total abstinence (68.2% versus 23.8%, p=0.014), and had a higher cumulative abstinence duration (mean 67.8 versus 51.8 days, p=0.047). There were no serious drug-related adverse events during the trial.		recommendations.

total abstinence (68.2% versus 23.8%, p=0.014), and had a higher cumulative abstinence duration (mean 67.8 versus 51.8 days, p=0.047). There were no serious drug-related adverse events during the trial.

One RCT (158) of 30mg/day baclofen versus benfotiamine (a dietary thiamine supplement), plus brief motivational intervention, to promote abstinence in alcohol-dependent patients was identified (n=122 participants). The trial found that, compared with the benfotiamine group, participants receiving baclofen remained abstinent for significantly more days (p < 0.05), had a significantly lower percentage of heavy drinking days (p = 0.001), and had significantly lower craving and anxiety scores (p = 0.001). The time to first relapse was similar in both groups.

One RCT (159) of 10 weeks high dose baclofen (up to 150mg per day), low dose baclofen (30mg per day), or placebo for alcohol dependence was identified (n=151 patients). The primary outcome measure was time to first relapse. The trial found that neither low nor high doses of baclofen were effective in the treatment of alcohol disorder and that adverse events were frequent, although usually mild and temporary.

One RCT (160) of 12 weeks baclofen (30mg/day or 75mg/day) versus placebo in alcohol dependant patients with or without liver disease was identified (n=104). The trial found a significant effect of the composite groups of baclofen on time to lapse (p<0.05, Cohen's d=0.56) and relapse (p<0.05, d=0.52). There was a significant treatment effect of baclofen for percentage of days abstinent (placebo 43%, baclofen 30mg 69%, baclofen 75mg 65%; p<0.05). There was one

Topiramate

New published evidence generally suggests that topiramate is effective in improving abstinence, drinking days and craving, compared with placebo, although1 trial found no benefit. There were no trials against an active comparator. Currently topiramate is not covered in the guideline, and as such it's use is neither recommended nor precluded for moderate and severe alcohol dependence after successful withdrawal. This evidence does not indicate if topiramate is superior or equivalent to drugs already mentioned in this guideline section and therefore evidence is deemed insufficient to change current guideline recommendations. The evidence will be revisited at the next surveillance review to see if there is a more robust evidence base to warrant a statement on the use of topiramate after successful withdrawal.

2019 surveillance summary	Intelligence gathering	Impact statement
overdose with 75mg baclofen. ### Topiramate One meta-analysis (161) of topiramate versus placebo for the treatment of alcohol use disorders was identified (7 RCTs; n=1,125 participants). Compared with placebo, topiramate was identified to improve abstinence (g=0.468, p<0.01), heavy drinking (g=0.406, p<0.01), and craving (g=0.312, p=0.07) outcomes. One RCT (162) of 100mg oral topiramate twice daily, versus placebo, plus rehabilitation twice weekly, for relapse prevention was identified (n=52 patients following detoxification). The trial found that after 6 weeks of treatment patients receiving topiramate had significantly fewer drinking days (p<0.05); less daily alcohol consumption (p<0.05); more days of treatment (p<0.05), compared with placebo. One RCT (163) of 100-300 mg/day topiramate for relapse prevention in alcohol dependant minimal withdrawal patients receiving a residential treatment program was identified (n=106 patients). The trial found that there was no significant difference between topiramate and placebo on the mean percentages of heavy drinking days, time to first day of heavy drinking, or other secondary outcomes. ### 2015 and 2013 surveillance A total of 29 studies focused on pharmacological treatments for alcohol dependence or harmful alcohol use (see clinical area 6: pharmacological interventions in the previous surveillance review). Note that the methods used for previous		New evidence is unlikely to change guideline recommendations. ### Other issues One expert stated that there is a need to examine the use of adjunctive medication in preventing relapse. However no new evidence was found to address this issue. A topic expert said that a statement on gabapentin misuse would be welcomed. This drug is not currently mentioned in the guideline, and no new evidence was identified for relapse prevention, although evidence was identified for withdrawal which is discussed above under recommendation 1.3.5. As the evidence on gabapentin is not deemed sufficient to update the guideline to include gabapentin as a treatment option, a statement on gabapentin misuse might cause confusion. Furthermore, a number of drugs used in alcohol withdrawal and relapse prevention have the potential to be addictive and thus misused.

2019 surveillance summary	Intelligence gathering	Impact statement
surveillance did not separate out studies according to recommendations but instead looked at clinical areas.		Recommendation 1.3.5.5 does already recommend that, for withdrawal in the community, people should not be given large quantities of medication to prevent overdose and diversion. One expert highlighted that there is little about recovery interventions in the guideline. However no new evidence was identified that would address this issue. One expert said that the guideline should refer to use of vitamins pre- and post-detox, as clinical practice varies widely as a result of a lack of guidance. However no new evidence was found to address this issue. One expert said there is new evidence that Acceptance and Commitment Therapy (ACT) has some impact in preventing alcohol relapse. However, no systematic reviews or RCTs of ACT were found that would address this issue. **2015 and 2013 surveillance** Previous surveillance also concluded that evidence identified at those time

2019 surveillance summary	Intelligence gathering	Impact statement
		points was unlikely to change guideline recommendations.

Recommendation section 1.3.7 Special considerations for children and young people who misuse alcohol

2019 surveillance summary	Intelligence gathering	Impact statement
2019 surveillance No evidence identified. Parent-based interventions One systematic review (164) of parent-based alcohol use interventions with adolescents (up to 18 years) (20 studies) found that the average treatment effect size across all drinking outcomes was statistically significant (g = -0.23; 95% CI 0.35 to -0.10). Parent-based interventions seemed to have larger mean effect sizes on adolescent drinking intention rather than binge drinking. The interventions targeting both alcohol-specific and general parenting strategies had larger average effect sizes than those targeting alcohol-specific parenting only. **2015 and 2013 surveillance** No relevant evidence identified.	Some topic experts suggested that there is an overlap between recommendations 6 and 7 in Alcohol-use disorders: prevention (NICE guideline PH24), and recommendations 1.3.7.1 to 1.3.7.4 in NICE guideline CG115. In particular, both guidelines cover initial assessment. However, views were mixed on whether the recommendations in the different guidelines are complementary or at odds, with some experts suggesting that the guidelines did not need amending as there was no overlap, whilst others felt an overlap was an issue that needed addressing.	**2019 surveillance** Parent-based intervention Published evidence indicates that parent-based interventions can be effective in reducing adolescent drinking, in particular drinking intention. The interventions targeting both alcohol-specific and general parenting strategies were most effective. This new evidence is in line with the guideline which recommends a range of interventions involving the parents, including multidimensional family therapy, functional family therapy and brief strategic family therapy. For details of parent strategies in relation to school-based interventions for alcohol misuse, see the scope of the NICE guideline in development on Alcohol: school-

2019 surveillance summary	Intelligence gathering	Impact statement
		based interventions.
		New evidence is unlikely to change guideline recommendations.
		Some topic experts also thought that there might be an overlap between recommendations 1.3.7.1 to 1.3.7.4 in CG115 and recommendations 6 and 7 in NICE guideline Alcohol-use disorders: prevention (NICE guideline PH24). However, other experts felt these recommendations were complementary as the focus of PH24 is prevention of alcohol misuse, whilst CG115 focusses on treatment of alcohol misuse. The guidelines have different treatment settings and as such recommendations 1.3.7.1 to 1.3.7.4 in CG115 are deemed complimentary to PH24, and no change is deemed necessary in either guideline.
		Footnote 16 is proposed to be amended to the new standard wording for unlicensed medicines, see Editorial and factual corrections

2019 surveillance summary	Intelligence gathering	Impact statement
		below.
Recommendation section 1.3.8 Interventions for conditions comorbid with alcohol misuse		
2019 surveillance Depression One RCT (165) of 12 weeks naltrexone combined with citalopram versus 12 weeks naltrexone alone in patients with co-occurring alcohol dependence and depression was identified (n=138 depressed alcohol-dependent adults who were not required to be abstinent at the commencement of the trial). The trial found improvements in both mood and drinking related outcomes in both groups, with no significant differences between groups. Women were found to have a slightly better response in terms of percent days abstinent. One RCT (166) of 12 weeks citalopram versus placebo, combined with group psychotherapy, in depressed alcohol-dependent individuals was identified (n=265 participants). The trial found that citalopram was not superior to placebo in terms of treatment outcomes, and actually produced poorer results for some outcomes. The participants in the citalopram group had a higher number of heavy drinking days throughout the trial, and had smaller reductions in frequency and amount of alcohol consumption at 12 weeks. Neither treatment group had changes in depression severity. One systematic review (167) of combining CBT and motivational interviewing, versus usual care, to treat comorbid	With reference to recommendation 1.3.8.2, 1 expert suggested that the risk of suicide may be too high to wait for an appointment with a psychiatrist which can takes several weeks. They queried whether there should be a reference to people at high risk of suicide being advised to seek an immediate appointment with the GP or going to A&E if there is a likely to be a wait for an appointment with the psychiatrist. One expert highlighted that there is now evidence on vaping that could be referred to in recommendation 1.3.8.4. One expert said that intramuscular Pabrinex is now offered extensively in the community, the previous restriction to inpatient settings is now lifted, with reference to recommendation 1.3.8.5 which addresses Wernicke-Korsakoff syndrome. The expert also highlighted that addiction services do not have access to budgets to treat Wernicke-Korsakoff syndrome and suggested that recommendations covering Wernicke-Korsakoff syndrome belongs in a NICE dementia guideline. One expert said that there has been a growing recognition that alcohol use disorders are often part of a complex pattern of comorbidities and this could be	**2019 surveillance** Depression Published evidence suggests that citalopram alone was not effective in reducing alcohol consumption in alcohol dependant patients with depression. Naltrexone alone or combined with citalopram was found to improve mood and drinking outcomes in patients with co-occurring alcohol dependence and depression, but the study was small. Combined motivational interviewing and CBT was also found to improve depressive symptoms and alcohol consumption, with digital interventions having higher efficacy than face-to-face interventions. Evidence in studies of people who misuse alcohol and have comorbid depression is unlikely to change current guideline recommendations, which encourages treating alcohol

2019 surveillance summary	Intelligence gathering	Impact statement
alcohol use disorder and major depression was identified (12 studies, n=1,721 patients).The review found that, compared with usual care, CBT/motivational interviewing decreased alcohol consumption (g=0.17, p<0.001) and decrease in depressive symptoms (g=0.27, p<0.001). Subgroup analysis found that digital interventions had a higher effect size for depression than face-to-face interventions (g=0.73 versus g=0.23, p=0.030).	given more detailed consideration here. One expert highlighted that they have seen the development of assertive outreach services, such as Alcohol Concerns "blue light" project and that consideration could be given to the effectiveness of this approach in patients with complex mental and physical health comorbidities.	misuse first, with referral to a psychiatrist if indicated, and use of condition specific guidelines.
		New evidence is unlikely to change guideline recommendations.
Post-traumatic-stress disorder		**Post-traumatic stress disorder**
One systematic review (168) of pharmacotherapy and psychotherapy for co-occurring post-traumatic stress disorder (PTSD) and alcohol use disorder was identified (16 studies). The review found that pharmacological interventions were generally effective in reducing drinking outcomes; but only one study using sertraline found that it was superior to placebo in reducing PTSD symptoms. However, psychotherapies were not found to be superior to a comparative treatment in reducing drinking outcomes. The authors noted that the evidence base was limited.		Integrated CBT and CBT plus supportive counselling were shown to have beneficial effects in alcohol use disorders with PTSD. However, the study was limited by a small sample size. Naltrexone with or without supportive counselling or prolonged exposure therapy was shown to reduce drinking days and PTSD symptoms but the results diminished by 6 months.
One RCT (169) of 12 once-weekly individual sessions of integrated CBT, versus CBT plus supportive counselling, for coexisting PTSD and alcohol use disorders was identified (n=62 participants). The trial found that both groups reduced PTSD symptoms but participants with integrated CBT who had received one or more sessions of exposure therapy had a two-fold greater rate of clinically significant change in clinician administered PTSD scale severity at follow-up than supportive counselling participants (OR 2.31, 95% CI 1.06 to 5.01).		This evidence is unlikely to change current guideline recommendations which encourages treating alcohol misuse first, with referral to a psychiatrist if indicated, and use of condition specific guidelines.
		New evidence is unlikely to

2019 surveillance summary	Intelligence gathering	Impact statement
However, supportive counselling participants had larger reductions in alcohol consumption compared with integrated CBT. One RCT (170) of 100mg/day naltrexone plus prolonged exposure therapy (12 weekly 90-minute sessions followed by 6 biweekly sessions), prolonged exposure therapy plus placebo, supportive counselling plus 100 mg/day naltrexone, or supportive counselling plus placebo in participants with PTSD and comorbid alcohol dependence was identified (n=165 participants). Participants in all 4 treatment groups had large reductions in the percentage of days drinking, and reductions in PTSD symptoms, although the naltrexone groups had lower percentages of days drinking than those who received placebo (p=0.008). Participants in all 4 groups had increases in percentage of days drinking after 6 months but those in the prolonged exposure therapy plus naltrexone group had the smallest increases. One RCT (171) of seeking safety (a type of CBT) plus sertraline, versus seeking safety plus placebo, for co-occurring PTSD and alcohol use disorder was identified (n=69 participants). The trial found that both groups demonstrated significant improvement in PTSD symptoms. The sertraline intervention group had a significantly greater reduction in PTSD symptoms than the placebo group at end of treatment, which was sustained at 12-month follow-up. ### Anxiety One Cochrane review (172) of pharmacotherapies for comorbid alcohol use disorders and anxiety was identified (5		change guideline recommendations. ### Anxiety The published evidence from a Cochrane review for pharmacotherapies for comorbid alcohol use and anxiety was inconclusive. This evidence is unlikely to change current guideline recommendations which encourages treating alcohol misuse first, with referral to a psychiatrist if indicated, and use of condition specific guidelines. New evidence is unlikely to change guideline recommendations. ### Tobacco use The published evidence from a single RCT found varenicline may reduce smoking overall but heavy drinking was only reduced in men, rather than the overall trial population. Given this limited evidence and uncertainty regarding

2019 surveillance summary	Intelligence gathering	Impact statement
RCTs, n=290 participants). The review found some effects of buspirone in reducing measures of anxiety, there was no effect of sertraline or paroxetine. However, paroxetine was identified to be equally effective as tricyclic antidepressants in reducing the severity of PTSD symptoms. There was no evidence that alcohol use was responsive to medication. Overall the authors concluded that the evidence base was inconclusive and further research is needed. **Tobacco use** One RCT (173) of varenicline 1mg twice daily plus medical management versus placebo for the treatment of co-occurring alcohol use disorder and smoking was identified (131 participants). The trial found that varenicline was associated with decreased heavy drinking among men and increased smoking abstinence in the overall sample. **Drug misuse** One Cochrane review (174) of psychosocial interventions for comorbid problem alcohol and illicit drug use (mainly opiates and stimulants) was identified (4 studies, n=594 participants). The review found no difference in effectiveness between different types of interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users. The authors noted the low quality of the included studies and lack of evidence. **2015 and 2013 surveillance** No relevant evidence identified.		whether varenicline can also reduce drinking, no impact on the guideline recommendation is expected. A topic expert also highlighted that there is new evidence on vaping. Recommendation 1.3.8.4 will be updated to cross-refer to Stop smoking services and interventions NICE guideline NG92, which includes advice on e-cigarettes and has replaced NICE guideline PH1. New evidence is unlikely to change guideline recommendations. **Drug misuse** The published evidence from a Cochrane review for psychosocial interventions for comorbid alcohol use and drug misuse was inconclusive. This evidence is unlikely to change current guideline recommendations. New evidence is unlikely to change guideline

2019 surveillance summary	Intelligence gathering	Impact statement
		recommendations.
		### Other issues
		Topic experts highlighted several issues. One expert said there is an issue around waiting times for psychiatrist appointments if someone is at risk of suicide. The committee did acknowledge that some people with depressive disorders will require immediate treatment (such as those at significant risk of suicide) and the recommendations were not meant to stand in the way of immediate treatment being provided in such a situation. Professionals are anticipated to safe guard individuals and take appropriate action if they are concerned about risk of suicide.
		Feedback was also received that there has been a growing recognition that alcohol use disorders are often part of a complex pattern of comorbidities and this could be given more detailed consideration. The committee was aware of this at the time of guideline development and in reviewing the

2019 surveillance summary	Intelligence gathering	Impact statement
		evidence for comorbid disorders related to recommendations within section 1.3.8, the committee did not find any treatment strategies or adjustments that should be made because of the comorbid condition and, in view of this, decided to refer to the relevant NICE guidelines. An expert said they have seen the development of assertive outreach services in relation to comorbid mental health conditions, but we did not find any RCT or systematic review level evidence that was available for consideration in this surveillance review. In relation to recommendation 1.3.8.5 which concerns Wernicke-Korsakoff syndrome, 1 expert stated that intramuscular Pabrinex [thiamine containing vitamin product] is now offered extensively in the community. The NICE guideline on alcohol-use disorders: diagnosis and management of physical complications (CG100) is being updated on thiamine, which recommendation 1.3.8.5 cross-refers to.

2019 surveillance summary	Intelligence gathering	Impact statement
		One expert highlighted that addiction services do not have access to budgets for treating Wernicke-Korsakoff syndrome. However, Wernicke-Korsakoff syndrome is such a significant complication of alcohol dependence that recommendations 1.3.8.5 and 1.3.8.6 are considered important to NICE guideline CG115, although it is acknowledged that they may be relevant to a range of service providers, as well as alcohol services. Footnote 17 is proposed to be amended to include Antisocial personality disorder: prevention and management (CG77). It will also be amended to say: 'Also see NICE guideline Coexisting severe mental illness and substance misuse: community health and social care services (NG58).' See Editorial and factual corrections below. **2015 and 2013 surveillance** No relevant evidence identified.

2019 surveillance summary	Intelligence gathering	Impact statement
Areas not covered in the guideline		
2019 surveillance Digital based interventions One Cochrane review (175) of digital interventions for reducing hazardous and harmful alcohol consumption in people living in the community (57 studies; n=34,390 participants) was found. Compared with no intervention, 15 studies (16 comparisons, 10,862 participants) found that participants who engaged with digital interventions had less than one drinking day per month fewer, 15 studies (9791 participants) found intervention participants drank one unit per occasion less, and 15 studies (3587 participants) showed about one binge drinking session less per month. Five studies (n=390 participants) compared digital and face-to-face interventions, and they found no difference in alcohol consumption. The authors noted that overall there is moderate-quality evidence that, compared with control, digital interventions may lower alcohol consumption, with an average reduction of up to 3 UK standard drinks per week. However, there was substantial heterogeneity and risk of publication and performance bias, which may mean the reduction was lower. One RCT (176) of computerised CBT plus treatment as usual, computerised CBT plus brief weekly clinical monitoring, or treatment as usual for alcohol use disorders was found (n=68 participants). The trial found significantly higher rates of	A topic expert highlighted that there is growing evidence of digital interventions for alcohol misuse. Experts provided several references which were incorporated in the 2019 surveillance summary as appropriate.	**2019 surveillance** Digital based interventions Published evidence suggests that digital based interventions may have a role in reducing alcohol consumption. However, the evidence included in the Cochrane review was heterogeneous and it is not clear if the interventions are specifically for harmful drinking, or at what stage of alcohol misuse (mild dependence, withdrawal, relapse prevention). Currently the guideline does not cover digital interventions. At present there is limited evidence on digital interventions for harmful alcohol use and no impact on the guideline is anticipated. This will be revisited at the next surveillance review to see if the evidence has progressed. New evidence is unlikely to change guideline

2019 surveillance summary	Intelligence gathering	Impact statement
treatment completion among participants assigned to one of the computerised CBT groups compared to treatment as usual (Wald = 6.86, p<0.01). All 3 treatment groups had significant reductions in alcohol use, with participants assigned to computerised CBT plus treatment as usual demonstrating greater increases in percentage of days abstinent compared to treatment as usual (p<0.01). The estimated costs of all self-reported alcohol-related services accessed by participants were considerably lower for those assigned to computerised CBT groups compared to treatment as usual. One RCT (177) of automated telephone continuing care following CBT for alcohol dependence, versus usual care, was found (n=158 participants). The trial found that drinking days per week increased over time for the usual care group but not for automated telephone continuing care, but there were no significant differences for other alcohol-related outcome measures between groups. The subset of participants abstinent at the end of CBT showed higher rates of continuous abstinence with telephone continuing care. One RCT (178) of a mobile phone intervention, versus a less intense mobile phone intervention, to increase adherence to naltrexone (50mg/day) for alcohol use disorders was found (n=76 participants). The intervention consisted of a medication event monitoring system and a prepaid smartphone, which received a daily text message querying medication side effects, alcohol use, and craving, as well as additional medication reminders and adherence assessment via text message. Those in the control group did not get the additional medication reminders and adherence assessment via text		recommendations **2015 and 2013 surveillance** There were no relevant studies identified.

2019 surveillance summary	Intelligence gathering	Impact statement
message. The trial found no difference in the primary outcome of proportion of participants with adequate adherence, or mean adherence at study midpoint (week 4) was 83% in the intervention group and 77% in the control condition. However, survival analysis found that the intervention group sustained adequate adherence significantly longer than those in the control group during the first month of treatment (19 days versus 3 days, p=0.04). But medication adherence did not predict drinking outcomes. One RCT (179) of optional videoconferencing-based treatment, versus usual care, for alcohol use disorders was found (n=71 participants). The trial found that compared with control, participants in the videoconferencing group had significantly lower drop outs at 6 months (6% versus 31%, p=0.008) and 1 year (25% versus 44%, p=0.02), and significantly more were still attending treatment after 1 year (p=0.03). One RCT (180) of a smartphone based application (A-CHESS) plus usual care, versus usual care, to support recovery from alcoholism after residential treatment was identified (n=349 participants). The A-CHESS group reported significantly fewer risky drinking days than the control group, with a mean of 1.39 vs 2.75 days (p=0.003) at 12 months. **2015 and 2013 surveillance** There were no relevant studies identified.		

Research recommendations		
4.1: Is contingency management effective in reducing alcohol consumption in people who misuse alcohol compared with standard care?		
No relevant studies identified at any surveillance time point.	No expert feedback was provided.	No relevant evidence identified. This research recommendation will be considered again at the next surveillance point.
4.2: What methods are most effective for assessing and diagnosing the presence and severity of alcohol misuse in children and young people?		
No relevant studies identified at any surveillance time point.	A topic expert highlighted that Alcohol-use disorders: prevention (NICE guideline PH24) does not recommend using AUDIT in this age group whereas CG115 does.	No relevant evidence identified. This research recommendation will be considered again at the next surveillance point.
4.3: Is acupuncture effective in reducing alcohol consumption compared with usual care?		
2019 surveillance One meta-analysis (108) of acupuncture for alcohol use disorders was identified (7 studies, n=243 participants).The analysis found that compared with control, acupuncture had a stronger effect on reducing alcohol-related symptoms and behaviours (g = 0.67). The authors suggested that a larger cohort study is required to confirm results One systematic review (109) of acupuncture to reduce alcohol dependency was identified (15 RCTs, n=1,378 participants). The review found	No expert feedback was provided.	Published evidence suggests that acupuncture may have some potential to reduce alcohol craving, however the evidence base is limited, and more research is needed. This research recommendation will be considered again at the next surveillance point.

that, compared with control, acupuncture reduced alcohol craving (SMD -1.24, 95% CI -1.96 to -0.51); and alcohol withdrawal symptoms (SMD -0.50, 95% CI -0.83 to -0.17). Secondary analyses showed that acupuncture reduced craving compared with sham acupuncture; reduced craving compared with controls in RCTs conducted in Western countries; and reduced craving compared with controls in RCTs with only male participants. **2015 and 2013 surveillance** There were no relevant studies identified		

4.4: For which service users who are moderately and severely dependent on alcohol is an assertive community treatment model a clinically- and cost-effective intervention compared with standard care?

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

4.5: For people with moderate and severe alcohol dependence who have significant comorbid problems, is an intensive residential rehabilitation programme clinically and cost-effective when compared with intensive community based care?

No relevant studies identified at any surveillance time point.	No relevant studies identified at any surveillance time point.	No relevant studies identified at any surveillance time point.

4.6: For people with alcohol dependence, which medication is most likely to improve concordance and thereby promote abstinence and prevent relapse?

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

Editorial and factual corrections

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

- Recommendation 1.3.3.2 is proposed to be amended to say: 'Offer behavioural couples therapy for harmful drinkers and people with mild alcohol dependence who have a regular partner who is willing to participate in treatment, unless there are indicators that a person has experienced, or is a perpetrator of, domestic abuse.'

- Recommendation 1.3.3.2 is proposed to be amended to include the following cross-referral: 'For advice on the use of nalmefene for alcohol dependence see Nalmefene for reducing alcohol consumption in people with alcohol dependence NICE technology appraisal guidance (TA325).'

- Recommendation 1.3.5.3 is proposed to be amended to add: 'Prescribers should be aware of the following legislation and advise patients accordingly: Drugs and driving: blood concentration limits to be set for certain controlled drugs in a new legal offence 2014'.

- Recommendation 1.3.5.11 is proposed to be amended to add: 'Prescribers should also see Addiction to benzodiazepines and codeine July 2011.

- Recommendation 1.3.8.4 is proposed to be amended with a cross reference to Stop smoking interventions and services NICE guideline NG92, which has since replaced PH1.

- Footnote 1 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.'

- Footnote 2 is proposed to be amended to reflect changes in licensing: 'Oral naltrexone is licensed for alcohol dependence. See SPC https://www.medicines.org.uk/emc/product/6073/smpc Prescribers should follow the safety advice around opioids'.

- Footnote 5 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.'

- Footnote 7 is proposed to be amended to reflect changes in licensing: 'Oral naltrexone is licensed for alcohol dependence. See SPC https://www.medicines.org.uk/emc/product/6073/smpc Prescribers should follow the safety advice around opioids'.

- Footnote 12 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. Prescribers should check the licensing status of benzodiazepines in this age group.'

- Footnote 13 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information. Prescribers should check the licensing status of benzodiazepines in this age group.'

- Footnote 16 is proposed to be amended to the new standard wording for unlicensed medicines: 'The prescriber should follow relevant professional guidance, taking full responsibility for the decision. Informed consent should be obtained and documented. See the General Medical Council's Prescribing guidance: prescribing unlicensed medicines for further information.'

- Footnote 17 is proposed to be amended to include Antisocial personality disorder: prevention and management (CG77). It will also be amended to say: 'Also see NICE guideline Coexisting severe mental illness and substance misuse: community health and social care services (NG58).'

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