## Kliiniline küsimus nr 1

*Kas kõiki alkoholitarvitamise häire kahtlusega patsiente tuleb järgnevate sekkumiste planeerimiseks alkoholi väärtarvitamise suhtes sõeluda vs mitte sõeluda?*

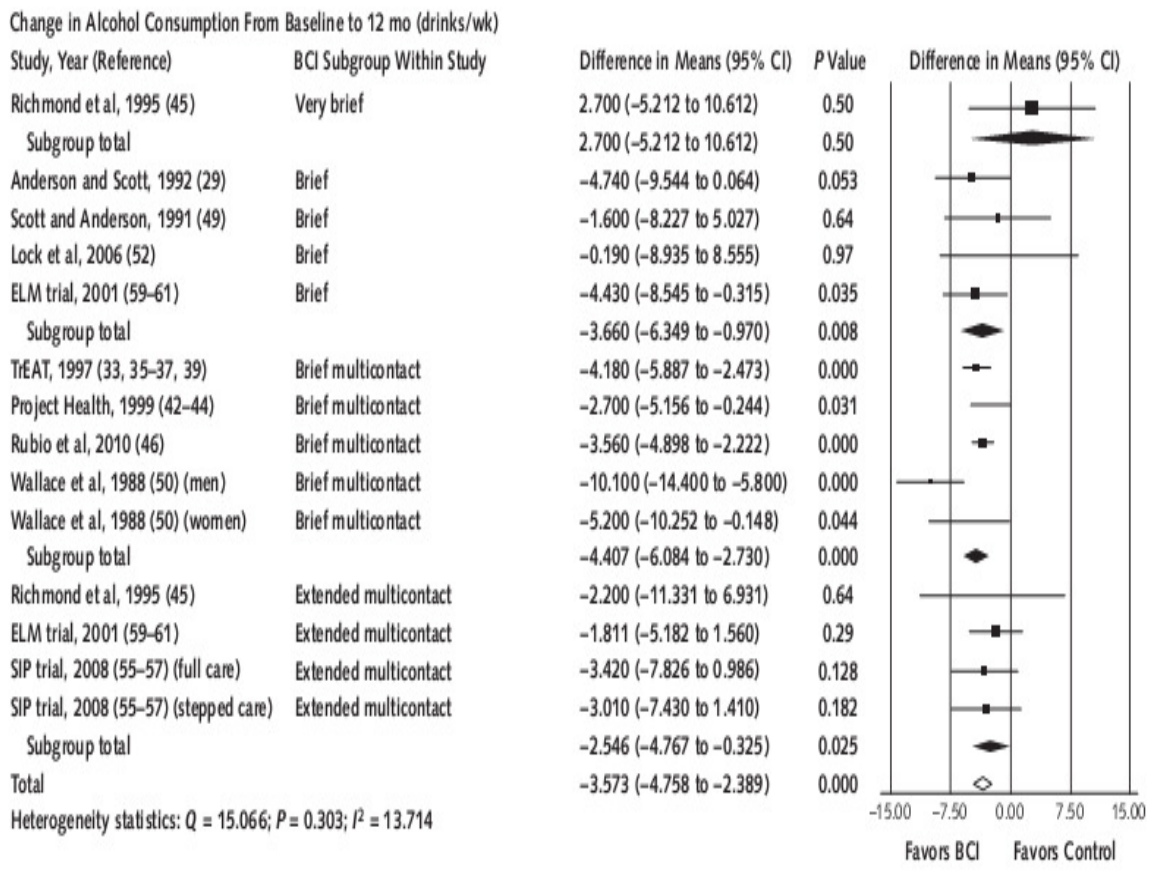
Kriitilised tulemusnäitajad: *uuringumeetodi tundlikkus ja spetsiifilisus, positiivne ja negatiivne ennustatav väärtus*

## Ravijuhendid

Kokkuvõte tõendusmaterjali kvaliteedist:

**Skriinimine:** Kõige põhjalikum tõendusmaterjal (mitmed süstemaatilised ülevaated ja läbilõikelised uuringud) käesoleva küsimuse kohta on ära toodud kahes alkoholi liigtarvitamise preventsiooni juhendis: "Preventing harmful drinking", NICE 2010 ja "Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: U.S. Preventive Services Task Force Recommendation Statement." Viiel süstemaatilisel ülevaatel põhinev ülevaade (Jonas et al.,2013) leidis, et mitmed skriiningtestid suudavad tuvastada alkoholi liigtarvitamist aktsepteeritava tundlikkuse ja spetsiifilisusega. Uuring leiab, et arvestades tundlikkust, spetsiifilisust ja ajakulu on ohustava alkoholitarvitmise ja kuritarvitamise skriinimiseks perearstiabis kõige paremad skriininginstrumendid: AUDIT (äralõikepunkti 4 juures tundlikkus 84-85%, spetsiifilisus 77%-84%), AUDIT-C (tundlikkus 74% to 76% ja spetsiifilisus 80% - 83%) ja ühe küsimuse esitamisega skriinimine (tundlikkus 82% - 87% ja spetsiifilisus 61% - 79%; küsides viimase 12 kuu kohta). Fiellin et al. (2000) analüüsisid 1966-1998 avaldatud esmatasandil teostatud uuringuid alkoholiprobleemide tuvastamises tehtud skriininguuringutest. Leiti 38 uuringut, mis vastasid kõigile kriteeriumitele. Leiti, et AUDIT test oli kõige spetsiilisem (78-96%) ja kõige parema tundlikkusega (51-97%) identifitseerimaks alkoholitarvitamise probleemidega isikuid (at-risk, hazardous, harmful drinking). CAGE küsimustik oli parim alkoholi kuritarvitamise ja sõltuvuse avastamises (tundlikkus 43-94% ja spetsiifilisus 70-97%). Artiklis on viidatud ka CAGE küsimustiku varasematele uuringutele, kus testi tundlikkus ohtliku alkoholitarbimise avastamisel on olnud vastavalt 14% ja 97% (Adams et al., 1996). Rohke alkoholitarvimisega (heavy drinking) patsientidel on CAGE küsimustiku tundlikkus ja spetsiifilisus olnud vastavlt 49-69% ja 75-95% (Aithal et al., 1998; Breadley et al., 1998). Üks süstemaatiline ülevaade (O'Connell et al., 2004) leidis, et CAGE küsimustik ei ole väga efektiivne eakatel psühhiaatrilistel patsientidel. Üks läbilõikeline uuring (Soderstrom et al.1997) leidis CAGE küsimustliku olevat efektiivne alkoholisõltuvuse skriinimisel trauma patsientidel. Läbilõikeline uuring (Rodriguez-Martos & Santamarina, 2007) leidis, et AUDIT-C oli efektiivne sõelumaks ohustava alkoholi tarvitamisega patsiente erakorralises meditsiiniabis. Ühes kirjaduse ülevaates (Reinert & Allen, 2007) tõdeti, et FAST küsimustlik on efektiivne skriinima alkoholiprobleemidega patsiente erakorralises meditsiiniabis. Vt.viited, süstemaatilised ülevaated (skriiningtestide efektiivsus).

**Lühinõustamine:** 6 hea kvaliteediga süstemaatilist ülevaadet (Ashenden et al., 1997, Ballesteros et al., 2004 a, Bertholet et al., 2005, Kaner et al. , 2007, Poikolainen , 1999, Whitlock et al., 2004) demonstreerisid, et lühinõustamised perearstiabis on efektiivsed vähendamaks alkoholi tarbimist (Ashenden et al. 1997: Change in consumption = 6.5 standard drinks/wk (P<0.05)). 6 süstemaatilist ülevaadet ( Ballesteros et al., 2004a; Bertholet et al., 2005; Whitlock et al., 2004; Kaner et al ., 2007; Poikolainen,1999; Ballesteros et al. , 2004b) leidsid lühinõustamise olevat efektiivne vähendamaks alkoholi tarvitamist nii meeste kui naiste hulgas. 3 süstemaatilist ülevaadet (D' Onofrio & Degutis, 2002; Havard et al., 2008; Nilsen et al. , (2008) leidsid vähe tõendust lühinõustamisele erakorralises meditsiinis tuvastamaks alkoholi väärtarvitavaid patsiente. 2 süstemaatilist ülevaadet (Kaner et al ., 2007; Ballesteros et al ., 2004a) demonstreerisid pikendatud lühinõustamiste (2-7 sessiooni, 1 sessiooni pikkus 15-50min.) efektiivsust. 1 süstemaatiline ülevaade (Jonas et al., 2012) hindas lühinõustamise kasusid ja kahjusid täiskasvanutele ja noortele, kes liigtarvitasid alkoholi. Parim tõendus oli mitme kontaktiga lühinõustamisele. Peale lühinõustamist vähenes keskmiselt alkoholi tarbimine võrreldes algse tarbimisega 3.6 dringi võrra nädalas (kaalutud keskmine erinevus, 3.6 drinki/nädalas [95% CI, 2.4 to 4.8 drinki/nädalas]; 10 uuringut; 4332 patsienti), 12% täiskasvanutel vähenesid raske joomise episoodid (risk difference, 0.12 [CI, 0.07 to 0.16]; 7 uuringut; 2737 patsienti) ja 11% täiskasvanuid ütlesid end 12 kuu jooksul tarbivat alkoholi all soovitatud tervisele lubatud koguseid (risk difference, 0.11 [CI, 0.08 to 0.13]; 9 uuringut; 5973 patsienti).




Vt. Viited, Süstemaatilised ülevaated (lühinõustamise efektiivsus).

Kokkuvõte ravijuhendite soovitustest:

Antud küsimusele vastamiseks vaadati läbi 2 alkoholi väärtarvitamise preventsiooni juhendit (USPSTF 2013 ja NICE 2010b) ja 10 ravijuhendit, millest 7 sisaldus info käesoleva küsimuse kohta (SIGN 2003, NICE 2011, Australia 2009, Soome 2010, NSW 2008, APA 2006, SAMHSA 2009). Kolmes ravijuhendis (BAP 2012, WFSBP 2008, NICE 2010a) käesoleva küsimuse kohta info puudus. Eelpool mainitud ravijuhenditest vaadati läbi teemaga seotud tõenduspõhised uuringud, millest kokkuvõtted on esitatud viidetes tabeli vormis. Ennetustöö juhendid (USPSTF 2013 ja NICE 2010b) ja 5 ravijuhendit (SIGN2003, NICE2011, Soome 2010,Austraalia 2009,SAMHSA2009) soovitavad skriinida kõiki täiskasvanuid alkoholi liigtarvitamise suhtes ning ohustava alkoholi tarvitamisega isikutele soovitavad lühinõustamist, kui efektiivset meetodit mõjutamaks alkoholi tarbimist ning ennetama alkoholist tingitud kahjusid.

Kui kõikide täiskasvanute skriinimine ei ole võimalik, siis tuleks tervishoiutöötajal skriinida vähemalt neid isikuid, kellel esinevad terviseprobleemid, mis võivad olla seotud alkoholi liigtarvitamisega (USPSTF 2013, NICE 2010b,Austraalia 2009,SAMHSA 2009, NSW 2008):

- hüpertensioon, GI või maksahaigused
- ärevus- ja meeleoluhäired
- seksuaalselt kuritarvitatud
- enesevigastamise riskiga
- sagedaste õnnetuste või traumadega isikud
- seksuaalse riskikäitumisega isikud
- võõrutusnähud ja intoksikatsioon

Mitte tervishoiutöötajad peaksid skriinima järgnevaid isikuid (NICE2010b):

- enesevigastamise riskiga

- kriminaalse või antisotsiaalse käitumisega isikud

- seksuaalselt kuritarvitatud isikud

- koduvägivalla all kannatavad isikud

- isikud, kelle lapsed on vajanud turvakodu teenuseid

- uimasti probleemidega

Kaalu patsiendi saatmist eriarsti juurde, kui (NICE2010b):

- esinevad mõõduka või raske alkoholisõltuvuse ilmingud

- lühinõustamine ei ole tulemust andnud ning patsient soovib edasist abi alkoholisõtluvusele

- esinevad rasked alkoholist tingitud kahjustused või esineb alkoholiga seotud komorbiidne haigus (nt. maksahaigus või alkoholist tingitud psüühikahäired)

**Skriiningtestid:** Kõige enam on soovitatud kasutada AUDIT testi alkoholi liigtarvitamise skriinimiseks ja otsustamiseks kas jätkata lühinõustamisega või suunata patsient edasi (NICE2010b, USPSTF 2013, Austraalia 2009, APA 2006, Soome 2010, Sign 2003). Kui aeg on väga piiratud võib kasutada AUDIT testi lühendatud versioone, nt AUDIT-C (NICE2010b, USPSTF 2013 Austria 2009, Soome 2010, SIGN 2003). Skriiningteste FAST ja PAT soovitavad 2 ravijuhist (NICE 2010b ja SIGN 2003) kasutada erakorralises meditsiiniabis. CAGE skriiningtesti soovitab kasutada APA 2006 ravijuhis psühhiaatrilise intervjuu tegemisel ja SIGN 2003 soovitab CAGE testi juhul, kui sellele on lisatud juurde 2 küsimust alkoholi tarvitamise koguste ja sageduse kohta. USPSTF 2013 soovitab sriinimiseks kasutada ka üksik-küsimust: ”Mitu korda eelmise aasta jooksul tarvitasite rohkem kui 5 (mehed) või 4 (naised ja patsiendid vanuses >65 e.a) drinki päevas?“

**Lühinõustamine:** kõige põhjalikumalt on skriiningujärgset lühinõustamist analüüsinud 2 ennetustöö juhendit NICE 2010b ja USPSTF 2013. Mõlemad juhendid soovitavad ohustava ja riskantse alkoholi tarvitamise korral lühinõustamist. NICE 2010b soovitab esmalt anda lühikest tagasisidet patsiendi alkoholitarvitamise kohta põhinedes FRAMES (feedback, responsibility, advice, menu, empathy, self-efficacy) printsiibile. Isikutel, kelle puhul lühike tagasiside ei ole piisav, tuleb rakendada pikemat (extended) lühinõustamist, mis sisaldab motiveerivat intervjuud ja kestab 20-30 minutit. USPSTF 2013 soovitab lühikest mitme kontaktiga lühinõustamist, millele on leitud kõige suurem efektiivsus. USPSTF 2013 leidis, et lühinõustamised perearstiabis muudavad ohustava ja riskitasemega alkoholi tarvitavate isikute joomiskäitumist vähenemise suunas: väheneb nädalane tarbitav alkoholikogus, järgitakse pikemalt soovitatavaid alkoholi tarvitamise limiite.

**Ravijuhendite soovituste tekstid (inglise keeles):**

**SIGN 2003**: *Abbreviated forms of AUDIT (eg FAST), or CAGE plus two consumption questions, should be used in primary care when alcohol is a possible contributory factor. Primary care workers should be alerted by certain presentations and physical signs, to the possibility that alcohol is a contributing factor and should ask about alcohol consumption.*

**Soome 2010:** *Evidently the best structured form for detecting high-risk consumption of alcohol is the AUDIT. A shorter series of three questions derived from the AUDIT test (AUDIT-C, minimum score 6 for men and 5 for women) would also appear to detect risk consumption effectively.*

**NICE 2010b**: Screening: *NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during new patient registrations, whenscreening for other conditions and when managing chronic disease or carrying out amedicine review. These discussions should also take place when promoting sexual health,when seeing someone for an antenatal appointment and when treating minor injuries.Where screening everyone is not feasible or practicable, NHS professionals should focus ongroups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. This includes people:with relevant physical conditions (such as hypertension and gastrointestinal or liver disorders) with relevant mental health problems (such as anxiety, depression or other mood disorders) who have been assaulted at risk of self-harm who regularly experience accidents or minor traumas who regularly attend GUM clinics or repeatedly seek emergency contraception. Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and people who have alcohol-related problems. For example,*

*this could include those: at risk of self-harm; involved in crime or other antisocial behaviour; who have been assaulted; at risk of domestic abuse; whose children are involved with child safeguarding agencies;with drug problems.)*

*Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type) or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ or FAST). Screening tools should be appropriate to the setting. For instance, in an emergency department FAST or PAT would be most appropriate.*

*Brief interventions: Offer a session of structured brief advice on alcohol. Use a recognised, evidence-based resource that is based onFRAMESprinciples (feedback, responsibility, advice, menu, empathy, self-efficacy). Adults who have not responded to brief structured advice on alcohol and require an extended brief intervention or would benefit from an extended brief intervention for other reasons. Offer an extended brief intervention to help people address their alcohol use. This could takethe form of motivational interviewing or motivational-enhancement therapy. Sessions should last from 20 to 30 minutes. They should aim to help people to reduce the amount they drink to low risk levels, reduce risk-taking behaviour as a result of drinking alcohol or to consider abstinence. Consider making a referral for specialist treatment if one or more of the following has occurred: they show signs of moderate or severealcohol dependence*

*have failed to benefit from structured brief advice and an extended brief intervention and wish to receive further help for an alcohol problem show signs of severe alcohol-related impairment or have a related co-morbid condition (for example, liver disease or alcohol-related mental health problems).*

**USPSTF 2013**: *Screening: recommends that clinicians screen adults aged 18 years or older for alcohol misuse and provide persons engaged in risky or hazardous drinking with brief behav-ioral counseling interventions to reduce alcohol misuse. The USPSTF prefers the following tools for alcohol misuse screening in the primary care setting: AUDIT, AUDIT-C, single-question screening, such as asking, "How many times in the past year have you had 5 (for men) or 4 (for women and all adults older than 65 y) or more drinks in a day?" Of available screening tools, AUDIT is the most widely studied for detecting alcohol misuse in primary care settings; both AUDIT and the abbreviated AUDIT-C have good sensitivity and specificity for detecting the full spec-trum of alcohol misuse across multiple populations.*

*Brief interventions: the following definitions of inter-vention intensity are: very brief single contact ( 5 minutes), brief single contact (6 to 15 minutes), brief multicontact (each contact is 6 to 15 minutes), and extended multicon-tact (7 1 contact, each7 15 minutes). Brief multicontact behavioral counseling seems to have the best evidence of effectiveness; very brief behavioral counseling has limited effect. The USPSTF found that counseling interventions inthe primary care setting can positively affect unhealthy drinking behaviors in adults engaging in risky or hazardous drinking. Positive outcomes include reducing weekly alco-hol consumption and long-term adherence to recom-mended drinking limits.*

**NICE 2011**: *Screening and brief intervention delivered by a non-specialist practitioner is a costeffective approach for hazardous and harmful drinkers.*

**Australia 2009**: *Screening for risk levels of alcohol consumption and appropriate intervention systems should be widely implemented in general practice and emergency departments. AUDIT is the most sensitive of the currently available screening tools and is recommended for use in the general population. AUDIT-C (the first 3 questions of AUDIT) also performs well at identifying alcohol misuse, especially in primary care.) (Patients drinking above low-risk levels (see NHMRC recommendations) should be offered a brief intervention. Those experiencing moderate to severe alcohol related problems, including dependence, require more comprehensive assessment and intensive treatment approaches.*

**NSW 2008**: *Routine screening upon intake should occur for acute presentations, such as intoxication and withdrawal, along with sufficient information about problematic drug and alcohol use such that an appropriate service can be mobilised to assist with the management of the client.*

**APA 2006**: *All individuals undergoing a psychiatric evaluation should be screened for a substance use dis-order, regardless of their age, presentation, or referral source. Several empirically validated screen-ing tools are available that do not require extensive training or time to use during an initial assessment. Commonly used screens include the four-item CAGE screen for alcohol abuse (Have you ever felt the need to C ut down on drinking, been A nnoyed by others' criticism of your drink-ing, felt G uilty about drinking, needed an E ye-opener drink first thing in the morning?), the 10-item Alcohol Use Disorders Identification Test).*

**SAMHSA 2009**: *recommends that screening and periodic reassessment of all patients for AUDs should become regular parts of patient management in primary care and general medical prac-tices because the problem has been shown to be more widespread than many primary care practitioners have realized. At a minimum, patients diagnosed with health problems often associated with AUDs should receive alcohol disorder screening.*

**Viited**
**Ravijuhendid**

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|---|---|
| The management of harmful drinking and alcohol dependence in primary care, a national clinical guideline, Scottish Intercollegiate Guidelines Network, 2003 | SIGN 2003 |
| Treatment of Alcohol Abuse, Current Care Guideline**,** The Finnish Medical Society Duodecim and the Finnish Society of Addiction Medicine,2010 | Soome 2010 |
| NSW Health Drug and Alcohol Psychosocial Interventions Professional Practice Guidelines, 2008 | NSW 2008 |
| Guidelines for the Treatment of Alcohol Problems, Australian Government Department of Health and Ageing, 2009 | Austraalia 2009 |
| Incorporating Alcohol Pharmacotherapies Into Medical Practice . Treatment Improvement Protocol (TIP) Series, Substance Abuse and Mental Health Services Administration, 2009. | SAMHSA 2009 |
| Practice Guideline For The Treatment of Patients With Substance Use Disorders, 2nd Edition, American Psychiatric Association, 2006 | APA 2006 |
| Alcohol-use disorders: Diagnosis and clinical management of alcohol-related physical complications, National Institute for Health & Clinical Excellence, 2010 | NICE 2010a |
| Alcohol-use disorders: preventing harmful drinking, NICE public health guidance 24, 2010 | NICE 2010b |
| Alcohol-Use Disorders: Diagnosis, Assessment and Management of Harmful Drinking and Alcohol Dependence, National Institute for Health & Clinical Excellence, 2011 | NICE 2011 |
| World Federation of Societies of Biological Psychiatry (WFSBP) Guidelines for Biological Treatment of Substance Use and Related Disorders, Part 1: Alcoholism, 2008 | WFSBP 2008 |
| Evidence-based guidelines for the pharmacological management of substance abuse, harmful use, addiction and comorbidity: recommendations from The British Association for Psychopharmacology,2012 | BAP 2012 |
| Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse: U.S. Preventive Services Task Force Recommendation Statement, U.S. Preventive Services Task Force, 2013 | USPSTF 2013 |

**Süstemaatilised ülevaated (Skriiningtestide efektiivsus)**

| Author/Year/ Study Design/Quality Rating | Population | Number of Studies Included | Total Number of Patients | List of Screening Instruments Included | Main results |
|---|---|---|---|---|---|
| Berks, McCormick, 2008<br><br>Systematic review ++ | Primary care, adults 60 or older Hazardous drinking Alcohol abuse or dependence | 9 | 6,353 | CAGE, MAST, SMAST, AUDIT ARPS, shARPS SMAST-G | AUDIT and AUDIT-C were superior to CAGE and various forms of MAST. From limited data, AUDIT-C seemed as good if not better than full AUDIT. |
| Berner et al., 2007<br><br>Systematic review ++ | Primary care, adults, college students, older adults At-risk drinking | 13 PC 1 college health | 22,195 | AUDIT | At cut -off of 8 points, sensitivity ranged from 31% to 89% and specificity from 83% to 96% across the 8primary care-based studies. Largest study was described as having a sensitivity of 76% and a specificity of 92% at a cut -off of 8 (Gordon et al., 2001, n=13,438 USA patients, 69.7% aged under 61 yrs, 53% male). One trial in general hospital inpatients reported a sensitivity of 93% and specificity of 94% (MacKenzie et al.,1996, n=240 UK patients, mean age 54 yrs, 53% male), a further trial in an emergency department gave a sensitivity of 75% and a specificity of 84% for men and 59% and 95% for women (Neumann et al., 2004, n=1927 patients) |

| Author/Year/ Study Design/Quality Rating | Population | Number of Studies Included | Total Number of Patients | List of Screening Instruments Included | Main results |
|---|---|---|---|---|---|
| Bradley et al., 1998<br><br>Systematic review ++ | Primary care and OB, mostly women<br>Heavy drinking<br>Alcohol abuse or dependence | 9 | Total:10,865<br>Women: 10,522 | CAGE, TWEAK, AUDIT, T-ACE | Sensitivity of CAGE for a lifetime diagnosis of abuse or dependence was only 38% in a primary care study in a largely White population of women.<br><br>For heavy drinking, AUDIT AuROC = at least 0.87 in female primary care patients. |
| Fiellin et al., 2000<br>Systematic review ++ | Primary care, adults<br>At-risk/ hazardous drinking<br>Alcohol abuse or dependence | 38 | NR | AUDIT, CAGE SMAST, single question, QF | Alcohol Use Disorders Identification Test (AUDIT) was most effective inidenti- fication of subjects with at-risk, hazardous or harmful drinking (sensitivity 51% to 97%, specificity 78% to 96%). CAGE was more effective in identi - fication of alcohol abuse and depen dence (sensitivity 43% to 94%, specificity 70% to 97%). These 2 tools performed better than other methods, including quantity - frequency questions. Single item screen (‘on any occasion during the last 3 months have you had more than 5 drinks containing alcohol?’) had sensitivity of 62% and 93% for identification of problem drinkers (Taj et al., 1998) |

| Author/Year/ Study Design/Quality Rating | Population | Number of Studies Included | Total Number of Patients | List of Screening Instruments Included | Main results |
|---|---|---|---|---|---|
| Kriston et al. , 2008<br><br>Systematic review ++ | primary care, inpatient populations, general population samples. risky Drinking, heavy binge drinking, any alcohol use disorder | 14 | 15,831 | AUDIT, AUDIT-C | Five studies including a total of 8679 patients examined the use of AUDIT and AUDIT-C in detecting risky drinking in primary care.<br><br>No statistically significant differences were observed between the accuracy of AUDIT and AUDIT-C in the detection of risky drinking, alcohol use disorders or unhealthy alcohol use in primary care patients. |

Quality rating (NICEb):

++ All or most of the checklist criteria have been fulfilled, where they have not been fulfilled the conclusions are very unlikely to alter.
+ Some of the checklist criteria have been fulfilled, where they have not been fulfilled, or not adequately described, the conclusions are unlikely to alter.
– Few or no checklist criteria have been fulfilled and the conclusions are likely or very likely to alter.

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| O'Connell et al., 2004<br><br>Systematic review + | Over 50 yrs adults, community and outpatient populations, inpatients, patients with psychiatric illness, nursing home sample. alcohol abuse and dependence | 13 | NR | CAGE, MAST, AUDIT, ARPS, shARPS | The sensitivity of CAGE was low in psychiatric popula-tions (38.9% for problem drinking at a cut -off of 1, Philpot et al., 2003) and emergency admissions to hospital (13% and 98% for alcohol dependence at a cut -off of 2 in emergency admissions to hospital. |
| Soderstrom et al.1997<br>Cross-sectional diagnostic Evaluation ++ | Adults,trauma centre alcohol abuse and dependence | N/A | 1118 | AUDIT, CAGE, BMAST | Vs AUDIT and B -MAST, CAGE had highest sensitivity (84%), specificity (90%), PPV (0.82) and NPV (0.91) at the stand ard cut -off point (ie. 2). Optimal threshold for AUDIT = ≥9 (1 more than standard score) (73%, 89%, 0.80, 0.86). O ptimal cutoff for B-MAST = 5 (1 unit less than standard score) (80%, 85%, 0.74, 0.89). CAGE most effective test in both men (sensitivity 84%, specificity 87%) and women (80%, 96%). |
| Rodriguez-Martos & Santamarina, 2007<br>Cross-sectional diagnostic Evaluation + | trauma emergency department, hazardous drinking | N/A | 120 | AUDIT-C | AUDIT -C<br>Optimal thresholds were defined as ≥ 5 for men (76% sensitivity, 73% specificity, PPV 66%, NPV 82%) and ≥4 for women (sensitivity 100%, specificity 95%, PPV 8 3%, NPV 52%) for the detection of hazardous drinking. |
| Reinert & Allen, 2007<br>Literature review | Range of settings: fracture Clinic, primary Care, dental hospital , A&E hazardous | N/A | N/A | AUDIT and shorter versions | Vt. Täpsemalt NICE2010b references. |

**Süstemaatilised ülevaated (Lühinõustamise efektiivsus)**

| Author/Year | Population | Number of Studies Included | Total Number of Patients | List of Interventions included | Main Results |
|---|---|---|---|---|---|
| Ashenden et al., 1997<br><br>Systematic review ++ | Adults, primary vare Hazardous drinkers | 6 | NR | general -practice-based lifestyle advice | A significantly greater proportion of intervention group subjects moderated their drinking to a safe level compared with control group participants (who received no inter-vention) in 3 of 6 included studies. |
| Ballesteros et al., 2004 a<br><br>Systematic review ++ | adults, Primary care hazardous drinkers | 13 | NR | minimal intervention (session of general alcohol-related advice lasting 3 to 5 min but without specific advice on reducing consumption), brief interventions (10 to 15 min<br>in 1 session, with the option of booster sessions of 3 to 5 min duration) and extended brief<br>interventions (10 to 15 min in 1 session, with a number of specific booster sessions of 10 to<br>15 min duration) | BIs more effective when delivered in general screening programmes (non-trea tment seekers, fixed effects model OR=2.19, 95%CI 1.68 to 2.84) vs consul-tation (treatment<br>seekers, fixed effects model OR=1.41, 95%CI 1.20 to 1.65). BIs more effective in heavy drinkers (fixed effects model, OR=1.94, 95%CI 1.55 to 2.43) vs moderate drinkers (fixed effects model OR=1.42, 95%CI 1.19 to 1.68) |
| Bertholet et al., 2005<br><br>Systematic review ++ | primary health care Non-treatment seeking patients | 19 | 5639 | ‘brief intervention’ or ‘motivational intervention’ or reporting use of feedback or<br>advice to reduce alcohol consumption. | 17 trials reporting alcohol consumption, 8 reported statistically significant effects of BI. No studies repor-ted negative eff ects of BI. In studies |

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|---|---|---|---|---|---|
| Kaner et al. , 2007 Systematic review ++ | Adults, primary care excessive alcohol consumption or have experienced harm as a result of their drinking | 29 | ( 7,619) (22 RCTs) | Brief intervention | Meta-analysis: participants receiving brief intervention consumed less alcohol than control subjects after 1 yr or longer of follow -up (mean difference = -38 g/wk, 95%CI – 54 to -23) (but consider-able heterogeneity between trials: I2=57%) Extended intervention had non-significantly greater reduction in alcohol consumption than brief intervention (mean difference= -28 g/wk, 95%CI -62 to 6, I2=0%). |
| Poikolainen , 1999 Systematic review ++ | adults, Primary care Patients misusing alcohol | 7 | 2546 | very brief interventions (of 5 to 20 min duration) and extended brief interventions (several visits) | Very brief interventions: Only statistically significant results were for combined gender very BI, but significant heterogeneity mean findings not meaningful.<br><br>Extended brief inter ventions: Only statistically significant results with low heterogeneity were for women receiving EBI. |
| Whitlock et al., 2004 Systematic review ++ | Adults (9trials), Adolescents (3), primary care Risky/hazardou s and harmful alcohol consumption | 12 | NR | *very brief interventions (1-5 mins)<br><br>*brief interventions (1 session of up to 15 mins)<br>* brief multi-contact interventions (15 min duration and foll ow-up contacts) | Brief multi-contact behaviouralcounselling interventions: 6/7 studies reported significant effect on at least 1 drinking outcome. 4 good quality trials reported reduction in weekly drinking of 13% to 34% more in BI group vs control (13% to 34% net r eduction). |

| Author/Year | Population | Number of Studies Included | Total Number of Patients | List of Interventions included | Main Results |
|---|---|---|---|---|---|
| D' Onofrio & Degutis, 2002 Systematic review + | Several settings, 4 trials in emergency departments | Total 32, Relevant 4 for ED | 741(ED patients) | Brief interventions ranged from 5 to 60 min and included up to 4 follow-up sessions. | Monti et al . 30 min brief motivational interview vs standard care among 18 -19 yr olds presenting to ED after alcohol-related event. At 6 months follow -up, BI group had significantly lower incidence of alcohol -related injuries ($p<0.01$), drinking and driving an d social consequences and alcohol -related social problems ($p<0.05$) vs standard care subjects (no further data reported). Both groups significantly reduced alcohol consumption during period (no further data reported). Vt. tapsemalt NICE2010b. |
| Havard et al., 2008 Systematic review ++ | Emergency department attendees (n range= 85 to 1334). reducing alcohol consumption and related harm | 13 | NR | Interventions were brief motivational counselling, with some including written materials, personalised feedback. (5-60min) | Alcohol-related injuries: 6 -12 months: pooled effect size OR = 0.59 (statistically significant, $P<0.005$) |
| Moyer et al., 2002 Systematic review ++ | non-treatment - seeking population,setting not reported | 34 | NR | Brief inter-vention (classed as providing no more than 4 ses-sions, typically including inter-view, feedback and advice,some with written materials. | At follow -up after >3-6 months, effect for BI vs control significantly larger if subjects with alcohol dependence were excluded. |

| Author/Year | Population | Number of Studies Included | Total Number of Patients | List of Interventions included | Main Results |
|---|---|---|---|---|---|
| Ballesteros et al. , 2004b Systematic review | Men and women in primary care | 7 | NR | Samad, mis 2004a uuringus | Brief interventions were found to have a broadly equivalent positive effect on alcohol consumption in both men and women. |
| Jonas et al.,2012 Systematic review | adults, primary care | 23, neist üks oli rasedate uuring. | 10,745 | Most trials tested brief multi-contact interventions (11 studies)or brief interventions(10 studies). Fewer tested very brief(2 studies), extended(1 study) , or extended mul-ticontact interventions (5 studies). | 23 included trials generally excluded persons with alcohol dependence. The best evidence was for brief (10- to15-minute) multi-contact interventions. Among adults receiving be-havioral interventions, consumption de-creased by 3.6 drinks perweek from base-line (weighted mean difference,3.6drinks/wk [95% CI, 2.4 to 4.8 drinks/wk]; 10 trials; 4332 participants),12% fewer adults reported heavy drinking episodes (risk difference, 0.12 [CI, 0.07 to 0.16]; 7 trials; 2737 participants), and 11% more adults reported drinking less than the recommended limits (risk difference, 0.11 [CI, 0.08 to 0.13]; 9 trials; 5973 participants) over 12 months compared with control participants (moderate strength of evidence). |

| Author/Year | Population | Number of Studies Included | Total Number of Patients | List of Interventions included | Main Results |
|---|---|---|---|---|---|
| Nilsen et al. , (2008) Systematic review ++ | Emergency department, 7 studies included adults 18yrs and over. | 14 | The number of patients ranged from 85 to 1139 | BriefIntervention sessions varied from few min to 1 hour. Most studies included 1session session. | BI patients showed greater reductions in negative outcomes than control group subjects. However control group patients also tended to show improvements. Antti-Poika observed that more than twice as many BI patients vs control group subjects had 'improved' at 6 months after intervention, with improvement classed as decrease in alcohol consumption by at least one third and decrease in GGT by at least 20%. |


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