**UK NATIONAL SCREENING COMMITTEE**

**Screening for Alcohol Misuse**

**17 November 2011**

## Aim

1. To agree the UK National Screening Committee's (UK NSC) formal policy position on screening for alcohol misuse.

## Background

2. A review of screening for alcohol misuse against the UK NSC criteria for appraising the viability, effectiveness and appropriateness of a screening programme was carried out in December 2010 by Dr Cathy Lines from Solutions for Public Health.

3. The screening review concluded that screening for alcohol misuse did not meet the UK NSC criteria for a number of reasons. These were:-

- Research is focused on self reported behaviour and subsequent self reported behaviour change to measure the test and treatment effectiveness. As a result of using self reported behaviour and behaviour change there is no independent measure (such as a biomarker) that can provide a single gold standard against which the screening test can be measured. This is a prerequisite of a formal screening programme and as such screening for alcohol misuse does not meet the UK NSC criteria.

- There is not a valid test that can be used for the whole population and cut off points have yet to be defined for some sub-groups of the population such as for young people, women, cultural minorities and those over 65. In addition there is limited evidence that brief interventions are effective for these same sub-groups.

- There is evidence that under research conditions use of an alcohol screening test and brief intervention can lead to Caucasian men reducing exposure to alcohol in the short to medium term. There is little evidence about how often testing would need to be carried out and whether repeat testing over a period of years would increase the motivation for someone to reduce alcohol intake. There is no clearly identified effective strategy for implementing a formal screening programme for alcohol misuse for any sub-group of the population.

- Currently there is limited evidence that the reductions in alcohol intake have an impact on morbidity and mortality rates and social harm. A prerequisite of a formal screening programme is that there is a clear reduction in morbidity and or mortality that can be measured over time by a randomised controlled trial. This evidence is not available for screening for alcohol misuse and therefore it does not meet the UK NSC criteria.

## Further Research

4. The screening review stated that there are significant trials in progress and the results of these will inform future screening policy reviews on screening for alcohol misuse. These trials are:-

- Coulton *et al* (2007) has submitted a Health Technology Assessment trial protocol to carry out a pragmatic randomised controlled trial evaluating the effectiveness and cost effectiveness of opportunistic screening and stepped care interventions for older hazardous alcohol users in primary care. This will be published by the HTA in 2013.

- The wide ranging 'Screening and Intervention Programme for Sensible Drinking Programme' (SIPS) will report within the next year on the three cluster randomised controlled trials of alcohol screening and brief intervention in the three settings of primary care (Kaner & Bland *et al* 2009), accident and emergency departments and the criminal justice system. The aim is to assess the most effective screening method, the most effective and cost effective intervention approach, and identify the barriers to implementation in each setting. The patient outcome measures will be, alcohol consumption, alcohol related problems, health related quality of life and health related and wider societal costs.

## Consultation

5. A copy of the review of screening for alcohol misuse against the UK NSC criteria was placed on the UK NSC website for consultation on 29th December 2010. The consultation closed on 29th March 2011. A copy of the consultation replies are available at Annex A.

## Recommendation

6. The UK NSC is asked to agree the policy position on screening for alcohol misuse as follows:-

*A national screening programme for alcohol misuse is not recommended.*

7. The UK NSC is asked to agree that the policy should be reviewed in three years time unless there is significant new peer reviewed evidence in the meantime.

**Annex A**

## Consultation Replies

### British Psychological Society

*Response to the UK National Screening Committee consultation:*
*The UK NSC Policy on Alcohol Problems Screening in Adults*

The British Psychological Society thanks the UK National Screening Committee (UK NSC) for the opportunity to respond to this consultation.

The British Psychological Society ("the Society"), incorporated by Royal Charter, is the learned and professional body for psychologists in the United Kingdom. The Society is a registered charity with a total membership of almost 50,000.

Under its Royal Charter, the objective of the Society is "to promote the advancement and diffusion of the knowledge of psychology pure and applied and especially to promote the efficiency and usefulness of members by setting up a high standard of professional education and knowledge".

The Society is committed to providing and disseminating evidence-based expertise and advice, engaging with policy and decision makers, and promoting the highest standards in learning and teaching, professional practice and research. The Society is an examining body granting certificates and diplomas in specialist areas of professional applied psychology.
We are content for our response, as well as our name and address, to be made public.

We are also content for the UK NSC to contact us in the future in relation to this consultation response. Please direct all queries to:-
Consultation Response Team[1], The British Psychological Society, 48 Princess Road East, Leicester, LE1 7DR.
Email: consult@bps.org.uk Tel: (0116) 252 9508

This response was prepared on behalf of the Society by Dr Philip Murphy, CPsychol, Chair of the Psychobiology Section with contributions from Dr Richard Cooke, CPsychol, member of the Division of Health Psychology, and Dr Tom Heffernan, CPsychol, Chartered Member of the Society. We hope you find our comments useful.

**Dr C A Allan, CPsychol, CSci, AFBPsS**
*Chair, Professional Practice Board*

1 formerly Policy Support Unit

***Response***
This report recognises the seriousness of excessive alcohol use and its related problems in Britain today. A broad base of evidence now exists of the prevalence of excessive consumption, and of its adverse consequences for health, and diverse aspects of psychological and social functioning (Heffernan *et al*., 2010; Mayor, 2010;

NHS Information Centre, 2010). Furthermore, these consequences carry implications for society as a whole in both the financial and 'quality of life' domains. These are appropriately summarised and acknowledged by this report.

The report concludes that current knowledge concerning alcohol does not meet the criteria of the UK NSC for a formal screening programme to be implemented. A recommendation is made, therefore, that a formal screening programme is not introduced, and that further evidence is sought. However, it is our feeling that although the report's conclusion is, in a strict sense, correct with regard to UK NSC criteria for such a programme, the subsequent recommendation is too limited in its scope as a response to the current serious situation. The misuse of alcohol, to whatever extent, is a complex phenomenon with regard to its causes and consequences, so the reliance upon a fixed set of general criteria designed to apply to all areas of health may be inappropriate here. In particular, the social, cultural, and psychological circumstances which may promote excessive alcohol use may be expected to continue to make the development of a universally applicable and reliable screening method very difficult; however, this need not mean that efforts to screen for excessive alcohol use should not be intensified. Indeed, the report notes that screening for Alzheimer's disease and depression is fairly common in GP practices although neither of these conditions meets the UK NSC criteria for a formal screening programme. In other words, formal screening procedures can be supported and applied outside the context imposed by these criteria. In the Society's opinion, screening for excessive alcohol use should similarly develop as a practice.

In summary, whilst the Society fully supports the call for further research into excessive alcohol use (particularly with regard to the implications for young people, women, and cultural minority groups), it is our opinion that the current situation requires more to be done in the shorter-term with regard to screening individuals for excessive use than to simply wait for further research findings. Whilst GP practices would have an important role to play here, they may not be the most appropriate context for some population groups, such as men aged under 35 years. Other appropriate contexts for screening might include university health centres, sporting facilities, and community centres.

Finally, the use of any screening procedure implies that some intervention is available for those who test positive for the condition; in this case, excessive alcohol use. In the current context of cuts to public spending, the Society believes it important for the wellbeing of society as a whole that policy makers recognise the importance of alcohol related problems in society today, and fund responses to these at a realistic and satisfactory level.

**References**

Heffernan, T.M., Clark, R., Bartholomew, J., Ling, J., & Stephens, R. (2010). Does Binge
Drinking in Teenagers Affect Their Everyday Prospective Memory? *Drug and Alcohol*
*Dependence, 109*, 73-79.
Mayor, S. (2010). New Figures Show Major Increase in Alcohol-Related Hospital Admissions in England. *British Medical Journal, 341,* Article c4790.

NHS Information Centre (2010). *Smoking, Drinking and Drug Use Among Young People*
*in England. Findings by region, 2006 to 2008*. Leeds: The Health and Social Care Information Centre.
*End.*

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**Response from the Department of Health Alcohol Programme Team**

Consultation Response to the National Screening Committee Report:
*Appraisal for screening for alcohol misuse*

General comments on the draft NSC report

We understand that the NSC has a set of clearly defined criteria which must be met before it is able to approve any screening subject for a formal population-based NSC screening programme. We also understand the NSC's view that the relevant evidence available currently for alcohol does not yet reach the very high standard that the NSC requires to meet a number of those criteria. We therefore understand the reasoning behind the conclusion of the NSC that it does not approve alcohol as a subject for a formal NSC screening programme.

However, there is ample evidence of the importance of alcohol-related health harms and for the efficacy of identifying, advising and treating people who misuse alcohol. The DH and NICE have both issued guidance based on this evidence and PCTs and NHS clinicians and their teams are acting on this widely.

In addition, the frequent use of the word "screening" as a generic term in many other contexts across the NHS and in academic research makes the use of the word itself subject to potential misunderstanding in the context of this review.

For these reasons, it is important that the report of the NSC review is absolutely clear about the parameters of its findings, so that these are understood within the context of the review alone, and no wider interpretations can be inferred.

This clarity is important so that this NSC review should not inadvertently cast a shadow over the current DH and NICE guidance or over PCTs' (and, in future, Local Authorities') commissioning of the relevant alcohol services within the NHS to identify and address alcohol misuse.

We have made some particular suggestions on the text, which aim to help ensure that both the context and the very precise nature of the Committee's conclusion is clear. We have also included some pointers on accuracy and for data updates since the report was drafted which we hope will be helpful too.

We would be very happy to discuss these comments further with the NSC.

**Consultation Response to the National Screening Committee Report:**
***Appraisal for screening for alcohol misuse***

**Response from the Department of Health Alcohol Programme team**

**Specific comments and suggestions on text in the draft NSC report**

**Summary**

**p4:** "In England in 2008 there were 6769 deaths wholly related to alcohol, an increase of 24% from 2001. The majority of deaths (4400) were caused by alcoholic liver disease (NHS Information Centre 2010). In Scotland in 2007 it was estimated that there were 1399 deaths directly attributable to alcohol consumption equating to 2.5% of all deaths (Information Services Division Scotland, 2009)".

**Comment:** Suggest using latest figures from ONS:

> 2009, England = 6582 (3% lower than 2008, but 20% higher than 2001 and 31% higher than 2000.
> [http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14496]
>
> 4154 deaths caused by alcoholic liver disease.
> [http://www.statistics.gov.uk/statbase/product.asp?vlnk=15096]
>
> Latest figures from the General Register Office for Scotland: 2009, Scotland = 1282 (9% lower than in 2008)
> [http://www.gro-scotland.gov.uk/statistics/theme/vital-events/deaths/alcohol-related/index.html]

**p.4** "The latest NICE guidance reflects the current view that, in order to reduce alcohol misuse, there needs to be a focus on limiting access to alcohol in the community by pricing, marketing and licensing interventions whilst also improving access to health care settings of early identification and management of risky drinking behaviour. "

**Comment:** The reference to elements of NICE guidance which are not relevant to the identification of alcohol misusers (i.e. limiting access, price, licensing, marketing) is confusing here, as these elements do not relate to screening.

Suggest the following alternative:

> The latest NICE guidance to the health service to ensure that people who misuse alcohol are identified and treated as appropriate recommends that there needs to be a focus on improving access to health care settings, early identification of misusers, brief advice, appropriate intervention and management of risky drinking behaviour.

**p.4:** "The review does not seek to assess the current SIPS trials or commissioned services within the NHS."

**Comment:** Some further clarification is needed here in the summary at the outset to ensure that the report does not inadvertently cast any doubts, either on the validity of current NHS commissioned services or on the SIPS research findings before they are published.

Suggest the following alternative:

> The review does not examine or assess those services, which are currently commissioned within the NHS to identify and treat alcohol misuse. Neither does it seek to assess the SIPS research trials which have been taking place over the last two years and which are due to publish their respective reports shortly.

**p4:** "In addition, there is the option of offering a screen to all men aged 35-54. "

**Comment**: Highlighting one particular "at risk" group which might be targeted for case finding is misleading (unless it is cited as one example alongside others).
As it appears here at present (and elsewhere in the draft report) citing this 35-54 group implies that this is the only option that PCTs could adopt locally in addition to the Directed Enhanced Service (DES). Suggest dropping this line.

Beyond the DES, PCTs have the option of introducing a Local Enhanced Service (LES). Through a LES, PCTs can make a *variety* of optional incentives available locally, aligned with their local needs and aimed at the 'at risk' groups they choose to target. PCTs might choose, for example, a LES for patients who fall into particular, recognised high-risk groups or who present with conditions associated with alcohol misuse.

**p4:** "There is no one valid test that can be used for the whole population and cut off points have yet to be defined for some sub-groups of the population such as young people, women, cultural minorities and those over 65."

**Comment:** This sounds as if there are no valid tests, rather than that there are many valid tools, albeit with limitations. (Also appears in the report conclusion). Suggest:
However, there is no single questionnaire or test, which has been validated for all of the different sub-groups within the whole population.
**p4:** "This is a prerequisite of a formal screening programme"

**Comment:** The context here is paramount and it needs to be clear to the reader immediately that this refers to a screening programme within the formal NSC definition of a screening programme. (The frequent use of the word "screening" as a generic term in many other contexts across the NHS and in academic research makes it important to be absolutely clear about the sense in which it is used here if this is not to be misunderstood).

Suggest:

> This is a prerequisite of a formal screening programme within the parameters for such a programme laid down by the National Screening Committee.

**p5:** "[…] Caucasian men reducing their exposure to alcohol in the short to medium term" (Comment also applies to the repeat uses of this example).

**Comment:** The use of this example alone is misleading as it undermines the other evidence that is available. It implies that there is no other evidence for the efficacy of identifying alcohol misusers and giving them brief advice (IBA) or other treatment as appropriate.

Suggestion: Cite some other examples to give a more balanced picture. There is, for example, evidence that 1 in 8 misusers given brief advice will reduce their consumption to within the Government's lower risk levels (Silagy & Stead, 2003). The 1 in 8 eight people who will reduce their drinking to within lower-risk levels compares favourably with smoking, where only one in twenty will act on advice given (or one in ten with nicotine replacement therapy). There is also evidence of cost effectiveness and a very large body of research evidence, including at least 56 controlled trials, supporting the efficacy of opportunistic case finding for alcohol misuse and the delivery of simple advice. (e.g. Moyer et al., 2002).

**p 5:** "The current evidence available about screening and brief interventions for alcohol misuse does not meet a number of the NSC criteria for a formal screening programme. It is not recommended that a formal screening programme for alcohol misuse is implemented. There are significant trials in progress and the results will inform a future NSC policy update"

**Comment:** It would be helpful to state clearly at this stage in the report exactly what the NSC has done in undertaking this review, what its purpose is and why it has chosen to do this now. These details need to be in the Summary at the start to avoid the potential for unintended and damaging misunderstandings which could impact on the good work currently being undertaken by clinicians in the field as part of their diagnostic practice.
Suggest the following is added:

> The NSC has undertaken this review to establish the NSC's policy in this area in the light of the increasing harms caused by alcohol misuse in the UK and the use of screening tools to identify people who misuse alcohol. This review is solely for the purpose of determining whether a formal NSC population-wide screening programme would be appropriate in this area. The review neither examines nor questions the validity of the current case-finding arrangements practised across the NHS, such as those for the Identification of and Brief Advice to alcohol misusers (IBA).

**Introduction**

**p5:** "In England alone there were 6769 deaths known to be directly attributable to alcohol misuse in 2008 whilst in 2008/9 there were 945,469 hospital admissions with alcohol-related conditions (NHS Information Centre 2009, Mayor 2010)."

**Comment:** See above for latest deaths figures.

The admissions estimate for 2009/10 was 1,057,000.

[http://www.nwph.net/alcohol/lape/download.htm]

**p6.** "The review does not seek to assess the current SIPS trials or commissioned services within the NHS".

**Comment:** The report needs be clearer here in the introduction, that the review does not consider (or seek to criticise) current NHS services and that it cannot yet consider SIPS. The review could otherwise cast an unintended shadow over the (much-needed) action in train in the NHS to identify and address alcohol misuse at a time when alcohol-related hospital admissions are continuing to rise steeply. It might also seem to be questioning the SIPS research before it is even published.

Suggested alternative:

> This NSC review does not review current services commissioned in the NHS to identify patients who misuse alcohol and acknowledges that the best evidence available so far is being used as the basis of guidance to commissioners. This review also does not consider the SIPS research trials which have been taking place over the last two years, as the reports of these trials have not been published yet.

**The condition should be an important health problem**

**p8:** "**Lower Risk Drinking:** This group of people drink alcohol in line with the Government's recommended lower risk limits and equates to 24.8m people (Department of Health 2007). "

**Comment:** Suggest using figure based on Office for National Statistics' 2009 General Lifestyle Survey = 26.3 million.

**p8:** "**Increasing Risk Drinking:** This group is the largest group of people misusing alcohol and is made up of an estimated 7.6m individuals "

**Comment:** Suggest using figure based on Office for National Statistics' 2009 General Lifestyle Survey = 7.0 million

**p8:** "**Higher Risk Drinking:** This group regularly drink well over the recommended limits and equate to around 2.9 million people "

**Comment:** Suggest using figure based on Office for National Statistics' 2009 General Lifestyle Survey = 2.2 million

**Comment:** NB. Need to be clear, for all the above ONS figures, that these are based on self-reported consumption. (Actual consumption is likely to be higher).

**p8:** "**Dependent Drinking:** This group is relatively small at around 4% (1.1million) of the population (Department of Health 2007). "

**Comment:** Figures for those aged 16 or over based on 2007 Adult Psychiatric Morbidity Survey = 3.8% / 1.6 million

**p8:** "Individuals, dependant on alcohol, will give a higher priority to drinking than to other activities and obligations".

**Comment:** Typo to correct to *dependent* (here and elsewhere in draft)

**p8:** "It is estimated that the 1.1 million people who are dependent drinkers cost the health economy twice as much per person as other drinkers "

**Comment:** Suggest removing the reference to 1.1 million as it is out of date. NB. However, updated costs have not yet been generated for the 1.6 million.

**p9:** "Harmful use"

**Comment:** This section mentions health harms but then only provides evidence for social harms. There is ample evidence available on the many health harms caused by alcohol and some of these should be included here. (Cancers, liver disease, mental illness, gastric illnesses, high blood pressure, poisoning, etc etc).
E.g. see the WHO 2011 *Global status report on alcohol and health.* This cites alcohol as a causal factor in 60 types of disease and injury, and as a component factor in 200 others. It also attributes 4% of deaths worldwide to alcohol.

**The epidemiology and natural history of the condition […].**

**p10:** "In England in 2008 there were 6769 deaths wholly related to alcohol, an increase of 24% from 2001. The majority of deaths (4400) were caused by alcoholic liver disease (NHS Information Centre 2010). In Scotland in 2007, it was estimated that there were 1399 deaths directly attributable to alcohol consumption equating to 2.5% of all deaths (Information Services Division Scotland, 2009). "

**Comment:** See updated data above.

**p10:** "In 2008/9 there were 945,469 hospital admissions linked to alcohol consumption related diseases or injury, a 47% increase on the 2004 levels (Mayor 2010)".

**Comment:** See updated data above. The increase since 2004/05 = 64%.

**p10:** "The North West Public Health Observatory (Jones *et al* 2008) have analysed data from 2005 to determine the total number of deaths wholly or partially due to alcohol consumption (Table 1). There are 12 ICD 10 diagnostic groups listing diseases wholly attributable to alcohol consumption (e.g. alcoholic liver disease, alcohol brain disease) and a number of conditions partially attributable to alcohol consumption such as cardiovascular disease, diseases of the nervous and digestive systems and some cancers. Over all Jones *et al* (2008) calculated that the total number of deaths attributed to alcohol in 2005 was 14,982".

**Comment:** Suggest using the 2008 figure = 15,600
[http://www.nwph.net/alcohol/lape/download.htm]

**p10:** "There are alleged protective effects of drinking alcohol within recommended limits and Interim Analytical Report (2003) noted that alcohol consumption could have prevented 18,000 deaths from coronary heart disease and several thousand deaths from stroke. "

**Comment:** Suggest using the more up to date data in the NWPHO report. This gave the estimated figure for 2005 of 3,813 (p26).
[http://www.nwph.net/nwpho/Publications/AlcoholAttributableFractions.pdf

**p10/11:** "There were 9.3% of men dependant on alcohol in 2007 compared to 11.5% in 2000, whereas 3.6% of women were dependant in 2007 compared to 2.8% in 2000. Only a very small proportion (0.1%) of all men were severely dependant on alcohol with the remainder being mostly mildly dependant. Virtually all women were only mildly dependant on alcohol (NHS Information Centre 2009)."

**Comment:** Typos underlined - should read dependent rather than "dependant".
**Comment:** Need to make it clear that the above breakdown is based on SAD-Q rather than AUDIT (That being so, it includes "mild dependence" and is therefore different from the 3.8% / 1.6 million figures quoted earlier in report.) Also need to say that it relates to men and women aged 16-74 only.

**p11, Table 2:**
**Comment:** Suggest using the more up to date info available from 2010 Information Centre publication. See: Chapter 2 *Drinking behaviour among adults and children Alcohol consumption (units per week) among adults, by gender and age, 2008*

**p11:** "The 16-24 year olds are most often associated with binge drinking which can result in very visible social harms. "

**Comment:** No information or reference given to support this.
Suggest using the information relating to percentage drinking > 8 (men) and 6 (women) units on heaviest drinking day from the above report.

**p12:** "The Interim Analytical Report (2003) noted that those who die from alcohol misuse are dying younger than in previous years. There was a shift especially noticeable for men of the highest death rates peaking at around age 70 between 1991-93 to a peak at around age 55-60 by 2000 "

**Comment:** This is rather dated. Suggest using the information from ONS, which shows that the proportion of alcohol related deaths accounted for by 35-54 year-olds increased from 37% in 1991 to 43% in 2009 among men and from 30% in 1991 to 39% in 2009 among women.
[http://www.statistics.gov.uk/statbase/Product.asp?vlnk=14496]

**All the cost effective primary prevention interventions […]**

**p14:** "University of Sheffield (2010) reviewed the evidence of the effectiveness of the use of biomarkers to distinguish between hazardous, harmful and dependant alcohol

misuse" and "For dependant drinking reference standards have included the criteria in DSM (III-R) (Aertgeerts *et al* 2001), and DSM (IV) (Coulton *et al* 2006), ICD 10 (Bradley *et al* 1998), and the Composite International Diagnostic Interview (Aertgeerts *et al* 2001) for alcohol dependency."

**Comment:** Typos underlined.

**p18:** "The small proportion of people identified as dependant with the highest risk scores would be referred to a specialist agency (Figure 1)"

**Comment:** Typo underlined.

**There should be evidence from high quality Randomised Control Trials […]**

***General comment on RCT and evidence:***
A large body of research evidence exists, including at least 56 controlled trials, supporting the efficacy of opportunistic case finding for alcohol misuse and the delivery of simple advice. (e.g. as cited above, Moyer et al., 2002, Anderson P. (2007), Cochrane Collaboration review (Kaner et al. 2007).

**p22:** "Data for 2008/9 from the national alcohol treatment monitoring system (National Treatment Agency for Substance Misuse 2010) showed that of the 100,098 people entering treatment 87% were white and 64% were male. The majority were self-referrals (38%) with 22% referred from GP practices and 8% from the criminal justice system. The median age for both men and women to enter treatment was 41. Of those exiting treatment (53,014) 12% were alcohol free, 37% were occasional users, 7% were referred to other agencies and 41% stopped treatment for a range of reasons (e.g.: dropped out, moved away, went to prison). "

**Comment:** NATMS data has now been published for 2009/10: See:
http://www.nta.nhs.uk/uploads/natmsannualstatisticsreport2009-2010.pdf

**Conclusion**

**p23:** "A prerequisite of a formal screening programme is that there is a clear reduction in morbidity and or mortality that can be measured over time by a randomised controlled trial. This evidence is not available for screening for alcohol misuse and therefore it does not meet the NSC criterion".

**Comment:** As previously in the Summary at the outset, the report needs to be clear that its conclusions relate solely to the potential for satisfying the strict criteria for a formal NSC screening programme, and that it does not inadvertently cast any doubts on the validity of current NHS programmes or clinicians' practice in identifying and advising alcohol misusers as part of their legitimate diagnostic processes.

Where the standard of evidence has been judged by the review as insufficient to meet one of the NSC's criteria for a formal NSC screening programme it needs to be clear that this is what is said (and that no more than this might be inferred). Otherwise, given the wide generic use of the word "screening" (for various case finding activities) the NSC runs the risk of discrediting all current the "screening" activities.

Suggest that clarity on this should need little more than inserting "NSC" more frequently at appropriate points. See the following alternative as an example:

> One prerequisite of a formal NSC screening programme is the NSC criterion that there is a clear reduction in morbidity and or mortality that can be measured over time by a randomised controlled trial. This level of evidence is not currently available for screening for alcohol misuse and therefore this NSC criterion is not met.

**p23:** "These are key areas where evidence is lacking and until more research has been reported a formal population based screening programme for alcohol use is not recommended. There are significant trials in progress and the results of these will inform a future policy update."

**Comment:** As above. Suggest the following alternative:

> These are key areas where this review has found that evidence is lacking for the purposes of a formal NSC screening programme. Until more research has been reported, a formal population based NSC screening programme for alcohol use is not recommended. There are significant research trials in progress and the results of these will inform a future NSC policy update.

**p24:** "Results from these research programmes will inform a future policy update on screening."

**Comment:** As above. Suggest the following alternative form of words:

> Results from these research programmes will inform a future NSC policy update on the conclusion reached here on the suitability of alcohol for a formal NSC screening programme.

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**Royal College of Physicians (RCP)**

The RCP is grateful for the opportunity to respond to the above consultation. We would like to make the following comments based on how our experts recommend alcohol screening, risk and interventions would be best approached.

**Individual level measures**

The philosophy for alcohol is that 1 in 8 people will reduce alcohol intake in response to brief directed health interventions. The RCP believes this to be an effective and cost effective strategy[1]. However, between 30% and 70% of subjects stop drinking when diagnosed with liver disease[2-4]. Unfortunately, because liver disease develops silently and presents late with fatal complications, it is too late for about 50% of patients to get a chance to stop drinking. Therefore consideration also needs to be given to the majority (7/8) of people who do not respond to screening and brief intervention. We

believe that the solution here is to incorporate an initial assessment of alcohol intake to a stepped program of interventions as outlined below.

**Primary Prevention - alcohol**

Detection of hazardous and harmful alcohol intake - This requires the use of a validated short questionnaire eg AUDIT-C (3 questions = 1-2 minutes).

Our experts believe that identification and recording of alcohol risk must be incorporated into routine health GP based screening programs. As a result, the additional cost implications will be low. We believe that detection of alcohol risk (and initial intervention) should also take place in a wider range of other locations eg emergency departments, secondary care, pharmacies or pubs and clubs – and that data must be passed to the GP.

A brief intervention and the full 10 item AUDIT questions would be given to subjects drinking hazardously or harmfully, with referral for specialist alcohol treatment in subjects drinking dependently.

Follow up assessment after 3 years in hazardous / harmful drinkers – co-ordinated by the GP irrespective of where detection occurred.

Persistent risk should activate a **common secondary prevention pathway**.

**Common Secondary Prevention (alcohol and elevated Liver Function Test [LFTs])**

If risk factors persist – alcohol with evidence of liver disease, or indeterminate elevation of LFTs and an objective non-invasive **assessment of liver fibrosis** should be performed in the community. Patients would be triaged as follows: subjects with advanced liver disease (red traffic light) would be referred to secondary care for specific therapy and investigation and prophylaxis of oesophageal varices, subjects with no evidence of advanced disease (green / amber traffic light) would undergo behavioural intervention if appropriate and re-assessment of fibrosis at 3 years if risk factors persist.

A **final common pathway approach** will simplify the diagnosis and staging of liver disease, increase treatment and referral of those in need, and reduce costs by reducing unnecessary secondary care referrals and admissions.

**Tertiary Prevention**

Access to nurse led specialist alcohol treatment services is vital for subjects with more advanced problems and for patients presenting or admitted to secondary care services to reduce relapse, and enhance detection.

**Assessment of liver fibrosis – the final common pathway:**

Candidates for this test include various algorithms combining blood tests and fibrosis markers, imaging or elastography techniques; with a common requirement that the test should identify the following categories:

- high risk of advanced disease (red)
- low risk of liver disease (green)
- intermediate risk (amber).

There is strong circumstantial evidence[4] together with pilot data[5] that in addition to triaging subjects to secondary care in a more efficient manner, this approach can substantially enhance behavioural interventions in the 'amber – at risk' group with an increase from 15% (brief intervention) to 70-80% possible although this sideline benefit requires further research to show that in the long term deaths and hospital admissions be prevented. It should be noted that the current system of primary care referrals for liver disease has never been subjected to any form of randomised clinical trial.

**Requirements for Specialist Alcohol Treatment:**

Any program of enhanced detection of alcohol risk will very likely fail unless specialist alcohol treatment services are improved. This would enable all dependent drinkers to have access to treatment, including patients in secondary care with alcohol related diseases.

The absence of treatment services is likely to prove an effective disincentive for detection irrespective of any financial rewards offered.

**Metrics**

- % of subjects in GP practice aged 30+ with a recorded alcohol risk level within the last 5 years
- % of hazardous / harmful drinkers retested for alcohol risk within 3 years
- % of persistently at risk drinkers aged 30+ undergoing liver assessment
- % of obese subjects aged 50+ undergoing a simple NALFD algorithm for liver disease
- Liver admissions
- Liver deaths

**RCP working party**

The RCP has convened a working party on 'Alcohol and sexual health'. This has also looked at the evidence for brief interventions (among other issues) and is due to publish its findings in 2011.

Yours sincerely

Dr Patrick Cadigan
Registrar

# Reference List

(1) National Institute for Clinical Guidance. PH 24 Alcohol-use disorders - preventing the development of hazardous and harmful drinking. 2010.
Ref Type: Report

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