Public Health Guidance

Alcohol-use disorders – preventing harmful drinking - Consultation on Review Proposal
Stakeholder Comments Table

10 – 24 March 2014

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Advertising Standards Authority	Recommendation 3: Marketing & EUAG discussions and conclusions: Marketing and Advertising		The UK Advertising Codes administered by the Advertising Standards Authority (ASA) contain robust alcohol rules that sit on top of general Code provisions that require ads not to mislead, harm or cause serious or widespread offence. The rules protect young people by both reducing the likelihood that they will see alcohol ads and, if they do, by ensuring the ads will not appeal strongly or particularly to them. In summary, the rules state that alcohol ads must not: • link alcohol with daring, antisocial, aggressive or irresponsible behaviour • link alcohol with seduction, sex or social success • show alcohol being handled or served irresponsibly • show people drinking or behaving in an adolescent or juvenile way or reflecting the culture of people under 18 years of age • depict people who are, or appear to be, under the age of 25. In non-broadcast media (including online and in the cinema) no medium should be used to advertise alcoholic drinks if more than 25% of its audience is under 18 years of age. As with broadcast scheduling rules, the content and placement rules should be viewed alongside each other.	Thank you for your comment and we welcome the ASA's contribution

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Advertising Standards Authority	See above		The alcohol ad rules are exceptionally robust, especially in relation to the protection of young people and vulnerable groups. The rules are a proportionate response to the evidence on the relationship between alcohol advertising and attitudes to alcohol. The current alcohol advertising rules were tightened significantly in October 2005, in response to the Alcohol Harm Reduction Strategy, which suggested a possible link between young people's awareness and appreciation of alcohol advertising and their propensity to drink. The rules were updated in line with Government's better regulation principles and in light of the best available evidence about the impact	Thank you for your comment

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			of alcohol advertising on society. The rules were reviewed again in full in 2008, taking account of the latest Department of Health commissioned evidence and subject to a full public consultation in 2009.	
Advertising Standards Authority	See above		Recommendation 3 makes reference to young people in the UK potentially having 'high levels of exposure to alcohol advertising on television and online media'. In 2013 the UK's communications regulator, Ofcom, published research into children's exposure to alcohol advertising on TV. This work showed that the number of TV alcohol ads seen by 4-15 year olds had increased from 2.7 ads per week in 2007 to 3.2 per week in 2011, in line with the overall increase in the amount of TV being watched by that age group. In light of that research and the data provided by Ofcom the ASA launched a full compliance investigation to establish whether there had been breaches of the scheduling rule. Ten adjudications have been published on the ASA's website, nine of which recorded breaches of the Code.	Thank you for your comments. NICE reviews its published guidance every 3 years. This document is the decision on review document. Its function is to inform the decision on whether to update the existing guidance on Alcohol-use disorders: preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance but represents the views of the EUAG and a pragmatic review of the evidence base. The final decision is that the guidance

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			In response to Ofcom's findings and taking into account the ASA's compliance work, in December 2013 the Broadcast Committee of Advertising Practice (BCAP) published a new, strengthened, guidance note on the scheduling of TV advertisements to help broadcasters identify which television programmes should exclude ads for alcohol and other age restricted products. The ASA will make sure the guidance is being followed by conducting a monitoring and enforcement exercise in 2014. Data for 2012 shows that exposure levels were 2.8 ads per week seen by 4-15 year olds (down from 3.2 in 2011). In 2012 alcohol impacts constituted 1.3% of the total commercial impacts on 4-15 year olds; in 2007, the share was 1.4%.	will not be updated but will be reviewed for update again in 2016.
Advertising Standards Authority	See above		The ASA is vigilant to the challenges of new media and ensuring that ads are responsible, no matter where they appear. For that reason the ASA published research ('Children and advertising on social media websites') in July 2013. Of the 427 ads seen by young people as part of the survey, only 3	Thank you for your comment.

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			were for alcohol, and these were delivered to those children who had registered with a false age. Results demonstrated that advertisers are acting in good faith, taking account of registered ages when delivering ads - but there was a trend for children to register with false ages. The robust rules in place today are the result of sustained engagement by the ASA system in the alcohol debate, resulting in a set of rules that best fit the available evidence and are proportionate to the risk of harm. We accept that for as long as alcohol related harm remains a problem, alcohol advertising is likely to remain subject to scrutiny – and rightly so. However, the ASA will remain of the view that the rules we administer must be evidence based and proportionate, and any further changes to the already robust Codes will require new evidence.	
Hartlepool Borough Council, Public Health Department.	Section 1		We would agree that the document does need updates at regular intervals of 3-years. This would take into account any new publications and evidence that could inform NICE in updating the recommendations from time to time.	Thank you for your comment and we welcome Hartlepool Borough Council, Public Health Department's contribution
Hartlepool Borough Council,	Section 3		**Price:** We would agree to the statement in your document that an	Thank you for your

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Public Health Department.			increase in price may be associated with a reduction in harms associated with drinking. We wholeheartedly back any decision to look into implementing a MUP for alcohol as there is strong evidence that this would help those higher risk drinkers without disadvantaging those who drink responsibly. Tax on alcohol should also be increased as this has also got associations with a reduction in drinking that will help in all of the above. **Availability**: Availability of alcohol goes alongside price and plays a major part in adding to the issues that we have with increased higher risk drinkers. This in turn can have an impact on the rate of alcohol related hospital admissions and therefore we would recommend any guidance to overcome this. In general the findings and conclusions from the evidence updates that are summarised in this section are all relevant and reflect what we see at a local level and therefore would be good to be updated and reviewed within the PH24 document.	comments
Hartlepool Borough Council, Public Health Department.	Section 6		From a local level we agree that MUP affects the population of drinkers at the highest risk across all socioeconomic categories, and	Thank you for your comment

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			people with the lowest income will not particularly be disadvantaged by MUP. The positives/benefits to all the population by having MUP would far outweigh any negatives.	
Hartlepool Borough Council, Public Health Department.	Section 7		We would agree with this overall conclusion and would give support any decisions that would highlight change in public health landscape when making a decision to update the guidance.	Thank you for your comment
Hartlepool Borough Council, Public Health Department.	General		Overall all research that has been undertaken and recommendations that have been suggested must be a t the forefront for NICE when updating any of the guidance. This is due to the fact that the recommendations highlighted are reflecting what is actually going on in localities within the North East and are issues that we are dealing with on a day to day basis. We would therefore welcome all updates as and when NICE feel it necessary to update their documents.	Thank you.
Institute of Alcohol Studies	General		The IAS welcomes the opportunity to comment on the review proposal for guidance on the NICE public health guidance 'alcohol-use disorders: preventing harmful drinking' (PH24), which covers issues including price, marketing, availability, screening and brief interventions. The core aim of the Institute is to serve the public interest on public policy issues linked to alcohol, by advocating for the use of scientific evidence in policy-making to reduce alcohol-related harm. The IAS is a company limited by guarantee, No 05661538 and registered charity, No 1112671. For more information visit www.ias.org.uk.	Thank you for your comments and we welcome the input of the IAS

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Institute of Alcohol Studies	Recommendation 1: Price		IAS welcomes the acknowledgement in the review proposal that the evidence base to support minimum unit pricing has strengthened since the original guidelines were developed. We have now seen 'real world' results from Canada that indicated a 10% increase in average minimum prices for alcohol was associated with an 8% reduction in consumption, a 9% reduction in hospital admissions and a 32% reduction in wholly alcohol caused deaths. We have also seen updated modelling from the Sheffield Alcohol Research Group that gives us greater detail on the impact minimum unit pricing would have in the UK on different consumption groups and income groups. This data indicates that low income heavy drinkers would benefit the most in terms of greater health outcomes following the introduction of a minimum unit price, whilst moderate drinkers from all income groups would see very little change to their expenditure on alcohol. This new evidence shows that minimum pricing has the potential to directly tackle health inequalities, which are currently exacerbated in the UK by alcohol harm, without unfairly penalising moderate drinkers. Since the publication of the PH24 guidance the Government has	Thank you for your comments and the analysis of information you have provided

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			proposed plans to introduce minimum unit pricing within its Alcohol Strategy, published in 2012. However, in 2013 these plans were reversed and a ban on 'below cost sales' was introduced instead – a measure that was estimated would reduce consumption by just 0.04%. This measure has been further weakened by the Budget 2014 announcements to cut beer duty and freeze duties on wine, cider and spirits, a move that will make alcohol more affordable and will, according to Treasury estimates, increase overall consumption in the UK. IAS believes that on the basis of the strengthened evidence outlined above, and the inadequate political response to the challenge of addressing affordability of alcohol, NICE should amend the PH24 guidance to recommend that minimum unit pricing is introduced as a matter of urgency, as opposed to just 'consider' introducing it, and that the alcohol duty changes made in the 2014 Budget – which have made alcohol more affordable – are also reviewed as a matter of urgency.	
Institute of Alcohol Studies	Recommendation 2: Availability		Since the publication of PH24 public health has been transferred to local authorities, and health bodies have been made responsible authorities in alcohol licensing decisions. However, public health has not been introduced as a fifth licensing objective, therefore health bodies are unable to assert any influence over licensing decisions.	Thank you for your comments and clarification regarding change in public health landscape

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			Given this major flaw in the licensing process, IAS recommends that PH24 guidance be updated to reflect this situation, with a more urgent call for the introduction of a public health licensing objective.	
Institute of Alcohol Studies	Recommendation 3: Marketing		IAS supports the conclusion of the EUAG that there is an omission in PH24's recommendations regarding the use of sports advertising, new media, the targeting of young people with new media and the impacts of adult advertising on young people.	Thank you for your comment
Institute of Alcohol Studies	Recommendation 4: Licensing		The transfer of local responsibility for public health to local authorities marks a major shift. Given that local authorities are also responsible for alcohol licensing, it is important that the guidance is updated to reflect this substantial shift.	Thank you for your comment
Institute of Alcohol Studies	Recommendation 5: Resources for screening and brief interventions		IAS supports the recommendations made in PH24 that screening and brief intervention is prioritised under a 'cost to save' framework – and that the changes within public health and the NHS are taken into consideration when updating this guidance, to ensure that screening and brief intervention remains a priority for key decision makers and commissioners.	Thank you for your comment
Lundbeck Ltd	General		Lundbeck is an ethical research-based pharmaceutical company specialising in brain disorders, such as depression and anxiety, bipolar disease, schizophrenia, Alzheimer's disease, Parkinson's disease and alcohol dependence. Of the estimated 1.6million people who are alcohol dependent in	Thank you for your comments and we welcome Lundbeck Ltd's comments

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			England, only approximately 6% per year receive treatment.[1] Reasons for this include the often long period between developing alcohol dependence and seeking help and the limited availability of specialist alcohol treatment services in some parts of England.[2] Reduction of drinking, especially of heavy drinking, is associated with a reduction in alcohol-attributable mortality, with the reduction being highest for the heaviest drinking category.[3] There are also many aspects in addition to the prevention of alcohol-attributable illnesses that are positively influenced when reducing alcohol consumption, including improvement in patient's productivity (employment and absenteeism)[4] improvement in social functioning, reduction in alcohol-related violence, avoidance of accidents, limiting risk of poverty, and reduction in the impact of alcohol problems on family, friends, and society as a whole. Lundbeck therefore welcomes the opportunity to comment on the proposed review of PH24 'Alcohol-use disorders: preventing harmful drinking'. Lundbeck supports the decision to defer any update to PH24 to 2016, but believe that a later review must focus on the implementation and measurement of screening, brief interventions and referral processes	

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			and that data must be routinely collected to measure the impact and implementation of PH24 to inform this review.	
Lundbeck Ltd	Recommendation 5		Alcohol services, in particular treatment services, are historically underfunded compared to drugs services. This has a negative impact upon alcohol treatment service provision and waiting times. There is an unmet need in the management of alcohol dependence, in particular for treatment options that are more easily accessible, that encourage and motivate adherence, and that result in better outcomes.[5,6] There is a need for commissioners to be appropriately incentivised to deliver screenings and brief interventions, in particular taking into account people with mild levels of dependence who do not require assisted withdrawal. Psychosocial intervention, such as extended brief intervention or motivational interviewing, is the mainstay of treatment for alcohol-dependence and has been shown to be effective in both reducing alcohol consumption and maintaining abstinence.[2,6] Community-based, non-specialist services which incorporate a range of psychological and pharmacological interventions will be better suited to the needs of these patients.	Thank you for your comment

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			Healthcare professionals need better educating about the benefits of screening and interventions in order to reach patients earlier and achieve better outcomes. • Approximately half of the patients seeking help at a range of services across the UK were found to choose reduction of alcohol consumption rather than abstinence as their preferred treatment goal when asked.[7] • There is also evidence that achieving a successful outcome of abstinence or reduction is related to initial goal preference, and allowing patients to set their own treatment goal is associated with a higher chance of success, regardless of preference.[8,9] • Treatment of alcohol dependence reduces levels of consumption either to abstinence or by a sizeable reduction of heavy drinking.[10] We also recommend measures for educating healthcare professionals about the benefits of identification and appropriate referral. This is particularly pertinent as a survey of GPs in England found low levels of motivation for addressing problem or dependent drinkers' alcohol issues, with busyness, lack of training or contractual incentives cited as the key barriers.[11] The impact of alcohol misuse cuts across the healthcare system, but responsibility for the funding of many treatment services, including	

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			alcohol misuse, now sits with local authorities. NHS England and Clinical Commissioning Groups meanwhile are also responsible for the delivery of aspects of the alcohol pathway, including enhanced services. It is therefore important to ensure that alcohol-related financial incentives are aligned across the treatment pathway and underpin the delivery of improved health outcomes for patients. Incentives should support providers to work collaboratively to address alcohol misuse by avoiding any perverse effects of activity-based payments across QOF, CQUIN, the Quality Premium and other local incentives.	
Lundbeck Ltd	Recommendation 9		The delivery of targeted screening and brief interventions for alcohol-related harm to selected populations at the appropriate time and setting can improve the identification of people at risk of alcohol misuse and is an important step in helping to reduce unsafe levels of alcohol consumption. Results from a recent QOF indicator pilot in North West London suggest that the introduction of an indicator around targeted screening for alcohol misuse has the potential to deliver significant benefits for the patient population.[12] The pilot, which ran from 2008-2011 and covered 30 practices, incentivised GPs to carry out alcohol screening and brief interventions in those with risky	Thank you for your comments and the information provided. This document is the decision on review document. Its function is to inform the decision on whether to update the existing guidance on Alcohol-use disorders:

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			drinking habits, through a QOF 'extra' scheme. The scheme was targeted at patients with or at risk of cardiovascular disease and those with a mental health condition.[12] Among patients eligible for the 'QOF-extra points', the screening rate increased from 4.8% to 65.7%. The screening rate also increased among ineligible patients, from 0.3% to 14.7%, suggesting that "financial incentives appear to be effective in increasing delivery of alcohol screening and brief interventions in primary care and may reduce hazardous and harmful drinking in some patients".[12] Screening and brief interventions for alcohol misuse meanwhile have been shown to be both clinically and cost-effective in changing a person's behaviour in reducing their alcohol intake over a period of time, as supported by recent studies: • Kaner et al. identified a total of 29 controlled trials from various countries, in general practice (24 trials) or an emergency setting (five trials). Participants drank an average of 306 grams of alcohol (over 30 standard drinks) per week on entry to the trial. Over 7,000 participants received a brief intervention or a control intervention, including assessment only. After one year or more, people who received the brief intervention drank less alcohol than people in the control group (average difference 38 grams/week, range 23 to 54	preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance but represents the views of the EUAG and a pragmatic review of the evidence base which will inform a decision on whether to update the guidance. The decision is not to update the guidance but to review for update again in 2016.

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			grams).[13] • A US study review of existing evidence suggested that screening and brief counselling was cost-saving from the societal perspective and had a cost-effectiveness ratio of $1755/QALY saved from the health-system perspective. Concluding that the results make alcohol screening and counselling one of the highest-ranking preventive services among the 25 effective services evaluated using standardised methods.[14] • The SIPS alcohol screening and brief intervention (ASBI) research programme funded by the Department of Health tested interventions of different intensities in primary care. It found that all three intervention approaches tested reduced drinking and alcohol use disorders at 6 and 12 months post-intervention, with reductions in AUDIT score greater at 12 months than at 6 months.[15] Targeted screening should apply to hypertension in particular as evidence suggests that excessive alcohol consumption is associated with raised blood pressure and poorer prognosis. • A further study suggested that drinking just 1 to 3 drinks a month increased hypertension risk among men by 11% after	

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			allowing for other risk factors. Results from the same study showed that one drink a day increased the risk of developing hypertension by 26%. Meanwhile the likelihood of developing hypertension was 53% higher among women drinking more than 4-5 drinks a day.[16] • Similarly, recent results from the REGARDS study confirmed that heavy drinking increased the likelihood of showing hypertension (OR 1.59).[17] Finally it is important to ensure that staff within GP practices are familiar with the AUDIT test and have the necessary skills to carry it out. The AUDIT test is considered to be the 'gold standard' alcohol risk questionnaire, and Lundbeck would therefore welcome a recommendation for targeted screening.	
Lundbeck Ltd	Recommendation 11		There is a need for further guidance for commissioners on the range of interventions available. Patients with alcohol dependence who do not require immediate detoxification may be suitable for a different management strategy, one of reduction of alcohol consumption. These patients are commonly seen in a primary care setting, which is a setting more appropriate to the needs of this patient group, as recommended by the commissioning guidance for NICE CG115.[18]	Thank you for your comments. This decision on review document is concerned with PH24. Interventions to address those individuals identified as being Alcohol dependent are not

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			NICE commissioning guidance recommends increasing the proportion of people in the local population with alcohol dependence who enter and complete treatment in a setting appropriate to their need.[2] This is especially true for people with mild alcohol dependence, defined in NICE Clinical Guideline 115 as those scoring 15 or less on the SADQ, which correlates broadly to those classified as 'higher risk' by the Department of Health.[19] People with mild alcohol dependence may not want to be assessed and treated in a specialist service alongside more severely dependent patients who require assisted withdrawal.[2] A more appropriate setting is primary care with management by GPs or other healthcare professionals. With this in mind it is important that commissioners support the delivery of appropriate services for alcohol dependence, taking into account people with mild levels of dependence, who do not require assisted withdrawal. Community-based, non-specialist services which incorporate a range of psychological interventions will be better suited to the needs of these patients.	covered by PH24. These interventions were considered in associated NICE clinical guideline 115: Alcohol dependence and harmful alcohol use (NICE 2011). Please see the NICE website for further details (www.nice.org.uk)
Lundbeck Ltd	Recommendation 12		Lundbeck recommends prioritising the delivery of appropriate referral pathways for harmful drinking and people identified with alcohol dependence.	Thank you for your comments. This decision on review document is

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			Patients who are suitable for treatment in the community setting for instance, such as those identified with mild dependence, should be assessed and treated in that setting where possible and referred onward appropriately. Ensuring that healthcare professionals understand the delivery of appropriate referral pathways can therefore contribute to service users accessing treatment in the most beneficial environment. Improving referral practice can also help to address alcohol dependence at an earlier stage, before people become more severely dependent and require more specialist treatment. In order to deliver effective referral pathways it is also important that alcohol services are commissioned through an integrated approach between local authorities and Clinical Commissioning Groups with clear lines of responsibility outlined for service provision. NICE reports that commissioning high quality alcohol services using an integrated, whole-system approach can increase access to evidence based interventions, which could improve outcomes for people, such as better health, wellbeing and relationships.[18]	concerned with PH24. Interventions to address those individuals identified as being Alcohol dependent are not covered by PH24. These interventions were considered in associated guidance NICE clinical guideline 115: Alcohol dependence and harmful alcohol use (NICE 2011).
British Beer & Pub Association	General		• The beer and pub sector is committed to promoting responsible drinking and to helping to reduce the harmful use	Thank you for your comments and we

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			of alcohol and has done a great deal through self regulatory and voluntary initiatives to tackle alcohol related harm.	welcome the British Beer and Pub Association's contributions
British Beer & Pub Association	General		• Through the Public Health Responsibility Deal and separately the brewing industry is committed to: - 80% of packaged beers on shelf at the end of 2013 having health warning information on - information on unit content of drinks is being communicated to consumers in a variety of ways - further work to improve training and awareness to continue to tackle underage sales - the industry continues to provide £5 million annual funding to Drinkaware to provide information and guidance to consumers on responsible drinking - complying with the rules around responsible advertising, marketing and sponsorship through the self regulatory framework - supporting local partnership schemes such as Pubwatch, Best Bar None, Purple Flag, Business Improvement Districts and Community Alcohol Partnerships which work to promote safer night time economies - working to **remove 1 billion units of alcohol sold annually from the market by December 2015 principally through**	Thank you for your comments and the information regarding the public health responsibility deal.

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			improving consumer choice of lower alcohol products.	
British Beer & Pub Association	General		• Whilst we have outlined below the key recommendations and measures that we do not believe are proportionate or effective we are very supportive of other suggested measures including targeted interventions for young people and harmful drinkers and better advice and screening in hospitals.	Thank you for your comments.
British Beer & Pub Association	General		**Minimum price** • No country in Europe has yet implemented a minimum unit price for alcohol therefore any assumptions about its effectiveness in tackling alcohol related harm are currently speculative. • Although outside of Europe, Canada has had a system of minimum pricing (or social reference pricing) in a number of provinces for some years. There have been some recent studies suggesting a significant impact in British Columbia, for example, in terms of reducing alcohol related deaths but still no systematic or comprehensive research across provinces on the effectiveness of social reference pricing in reducing the harmful use of alcohol in Canada. The retail environment in Canada is also very different to the UK.	Thank you for your comments. This document is the decision on review document. Its function is to inform the decision on whether to update the existing guidance on Alcohol-use disorders: preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance but

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			• The existing balance of evidence does not appear to support whole population measures such as minimum pricing as an effective and proportionate means to tackle alcohol related harm. • Increases in price particularly impact those on lower incomes and also penalise moderate drinkers. Recent studies by the IFS[1] and CEBR[2] highlight that the poorest households are hit hardest (whilst levels of hazardous and harmful drinking are greater among higher income households). Indeed, most studies conclude that that those drinking at harmful levels are the least sensitive to changes in price[3]. • The Sheffield model, most frequently cited at the key evidence to support the introduction of MUP, makes the assumption that there is a causal link between overall per capita	represents the views of the EUAG and a pragmatic review of the evidence base which will inform a decision on whether to update the guidance now, at another time or not at this time. The EUAG agreed that evidence available affirmed the original recommendations. The guidance will be reviewed for update again in 2016

[1] *The impact of introducing a minimum unit price on alcohol in Britain*, Institute of Fiscal Studies (2010) http://www.ifs.org.uk/publications/528

[2] *Minimum Alcohol Pricing: a targeted measure?*, Centre for Economics and Business Research (2009)

[3] *Effects of Beverage Alcohol Taxes and Price on Consumption: A systematic review and meta analysis of 1003 estimates from 112 studies*, Wagenaar et al (2008)

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			consumption and levels of harmful drinking which there is little evidence to support.[4] • The Sheffield study also acknowledges that at a total alcohol level moderate drinkers are more price sensitive than heavy drinkers but then does not attempt to reconcile this with the subsequent contradictory findings of the model.[5]	
British Beer & Pub Association	General		**Availability** • Availability of alcohol is already fully regulated through the Licensing Act and reducing or restricting generally is not a targeted approach to tackling alcohol related harm and is likely to disproportionately penalise the majority of responsible drinkers. • Local authorities have powers to ensure compliance with the licensing objectives and now have responsibility for public health as part of their remit. However, health is not a licensing objective and as such NICE should be very cautious about recommendations to use the licensing system to 'manage	Thank you for your comments. This document is the decision on review document. Its function is to inform the decision on whether to update the existing NICE guidance on Alcohol-use disorders: preventing harmful

[4] *The Minimal Evidence for Minimum Pricing: The fatal flaws in the Sheffield Alcohol Policy Model*, John C Duffy and Christopher Snowden, The Adam Smith Institute http://www.adamsmith.org/sites/default/files/research/files/ASI_SAPM.pdf

[5] *Independent review of the effects of alcohol pricing and promotion: Part B (p51),* University of Sheffield https://www.shef.ac.uk/polopoly_fs/1.95621!/file/PartB.pdf

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			availability' from a health perspective. • The Government consulted on the introduction of health as a licensing objective in relation to Cumulative Impact Zones, however in their response to the alcohol strategy consultation it was made clear that the evidence on the link between health and licensed premises is insufficient for this to be practical at present. • People often have very different hours of work and hours of leisure e.g. shift work, night work etc and reducing availability either through reducing density or restricting opening hours is likely to simply restrict their ability to purchase alcohol to consume during their leisure time.	drinking (PH24) published 2010. It does not constitute NICE guidance but represents the views of the EUAG and a pragmatic review of the evidence base which will inform a decision on whether to update the guidance. The decision was to review the guidance again for update in 2016 and the original recommendations still stand.
British Beer & Pub Association	General		**Marketing and advertising** • Alcohol advertising and marketing is intended to increase market share not increase overall consumption. The majority of research on the subject concludes that advertising has little, if any, effect on consumption.[6]	Thank you for your comments. This document is the decision on review document. Its function is to inform the decision on

[6] Independent review of the effects of alcohol pricing and promotion, ScHARR University of Sheffield 2008

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			• A study by the French Parliament has concluded that the Loi Evin, the French law which bans alcohol advertising, had no effect on alcohol consumption[7]. • In Norway, where alcohol advertising is also banned, alcohol consumption increased by nearly 30 per cent in a decade after the ban was introduced.[8] • Young people's exposure to alcohol advertising has been a frequent issue of debate; however, the balance of evidence does not support a direct link between alcohol advertising and young peoples' drinking levels. Studies have shown that the principal influences on young peoples' drinking are parents and peers.[9] Additionally there are already restrictions on advertising that protect children.	whether to update the existing NICE guidance on Alcohol-use disorders: preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance but represents the views of the EUAG and a pragmatic review of the evidence base which will inform a decision on whether to update the guidance now. The decision was to review the guidance again for update in 2016 and the original recommendations still stand.
British Beer & Pub Association	General		**New areas for consideration** • The reference to Late Night Levies and Early Morning Restriction Orders as 'industry interventions' is unclear, as	Thank you for your comments. Reference to Late Night Levies and Early

[7] 3. Berger, G. et al. La Loi relative à la lutte contre le tabagisme et l'alcoolisme: rapport d'évaluation. La Documentation Française, 106.
[8] BBPA Response to the Health Select Committee
[9] Donovan, JE. 2004. *Adolescent alcohol initiation: a review of psychosocial risk factors.* Journal of Adolescent Health, 35(6):529.e7-18

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			both of these are licensing powers introduced under the Police Reform and Social Responsibility Act which local authorities may choose to introduce. • The licensed trade has been strongly opposed to these measures as they cut across existing partnership working through schemes such Pubwatch, Best Bar None and Business Improvement Districts and place further burdens on businesses. • Whilst there have been a number of consultations on both measures, only three local authorities have agreed to introduce the Late Night Levy (Newcastle, Cheltenham and Islington) and no local authority has yet introduced an Early Morning Restriction Order due to lack of support from trade, partnership schemes and local authorities. Therefore, we do not believe that it is appropriate for NICE to take a position on this issue.	Morning Restriction Orders are made with regard to discussions by EUAG of potential new areas for considerations and the evidence underpinning current industry interventions (p.10) in any update of PH24 that is within scope and isn't currently considered. This document is the decision on review document. Its function is to inform the decision on whether to update the existing NICE guidance on Alcohol-use disorders: preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance in and of itself. The decision was to review the guidance again for update in 2016.
British Beer & Pub	1		Recommendation 1 – Price	Thank you for your

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Association			Evidence Update (EU) – conclusions on affordability of alcohol • As referenced above the balance of evidence suggests that those drinking at harmful levels are the least sensitive to changes in price[10] therefore an increase in the price of alcoholic drinks is likely to be a very blunt tool and a disproportionate measure to reduce alcohol related harm. • Whilst some research indicates a slight relationship between affordability of alcohol and consumption in different countries, it has also been shown that affordability of alcohol is unlikely to be a significant factor in alcohol related harms.	comment. This document is the decision on review document. Its function is to inform the decision on whether to update the existing NICE guidance on Alcohol-use disorders: preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance. The decision was to review the guidance again for update in 2016.
British Beer & Pub Association	1		Recommendation 1 – Price EU conclusions on minimum unit pricing • As stated above, although it is the case that harmful drinkers are more likely to be those on higher incomes this does not mean that those on lower incomes will be less affected by any pricing measures.	Thank for your comment. This document is the decision on review document. Its function is to inform the decision on whether to update the existing NICE guidance on Alcohol-use disorders:

[10] *Effects of Beverage Alcohol Taxes and Price on Consumption: A systematic review and meta analysis of 1003 estimates from 112 studies*, Wagenaar et al (2008)

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			• As most current research suggests that that those drinking at harmful levels are the least sensitive to changes in price[11] and the majority of those drinking to harmful levels are on higher incomes anyway MUP is unlikely to target the majority of those who are at the most risk. • If higher risk is determined by higher consumption then those that are better off are most at risk. These drinkers are less likely to opt for 'cheap' drinks. Again, this is why An increase in price has the least overall impact on consumption levels among heavy drinkers.	preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance. The decision was to review the guidance again for update in 2016.
British Beer & Pub Association	1		Recommendation 1 – Price EU conclusions on taxation price and affordability • As stated above the link between affordability and harmful consumption is not established and the reasons for different consumption and harm levels country to country are complex.[12]	Thank you for your comment. This document is the decision on review document. Its function is to inform the decision on whether to update the existing NICE guidance on Alcohol-use disorders:

[11] *Effects of Beverage Alcohol Taxes and Price on Consumption: A systematic review and meta analysis of 1003 estimates from 112 studies*, Wagenaar et al (2008)
[12] *Effects of Beverage Alcohol Taxes and Price on Consumption: A systematic review and meta analysis of 1003 estimates from 112 studies*, Wagenaar et al (2008)

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			• It is far more likely to that increasing alcohol prices through taxation will simply disadvantage moderate drinkers and further damage the pub and brewing industry which support over 900,000 jobs and contributes £22 billion to UK GDP. • Beer duty in the UK remains the second highest in the EU. Across Europe there is little correlation between consumption levels and the excise duty rate. What is clear is that a higher excise duty rate encourages fraud. • Any taxation system should not discourage the production and consumption of lower alcohol drinks and it is vital that lower-strength products, such as beer, pay a lower rate per unit of alcohol. • Currently in the UK spirits (and higher-strength products generally) are taxed more than lower-strength ones, on a per unit basis. This is the case in virtually every country in the world, and certainly all EU countries. • Equalising the tax per unit across drinks would lead to spirits being significantly cheaper than beer as production and distribution costs are far lower for a more concentrated form of	preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance. The decision was to review the guidance again for update in 2016 and the original recommendations still stand.

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			alcohol. Beer also supports many more jobs than spirits within the UK and therefore any move towards a system that leads to spirits being much more affordable than beer will lead to a fall in employment. • Whilst duty should not be used to control affordability per se it should be encouraging the consumption of lower-strength products, such as beer, as a more responsible way to consume alcohol. Whilst strength should be a factor in setting duty rates, equalisation of excise duties across all drinks does the opposite and should not therefore be a recommendation in any public health guidance.	
British Beer & Pub Association	2		Recommendation 2 – Availability EU conclusions on availability • The evidence linking alcohol harms to density of licensed premises is not clear cut and there is certainly not a clear causal link between number of off-licensed premises and harms. • It is difficult to comment fully without seeing the source data, however, the granting of licences should generally be on a	Thank you for your comments. The evidence update that was used as the basis for discussions by EUAG in the development of the decision on review document is available on the NICE evidence search website. A link was also provided in the decision on review document (p.2). This

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			case by case basis and shouldn't pre-judge the impact that they will have a on a particular area as there should be no automatic assumption that they will be a cause of alcohol related harm. • The existing recommendations around limiting the number of licensed premises in areas should only ever be a last resort and should be fully evidence based.	document is the decision on review document. Its function is to inform the decision on whether to update the existing NICE guidance on Alcohol-use disorders: preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance. The existing recommendations within NICE PH24 are based on the best available evidence, committee deliberation and stakeholder consultation. The decision was to review the guidance again for update in 2016 and the original recommendations still stand.
British Beer & Pub Association	3		Recommendation 3 – Marketing • As stated above the link between young people's exposure to alcohol advertising and consumption is not established and	Thank you for your comments. The existing recommendations within NICE PH24 are based on the

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			the balance of evidence does not support a direct link between alcohol advertising and young people's drinking levels. • Studies have shown that the principal influences on young people's drinking are parents and peers.[13] • Additionally there is already a strict and effective self-regulatory system through the Portman Group Code which regulates packaging and marketing and the Advertising Standards authority which regulate alcohol advertising. This ensures that all advertising and marketing is appropriate and does not seek to target children. • Rules set by the ASA also ensure that advertising is not included between programmes where the majority of the audience are under 18. • We therefore do not believe that the existing evidence supports the existing recommendation of an assessment of the need for a complete advertising ban.	best available evidence, committee deliberation and stakeholder consultation. Current recommendations in PH24 (Recommendation 3: marketing) do not recommend a 'complete ban' on alcohol advertising. This document is the decision on review document. Its function is to inform the decision on whether to update the existing NICE guidance on Alcohol-use disorders: preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance. The decision on review document does not outline or recommend a ban of alcohol advertising. The decision was to review the

[13] Donovan, JE. 2004. *Adolescent alcohol initiation: a review of psychosocial risk factors.* Journal of Adolescent Health, 35(6):529.e7-18

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				guidance again for update in 2016 and the original recommendations still stand.
British Beer & Pub Association	4		Recommendation 4 – Licensing • Whilst design of licensed premises may contribute to ensuring a safer and more secure drinking environment there is no evidence that factors such as loud music or other environmental factors automatically contribute to 'risky drinking, intoxication and violence'. • Any review of licences should be based solely on compliance with the licensing objectives, on a case by case basis and applications or reviews should not be pre-judged by environmental factors which may or may not have an impact on alcohol harms or crime in the vicinity. • We would therefore support the view that the evidence is insufficient to influence any recommendations in the NICE guidance.	Thank you for comments. This document is the decision on review document. Its function is to inform the decision on whether to update the existing NICE guidance on Alcohol-use disorders: preventing harmful drinking (PH24) published 2010. It does not constitute NICE guidance but represents the views of the EUAG and a pragmatic review of the evidence base which informs a decision on whether to update the guidance. The decision was to review the guidance again for update in 2016 and the original recommendations still stand.

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Public Health England	General		Public Health England (PHE) support NICE's recommendation that the evidence reviewed supports the existing guidance, strengthens the evidence base for many of the current recommendations but does not require any of them to be changed at present. PHE agrees with NICE's intention to review the guidance for potential update in 2016.	Thank you and we welcome PHE's comments.
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.	General		We agree that the existing guidance is likely to be strengthened but not changed, by existing and future research.	Thank you for your comments and we welcome domUK's contributions
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.	General		We agree that the move of public health into local authorities may strengthen local abilities to use existing powers with regard to licensing applications. We also feel it is important that all local authorities consider the geographical location of applications with regard to places where young people are likely to congregate (e.g. schools, churches, scouts halls, youth clubs and so on). We welcome a future focus on the extent to which changes to the public health landscape have in fact impacted upon alcohol consumption.	Thank you for your comments
Dietitians in Obesity Management UK (domUK), a specialist group of the British	Recommendation 1 page 5		We are interested in the findings of EUAG with relation to minimum pricing and the finding that there is no apparent disadvantage to those on lowest incomes. Differential pricing is also often suggested as a	Thank you for your comment. The 'use of pricing to encourage

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Dietetic Association.			means to change poor dietary habits and increased disadvantage to those with lowest incomes is used as a reason not to apply pricing measures. However, we recognise that food and alcohol are not the same. We would welcome in the future consideration of using pricing to encourage consumption of non-alcoholic drinks in addition to minimum pricing of alcohol and the extent of an impact in different groups. We would like to see this added to potential new areas of consideration.	consumption of non-alcoholic drinks in addition to minimum pricing of alcohol and the extent of an impact in different groups is beyond the remit of this piece of guidance and thus its review. There is a mechanism on the NICE website where topics for future consideration can be made (www.nice.org.uk).
Dietitians in Obesity Management UK (domUK), a specialist group of the British Dietetic Association.	Recommendation 3 page 6 and Marketing and advertising page 9		We agree that young people in the UK have high levels of exposure to alcohol advertising from a variety of media. In particular we have concern over links between alcohol consumption, sports and sports personalities. We would like to see a recommendation for the sporting industry to work with alcohol awareness groups and reduce the exposure of young people to alcohol messages, in particular given the emphasis on encouraging physical activity in young people. This may inadvertently increase their exposure to such messages, but is at the least a conflict.	Thank you for your comment.
Dietitians in Obesity Management UK (domUK), a specialist group of the British	Marketing and advertising page 9		We would welcome re-consideration in the future of effect of banning advertising in media outlets where more than 5% of the audience is under 18.	Thank you for the comment. The decision was to review the guidance again for

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Dietetic Association.				update in 2016 and the original recommendations still stand. Although current guidance does not recommend a 'ban on advertising in media outlets where more than 5% of the audience are under 18' there is a mechanism on the NICE website where topics for future consideration can be made (www.nice.org.uk).
The Royal College of Psychiatrists	General		It is noteworthy that evidence to support the existing recommendations have been largely strengthened to add weight to this guidance. Excessive drinking and its consequences remain high profile and hopefully this will stimulate research in the areas where new evidence is lacking.	Thank you for your comment and we welcome the Royal College of Psychiatrists contributions
Department of Health	General		We agree that the guidance should not be updated at this stage.	Thank you for your comment and we welcome the DH's contributions
Royal College of Nursing	General		The Royal College of Nursing welcomes the consultation on proposals regarding the review of this public health guidance.	Thank you and we welcome the RCN's contributions
Royal College of Nursing	3		There does not seem to be any mention in the document to the effects of drinking on expectant mothers – increasing likelihood of Foetal	Thank you for your comment. This

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			Alcohol Spectrum Disorder (FASD). This is a lifelong disability that is little understood by the public. It is not clear if this is within scope or if it is covered elsewhere?	stakeholder consultation is about the decision on review of PH24 alcohol use disorders and does not constitute NICE guidance. The scope for PH24 did not exclude pregnant women and thus they are not excluded from any potential update or from the decision on review document. PH24 does highlight the impact of alcohol use in pregnant women and its potential impact with specific reference to impacts on developing foetuses in section 2: public health need and practice (p.24). Foetal

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				Alcohol Spectrum Disorder is one of a multitude of potential outcomes that PH24 aimed to impact on but the guidance is aimed at adults and young people over 10 and isn't focused exclusively on intervention regarding pregnant women and FASD. NICE clinical guidance CG110 (NICE 2012) provides some further information regarding Pregnancy and complex social factors
Alcohol Concern	General		Alcohol Concern is a member of, and has contributed to the response of, the Alcohol Health Alliance. Much of our input therefore will mirror that of the AHA. We believe that the guidance remains substantially up to date and relevant. However, since the publication of this guidance, the evidence base on some of these areas has	Thank you for your comments and we welcome Alcohol Concern's comments

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			strengthened significantly, particularly around alcohol pricing, and this supports a corresponding strengthening of the recommendations in the guidance. We do, however, also support the EUAG's identification of new areas for consideration, including locally-run schemes such as 'late night levies'; the relationships between screening, care and the potential stigmatisation of certain patient groups; and the evidence regarding different models of taxation.	
Alcohol Concern	1		The recent evidence including further modelling research on minimum unit pricing (MUP) from the University of Sheffield and new data from Canada support earlier conclusions that MUP: • has the greatest impact on the heaviest drinkers across all income groups, • does not particularly disadvantage people on low incomes in general, and • predominately affects consumption of the higher-strength alcohol products favoured by heavier drinkers. This evidence would support a significant strengthening of the recommendations in PH24, which currently advise that policy-makers only "consider" introducing MUP.	Thank you for your comments

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Alcohol Concern	2		We agree than high outlet density is linked to increases in the alcohol harms listed. However there is also growing research evidence (although more is needed) showing that density is also linked to other harms not listed, most notably car crashes and pedestrian/vehicle collisions, sexually transmitted infections; and attempted and completed suicide rates. It's also worth noting that outlet density tends to be greater in deprived areas, which have poorer overall health outcomes than more affluent areas, even though overall consumption is lower.	Thank you for your comments
Alcohol Concern	3		Alcohol Concern strongly supports the inclusion of new mediums of advertising in PH24. The evidence shows clearly that exposure to alcohol advertising increases consumption particularly in under-18s. To provide the greatest protection to children and young people alcohol advertising across all forms should be prohibited. Severely restricting young people's exposure is the next best approach which should be complimented by restricting alcohol advertising, where it is permitted to only product characteristics (origin, composition, means of production etc...). Young people spend more hours online and on social networking sites than other groups. The drinks industry has substantially invested in new media and social media marketing in particular uses sophisticated techniques to infiltrate young people's everyday social lives,	Thank you for your comment

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			representing alcohol as routine and essential for celebrations. The boundaries of what is official and unofficial advertising on digital marketing can become blurred, and online peers become brand ambassadors. Alcohol Concern research suggests currently only half of young people consider alcohol brand Facebook pages to be 'advertising' (Overexposed and overlooked, 2012). The impact of advertising on new media is only now being fully understood as the research catches up with the technology. • Advertising alcohol on new media and on social media in particular should be prohibited In addition • All alcohol sponsorship should be prevented • Cinema advertising should be restricted to 18 certificate films • The permitted % of under-18s viewers for televised alcohol advertising should be drastically reduced from the current rate of 25%. • Advertising regulation should be statutory and independent of the advertising industry and should enforce compliance with meaningful sanctions such as fines.	
Alcohol Concern	4		The transfer of local responsibility for public health to local authorities marks a major shift. Given that local authorities are also responsible	Thank you for your comment

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			for alcohol licensing, it is important that the guidance is updated to reflect this substantial shift.	
Alcohol Concern	10 - 12		The terminology used in the guidance is still 'hazardous' and 'harmful' whereas the new definitions are 'increasing risk' and high risk'. For consistency, it might be better to use the new terms.	Thank you for the information.
Alcohol Health Alliance	General		The AHA welcomes the opportunity to comment on the review proposal for guidance on the NICE public health guidance „alcohol-use disorders: preventing harmful drinking" (PH24), which covers issues including marketing, price, availability, screening and brief interventions. Since the publication of this guidance, the evidence base on some of these areas has strengthened significantly, particularly around alcohol pricing, and this supports a corresponding strengthening of the recommendations in the guidance. Moreover, a number of significant policy developments which have occurred since the publication of the guidance – not least the implementation of the Health and Social Care Act in April 2013 and the government consultation on its alcohol strategy in January 2013 – further support a full review of the guidance so as to enable policy-makers at a national, regional and local level to understand the evidence and its implications within the current policy context.	Thank you and we welcome the AHA's contribution.
Alcohol Health Alliance	General		The AHA would also like to see an acknowledgment of the relationship	Thank you for your

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			between health inequalities and alcohol consumption, and for this relationship to be reflected in the recommendations and guidance offered in PH24. For example, in Scotland, rates of alcohol-related hospital discharges were approximately six to seven times higher for patients living in the most deprived areas compared to those living in the least deprived areas (from 2008/09 to 2012/13). The guidance should be reviewed to support the tailoring of interventions, in line with the principle of proportionate universalism, to help tackle the social gradient in alcohol-related harm. This warrants a full review of the guidance.	comment. This consultation is on the decision on review document for PH24 and does not constitute NICE guidance. PH24 considered health inequalities and impact regarding availability and accessibility for different population groups in its development (reference is made to health inequalities in sections 3: considerations and section 4: implementation) any update of the guidance would take this into consideration.

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				The decision was to review the guidance again for update in 2016 and the original recommendations still stand.
Alcohol Health Alliance	General		The AHA supports the Evidence Update Advisory Group"s (EUAG"s) identification of new areas for consideration, including locally-run schemes such as „late night levies"; the relationships between screening, care and the potential stigmatisation of certain patient groups; and the evidence regarding different models of taxation. A review of the guidance would enable these issues to be considered and, where appropriate, incorporated. As such, the AHA advocates in favour of a review of the guidance.	Thank you for your comments.
Alcohol Health Alliance	Recommendation 1: Price		As described in the review proposal, new evidence including further modelling research on minimum unit pricing (MUP) from the University of Sheffield and new data from Canada support earlier conclusions that MUP: • has the greatest impact on the heaviest drinkers across all income groups, • does not particularly disadvantage people on low incomes in general, and • predominately affects consumption of the higher-strength alcohol products favoured by heavier drinkers.	Thank you for your comments

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			This evidence would support a significant strengthening of the recommendations in PH24, which currently advise that policy-makers only "consider" introducing MUP. This is particularly pertinent given changes in policy and practice, including: • The government"s decision not to implement a national MUP, and • Local efforts to work towards introducing regional MUP measures in English regions, which would be significantly strengthened by NICE guidance that reflected the findings of recent research.	
Alcohol Health Alliance	Recommendation 3: Marketing		The AHA supports the conclusion of the EUAG that there is an omission in PH24"s recommendations regarding the use of sports advertising, new media, the targeting of young people with new media, and the impacts of adult advertising on young people. Recent work on the use of marketing in English football (Adams 2013) and on brand awareness in Welsh children (Alcohol Concern Wales) strengthens the need for recommendations and supports the views on page 9 on the review proposal reagrding sports sponsorship and the need to consider the impact of "adult" marketing on children. This warrants a full review of the guidance.	Thank you for your comments
Alcohol Health Alliance	Recommendation 4: Licensing		The transfer of local responsibility for public health to local authorities marks a major shift in both policy and practice for many of the issues covered by the guidance. Given that local authorities are also responsible for alcohol licensing, it is important that the guidance is updated to reflect this substantial	Thank you for your comments

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			shift.	
Alcohol Health Alliance	Recommendation 3: Marketing Recommendation 6:		There is a growing body of evidence to indicate that alcohol has a non-trivial impact on the developing adolescent brain, and that brain development continues up to the age of 25.	Thank you for your comments
Alcohol Health Alliance	Supporting children and young people aged 10–15 Recommendation 7: Screening young people aged 16 and 17 and Recommendation 8: extended brief intervention with young people aged		It is now clear that brain maturation occurs over a much longer period than previously understood. Synaptic pruning and myelination in the frontal lobes, for example, continue into the mid-20s and these changes seem to be particularly important to higher cognitive functions such as abstract thought and impulse inhibition. Consequently, exposures to alcohol which interfere with these processes could, potentially, have a significant and protracted effect on an individual"s higher cognitive function, psycho-social maturation, and vulnerability to behavioural disorders. In addition, reviews of the available evidence raise the possibility that the adolescent brain is more vulnerable to the effects of alcohol than the adult brain. This is suggested by animal studies and but also by studies in humans which have compared brain structure in adolescents who do and do not have a history of heavy alcohol consumption. Given this accumulating evidence suggesting that adolescents are	Thank you for your comments and information on this particular area.

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	16 and 17		more vulnerable to the effects of alcohol on brain structure than adults, it is important that PH24 is fully reviewed in order to strengthen its recommendations around the protection of young people. This includes protection from exposure to marketing, promotion, and other activities which increase their likelihood to consume alcohol, as well as guidance regarding treatment services for young people. Recent evidence published by NHS Health Scotland (a Process evaluation of Alcohol Brief Interventions in wider settings (Young People and Social Work, 2014) suggests that it seems feasible and acceptable to deliver ABIs in young people"s care settings.	
Royal Pharmaceutical Society	General		The Royal Pharmaceutical Society, the professional body for pharmacists and pharmacy, considers the recommendations in PH24 as still relevant and useful. We support the review proposal that the recommendations do not need to be changed.	Thank you and we welcome the Royal Pharmaceutical Society's contribution
Royal Pharmaceutical Society	Recommendation 1: price.		The Royal Pharmaceutical Society welcome findings that strengthen the recommendation in NICE PH24 to consider introducing minimum unit pricing. We have, along with Alcohol Health Alliance UK and other professional bodies, called for a minimum price for alcohol of 50p per unit.	Thank you for your comment
Royal Pharmaceutical Society	Recommendation 10: brief advice for adults.		PH24 includes pharmacies for brief alcohol interventions. There is increasing evidence on the effectiveness of alcohol interventions in community pharmacies.	Thank you for your comment

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Royal Pharmaceutical Society	General		With public health services increasingly provided by pharmacists and their teams, the profession has recently published "Professional Standards for Public Health Practice for Pharmacy". We also have guidance for pharmacy on alcohol-use disorders.	Thank you for the information and update on your professional standards