Public Health Programme Guidance
Alcohol-use disorders (prevention)
Guidance consultation – stakeholder response table
13 October – 10 November 2009

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Advertising Association			Recommendation 3: Marketing	p.20	The Advertising Association represents all sides of the advertising industry, including advertisers, advertising agencies, and the media. Recommendation 3 on Marketing goes well beyond, and should fall outside, the scope of NICE's public health guidance, which has been requested by DH to develop practical prevention and early identification measures. Recommendation 3 ignores the fact that advertising falls within the remit of the DCMS and related regulatory and self-regulatory agencies – Ofcom, the OFT and the Advertising Standards Authority (ASA), and not within NICE's remit. We find it surprising that NICE has made far-reaching proposals for new advertising and marketing restrictions without consulting either the Advertising Standards Authority or the advertising industry, through the Advertising Association. Such an approach ignores Best Practice Better Regulation Principles, which require bodies to consult the industries concerned, evaluate the impact on the industry of the proposals, and be clear about the outcomes. **Cont below**	The recommendation on marketing has been revised by the Programme Development Group following comments from stakeholders In terms of remit, NICE produces public health guidance for the promotion and protection of good health and the prevention of disease As such recommendations may be made at population, community, organisational group, family or individual level (see introduction section of CPHE process methods available at: www.nice.org.uk/phmethods) The recommendation on marketing is an example of a population measure which can be considered to reduce the harms to health associated with harmful or hazardous drinking.(Consultation with stakeholders is very important to us and are so you were not involved earlier in the process. Potential stakeholders are alerted to new guidance referrals via: a press release; posting the topic on the NICE website with details of how to register as a stakeholder; contacts stakeholder organisations that registered for previous guidance. We do try our best to identify new stakeholders who have not been involved before and also rely On existing stakeholders (for example Government Departments who are automatically notified through the Department of Health) to alert others who may have an interest in particular topics and who may not be familiar with our processes.

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Advertising Association			Recommendation 3: Marketing	p.20	**Cont** The Advertising Association therefore considers that NICE should not be making recommendations of this nature, and that its proposals for new restrictions and an effective ban on alcohol advertising and marketing go well beyond the inconclusive evidence that it puts forward to justify such an approach. There is no evidence that demonstrates that the recommendation being proposed will have the beneficial health impacts outlined by the consultation. But there would be an adverse impact on advertisers (whose ability to compete for brand share would be limited or removed by such proposals), and on media in terms of loss of revenues and resultant impact on programme/editorial investment.	

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Advertising Association			Recommendation 3: Marketing	p.20	NICE's Recommendation do not set out the current framework for the regulation of alcohol advertising by the Advertising Standards Authority (ASA). Alcohol advertising is subject to detailed content rules and scheduling/placement restrictions, set out in the CAP and BCAP Codes, which are enforced by the ASA. Details of the ASA system and the rules that apply have already been given to NICE in a response to the previous consultation by the Advertising Standards Authority. The current regulatory regime for advertising is robust, comprehensive, applies to advertising across all media, and is independently enforced by the ASA. The Codes can be found on the ASA website. The alcohol advertising rules were significantly tightened in 2005 in response to Government objectives. Alcohol advertising is permitted as long as it does not appeal to, or target, under-age drinkers or glamorise irresponsible drinking and anti-social behaviour. The rules were tightened up in four main areas to prevent: • linkage between alcohol and the success of a social occasion • the linking of sexual success with alcohol • the potential to appeal to under 18's • the portrayal of alcohol being served or handled irresponsibly.	Thank you for your comment. When developing the recommendations the committee did consider the current advertising regulations and have now revised the guidance to make explicit the current regulatory system.

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Advertising Association			Recommendation 3: Marketing Background documents - Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People	p.20 p. 190-191	Advertising rules are drawn up to ensure that the advertising is targeted appropriately and that children and young people are protected. Research conducted by the ASA and Ofcom in 2007 (referred to on Page 190-191 of the supporting evidence) showed the rule changes had been effective. The comment that "young people were more likely to say that advertisements make a drink look appealing…" is selectively lifted from the research and gives the wrong impression. The ASA noted that the advertisements chosen for the research were not representative of all alcohol advertising but were a selection of alcohol advertisements, and these were described as being from the "edgier" end of the market – ads that may be considered borderline.	Thank you for your comment. The OFCOM/ASA evaluation of the revised regulations was included within the evidence review considered by the committee. The methods used to develop the guidance are summarised within Appendix B of the guidance document (www.nice.org.uk/ph24)and the complete methods manual can be found on the NICE website (www.nice.org.uk/phmethods). The methods used by NICE are based on the principles of systematic reviewing which seeks to identify all types of evidence relevant to the scope questions and assesses this evidence against a set of predetermined quality criteria..

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Advertising Association			Recommendation 3	p. 20	The Advertising Association agrees with the statements made at the beginning of Recommendation 3, that there is "only limited evidence" on how alcohol advertising affects consumption among adults, and that the evidence on whether or not a complete ban would be effective in preventing the onset of drinking amongst children and young people, and in preventing increased consumption amongst the young, is "inconclusive". It is inappropriate to make far-reaching proposals for an advertising ban on the basis of inconclusive evidence. Brands do not advertise to get young people to drink, nor to increase consumption –they advertise to promote their brand against others in the same category. An analysis of advertising expenditure for each drink category compared with total sales demonstrates that there is no link between the two, so the argument that companies advertise to increase consumption is flawed. The statement at the end of the recommendation that "a tobacco advertising ban has helped reduce the prevalence of smoking" is highly questionable, as we know of no evidence that could corroborate such a statement. It is, anyway, irrelevant in this context, because alcoholic drink is a very different product to tobacco. Policy in relation to alcohol and the advertising of alcoholic products is appropriately focused on preventing the misuse of alcohol, not its moderate consumption.	Thank you for your comment. The recommendation has now been revised by the Programme Development Group In terms of the comment on tobacco, the guidance has been appropriately amended.

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Advertising Association			Evidence for Recommendation 3 – some new research	p. 20	The 'evidence' mentioned in relation to recommendation is unreferenced, though there are some unsourced evidence statements at the back of the guidance, and a collection of 'background documents' online, which are used to support Recommendation 3. However, the evidence used to support the recommendation is drawn from academics who support an advertising ban (eg Hastings, Anderson) and who rely for their findings on small-scale experimental studies and a limited range of longitudinal studies mostly conducted outside the UK and indeed from outside Europe, with very different country-specific factors to the UK's. NICE should take into account an academic paper entitled "What's the BMA been drinking? The case against an Alcohol Ad Ban", published in September 2009 for the Democracy Institute by Patrick Basham and John Luik, (who state that neither they nor the D.I. received funding for, or discussed, the research with the alcohol industry or any affiliated organisation).	Thank you for your comment. Appendix C sets out the evidence statements upon which the recommendations have been based and links them to each recommendation. These evidence statements are then linked back to the independent reviews which were prepared for the PDG during the development stage of the guidance. Appendix E provides the link to the NICE web pages where these reviews can be found. The public consultation on the evidence reviewed for this guidance took place during May and June 2009 when all stakeholders were invited to submit additional evidence and comment on the interpretation of the evidence. Whilst the evidence identified here was outside that period the PDG were made aware of its existence.

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Advertising Association			Evidence for Recommendation 3: Marketing	p.20	This paper strongly challenges the research by academics like Hastings, who argue for an advertising and marketing ban. Basham and Luik demonstrate that the claims about the link between alcohol consumption and alcohol abuse is based on a flawed approach for several reasons: (1) it ignores numerous econometric analyses that do not show that alcohol advertising leads to drinking initiation or increases total consumption, (2) only a handful of the econometric and longitudinal studies find that advertising restrictions/bans have had a statistically significant effect on either initiation or consumption, (3) there is strong evidence that restrictions have not reduced consumption, and (4) that the evidence from jurisdictions that have removed bans shows that consumption has not increased when advertising has resumed. Basham and Luik conclude that "there is no public policy justification for measures to substantially restrict or completely ban alcohol advertising that is directed to legal consumers".	Please see previous comment.

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Advertising Association			Evidence for Recommendation 3 - Background documents - Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People	p.197-8	The document entitled 'Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People' contains a discussion section (p.197-8). This states that "social influence may also influence binge drinking among young people" and that "this was a topic outside the remit of this review". However, recent research by Paul Ormerod (2008) demonstrates that social influence is crucial to understanding the causes of binge drinking amongst 18-24 year olds, and that without factoring this in, policy interventions will not be successful. Ormerod concludes that social (peer) influence, operating through personal friendship networks, is sufficient by itself to explain the large rise in binge drinking amongst young people. He believes that binge drinking is a "fashion" phenomenon, spread by people observing and copying what their friends do. This study finds that relatively small networks of friends can generate and spread a culture that often includes anti-social behaviour linked to alcohol abuse.	Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions specially aiming to address the social influences on binge drinking were not included in the review work – the PDG recognises the importance of these influences on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Advertising Association			Interventions on Control of Alcohol Price, Promotion and Availability for Prevention of Alcohol Use Disorders in Adults and Young People	p. 198	This background document also justifies restrictions/bans on alcohol advertising on the basis that alcohol ads are permitted on TV before 9 pm, sourcing work by Alcohol Concern in 2007. This statement ignores the fact that there are effective scheduling restrictions already in place, designed to prevent alcohol ads appearing in or around any programmes where the proportion of viewers under 18 is more than 20% above the average audience. There are also placement restrictions governing alcohol advertising in other media.	Thank you for your comment. The committee are aware of the current scheduling restrictions that are currently in place. Following the consultation process changes were made to the advertising recommendation.

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Advertising Association			Evidence for Recommendation 3 - Modelling findings on advertising M55-M58		In section 4.5 of the accompanying research on the website, looking at the published modelling findings, the paper says "The published quantified evidence on the effects of restrictions on advertising, including the small number of UK studies, exhibit considerable uncertainty…" (M55), and that "there is disagreement in the academic research literature concerning whether advertising bans … reduce alcohol consumption, or increase it" (M58). The Advertising Association points out that such statements on the research findings do not provide sufficient justification to demand changes in the existing, already strict, regulatory and self-regulatory regime for alcohol advertising.	Thank you for your comment. When developing the recommendations the committee considered all of the evidence that was presented to them and used their expertise to interpret the evidence. Recommendation 3 was reviewed during consultation and has been revised.

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Alcohol Concern			**Recommendation 1 – Price**		Alcohol Concern believes that the Alcohol Harm Reduction Strategy for England, launched in 2004, mistakenly viewed alcohol misuse as the preserve of a small minority and particularly focused on chronic and binge drinkers. While rightly pointing out the large-scale harms associated with this, the strategy failed to acknowledge the relationship between price, public health and our heavy drinking culture, or the potential for government to achieve real behaviour change by using the levers available to them, including price. Safe, Sensible, Social – The Next Steps in the Alcohol Strategy (SSS), which was published in 2007, has belatedly re-focused efforts to combat hazardous and harmful drinking, while the subsequent PSA target to reduce the rate of alcohol related hospital admissions was welcomed by health groups. However, in the context of attempting to reduce the scale of alcohol harms, both strategies appear to have failed to provide the necessary levers addressing the affordability and availability of alcohol to adequately change the prevalence of heavy drinking or the resultant harms arising from it.	Thank you for your comment.

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Alcohol Concern			**Recommendation 1 – Price**		For this reason, Alcohol Concern recommends a minimum price per unit of alcohol and supports the draft NICE recommendation to consider minimum price (and linking duty to inflation and earnings). We have major concerns that alcohol is sold too cheaply, whether on promotion or at a standard low cost. Alcohol in 2008 was 75% more affordable than it was in 1980 (NHS Information Centre, Statistics on Alcohol: England 2009), the direct consequences of cheaper alcohol are higher consumption levels and higher levels of alcohol-related harm. This is because, as research shows, alcohol responds to price increases like most consumer goods on the market, i.e. when other factors remain constant, an increase in the price of alcohol generally leads to a decrease in consumption and vice versa.[i] In support of this principle, analysis of trends in alcohol price and consumption show that, as the price of alcohol has decreased in the UK, consumption has increased (World Health Organisation, 2007, Second Report of the Expert Committee on Problems Related to Alcohol Consumption, Technical Report Series 944).	Thank you for your comment.

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Alcohol Concern			**Recommendation 1 – Price**		While increasing the price of alcohol has been shown to reduce alcohol-related harm across all population groups, some groups of drinkers are more price sensitive than others. Young drinkers, frequent and heavier drinkers, tend to experience a more significant reduction in consumption levels than less frequent and moderate drinkers (Laixuthia & Chaloupka, 1993, in ScHARR, University of Sheffield, 2008, Independent Review of the Effects of Alcohol Pricing and Promotion, Part A: Systematic Reviews). This is because hazardous drinkers tend to choose cheaper drinks, this is true for both young binge-drinkers and for problem drinkers (Weschler et al, 2000 & Stockwell, 2000, in ScHARR University of Sheffield, 2008, Independent Review of the Effects of Alcohol Pricing and Promotion, Part A: Systematic Reviews). However, Alcohol Concern does not believe that minimum pricing alone would tackle problematic or dependent drinking. Minimum pricing might reduce consumption and consequently reduce harm but to tackle this problem effectively, as a whole, we need a greater investment in specialist alcohol treatment.	Thank you for your comment.

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Alcohol Concern			**Recommendation 1 – Price**		The aim of minimum pricing is to ensure that retailers are unable to sell alcohol below a baseline cost; it is a fundamentally different approach to changes in taxation. Therefore, even when offering price promotions and discounts, the price per unit of alcohol must not fall below the designated minimum. A minimum price per unit which applies to all alcohol types is necessary to ensure that the policy is effective. The application of an across-the-board unit price ensures that drinkers do not switch to other types of alcohol with a lower per unit price. The School of Health and Related Research, University of Sheffield, produced an influential review of minimum pricing for the Department of Health in December 2008 (School of Health and Related Research, 2008, Independent Review of the Effects of Alcohol Pricing and Promotion). This research modelled the potential impact of minimum pricing at various levels and on a variety of population groups.	Thank you for your comment.

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Alcohol Concern			**Recommendation 1 – Price**		Based on the evidence presented in that review, Alcohol Concern advocates a 50p per unit minimum price for alcohol, in line with the recommendations of the Chief Medical Officer (Sir Liam Donaldson, Department of Health, 2009, 150 Years of the Annual report of the Chief Medical Officer: The State of Public Health in 2008). Setting a 50p level would result in a significant reduction in alcohol-related harms, whilst ensuring that alcohol remains affordable for moderate drinkers. Additionally, the research found that moderate drinkers would experience only a negligible negative financial effect if minimum pricing was introduced. For example, a minimum price of 50p per week would mean a less than 23p per week increase in spending on alcohol per moderate drinker (School of Health and Related Research, 2008, Independent Review of the Effects of Alcohol Pricing and Promotion, Part B: Modelling the Potential Impact of Pricing and Promotion Policies). In a recent study, Record and Day have shown that since	Thank you for your comment. The committee did not consider the level at which any minimum price/unit should be set only the effectiveness of the policy itself.

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Alcohol Concern			**Recommendation 1 – Price**		80% of alcohol is consumed by 30% of the population, the introduction of a 50p per unit minimum price would result in 70% of the population financially benefitting, as moderate drinkers would no longer be subsidising the consumption of hazardous and harmful-level drinkers. This is because the 24% increase in average off-sale prices could be offset by supermarkets reducing the price of non-alcoholic products by 2.8% (Record & Day, Clinical Medicine, Volume 9, Number 5, 2009). The research from the School of Health and Related Research found that a minimum price of 50p per unit of alcohol would (in England): • lead to 97,900 fewer hospital admissions per year once in full effect • lead to 3,393 fewer deaths per year once in full effect • lead to a saving of £66m in the first year and £1.3bn in healthcare costs over ten years There would also be significant reductions in alcohol-related crimes and workplace absences and unemployment (School of Health and Related	Thank you for your comment.

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Alcohol Concern			**Recommendation 1 – Price**		Research, 2008, Independent Review of the Effects of Alcohol Pricing and Promotion, Part B: Modelling the Potential Impact of Pricing and Promotion Policies). Minimum price is the most effective and efficient lever to tackle irresponsible drinking, whilst not significantly affecting moderate, responsible drinkers. This approach will target irresponsible drinking; impacting on binge-drinkers and harmful drinkers, while imposing a minimal financial effect on moderate drinkers. The resulting reduction in crime, health harms, lost productivity and unemployment makes a strong case for the introduction of a minimum price for alcohol.	

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Alcohol Concern			**Recommendation 2 – Availability**		Alcohol Concern supports the draft recommendation to restrict the availability of alcohol. The number of premises licensed to sell alcohol in England and Wales has dramatically increased over the last 30 years, from 128,054 in 1980 to 162,300 in 2008 (DCMS, 2008, Statistical Bulletin: Alcohol, Entertainment and late Night Refreshment Licensing). Alcohol Concern believes that the Licensing Act 2003 should be amended to include a public health objective that informs decisions about licensing applications, reviews and cumulative impact zones. Licensing authorities should have access to a nationally standardised collection of A&E, ambulance, hospital admissions and treatment data. This would allow local authorities the power to refuse additional licenses or extensions if local alcohol-related health harms were increasing or a matter of significant concern. Incorporating a public health objective into the Act, to protect the community's health, would bring a greater coherence to the government's programme to reduce alcohol-related harms.	Thank you for your comment.

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Alcohol Concern			**Recommendation 3 - Marketing**		Alcohol Concern agrees with the draft recommendation that all alcohol marketing, including newer media, should be covered by a regulatory system which includes monitoring of practice. Alcohol Concern agrees with the recommendation that alcohol advertising should be banned from outlets where more than 5% - or 10% at the very least – of the audience is under the age of 18 years. Alcohol Concern recommends that all sponsorship of sports and music, including events and teams, should be banned. Alcohol Concern further advocates a ban on alcohol advertising before the watershed of 9pm. This should include advertisements by supermarkets where a range of products, including alcohol, are offered.	Thank you for your comment. Following the consultation process the recommendations have been amended. The PDG did not believe it appropriate at this time to recommend the introduction of a watershed.

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Alcohol Concern			**Recommendation 3 - Marketing**		Clearly, if alcohol advertising occurs before 9pm there is a stronger possibility that children may be watching. The World Health Organisation's European Charter on Alcohol states that: "All children and adolescents have the right to grow up in an environment protected from the negative consequences of alcohol consumption and, to the extent possible, from the promotion of alcoholic beverages." Several studies have shown that young people are increasingly adept at interpreting the cultural messages contained in alcohol advertisements. Research undertaken at the University of Strathclyde into attitudes to alcohol advertising among 10-17 year olds indicate that 88% of 10-13 year olds and 96% of 14-17 year olds were aware of alcohol advertising and 76% of these (across the whole age range) could identify three or more advertisements when the brand name was masked (Drug and Alcohol Research Unit Ireland (2008) Drugnet newsletter, Issue 27).	Thank you for your comment.

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Alcohol Concern			**Recommendation 3 - Marketing**		A report from the US National Bureau of Economic Research found that alcohol advertising (the majority of which focuses on beer and spirits rather than wine) had a positive effect on the decisions young people make on whether to drink and how much they consume (*Alcohol* Advertising and Alcohol Consumption by Adolescents, National Bureau of Economic Research, Working Paper No. 9482: 2004) A long-term national study in the U.S published in 2006 concluded that for each additional dollar per capita spent on alcohol advertising in a local market, young people drank 3% more (L.B. Snyder et al, 2006, Effects of alcohol advertising exposure on drinking among youth, Archives of Paediatrics and Adolescent Medicine 160: 18-24). The Academy of Medical Sciences report, Calling Time, demonstrates a clear link between spending on alcohol advertising and children's drinking (British Academy of Medical Sciences (2004) 'Calling Time – The Nation's Drinking as a Major Health Issue'). In 2009, a BMA report recommended a comprehensive ban on all alcohol marketing communications (British Medical Association, 2009, Under the influence: The damaging effect of alcohol marketing on young people).	Thank you for your comment.

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Alcohol Concern			**Recommendation 4 - Licensing**		Alcohol Concern agrees with the recommendation and suggestions for action laid out in the draft guidelines. These should be underpinned and supported by an inclusion into the Licensing Act 2003 to include a public health objective that informs decisions about licensing applications, reviews and cumulative impact zones. Licensing authorities should have access to a nationally standardised collection of A&E, ambulance, hospital admissions and treatment data. This would allow local authorities the power to refuse additional licences or extensions if local alcohol-related health harms were increasing or a matter of significant public concern. Incorporating a public health objective into the Act, to protect the community's health, would bring a greater coherence to the government's programme to reduce alcohol-related harms. The Department of Health (DH) should consider demanding of local commissioners that waiting times for alcohol treatment match targets for drug treatment in the next NHS operating framework. This is now possible as service providers must report alcohol treatment and waiting time data to the National Drug Treatment Monitoring System (NTDMS).	Thank you for your comment.

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Alcohol Concern			**General**		The Department of Health (DH) should consider demanding of local commissioners that waiting times for alcohol treatment match targets for drug treatment in the next NHS operating framework. This is now possible as service providers must report alcohol treatment and waiting time data to the National Drug Treatment Monitoring System (NTDMS).	Thank you for your comment.
Alcohol Concern			**General**		Every hospital ward and A&E Department should have access to an alcohol health liaison worker.	Thank you for your comment amendments have been made to the guidance document.
Alcohol Concern			**General**		The Department of Health should establish an optimal level of access for alcohol treatment for England and Wales. The current access level of 1 in 18 should be reduced to around 1 in 7 (15%) – this would chime with moderate treatment access targets in the USA, as described in the Alcohol Needs Assessment Research Project. While access is poor in many areas, more than a few trusts are able to offer 'high' numbers of treatment places. Establishing a national consensus on a realistic target would help trusts measure their performance against a credible baseline in the medium term.	Thank you for your comment amendments have been made to the guidance document.

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Alcohol Concern			**General**		Primary Care Trusts (PCTs) should be required to produce an Alcohol Needs Assessment of alcohol issues in their areas, measuring the level of need across at-risk groups. This should include a plan for how needs will be commissioned for all drinking groups across the four tiers based on Models of Care for Alcohol Misusers. Strategic Health Authorities should performance manage PCTs' needs assessments.	Thank you for your comment. The guidance states that local joint needs assessment should be carried out.

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Alcohol Health Alliance			General – Introduction		**1. The Alcohol Health Alliance UK** The Alliance is a group of 24 organisations whose mission is to reduce the damage caused to health by alcohol misuse and who are working together to: • Highlight the rising levels of alcohol-related health harm • Propose evidence-based solutions to reduce this harm • Influence decision makers to take positive action to address the damage caused by alcohol misuse While coalitions have previously been formed on specific topics in the medical field, notably tobacco control, this is the first time that a group has existed specifically to co-ordinate campaigning on alcohol, bringing together medical bodies, patient representatives and alcohol health campaigners.	Thank you for your comment.

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Alcohol Health Alliance			Section 3	Section 3.1 Page 9 -16	We support overall the approach taken by the PDG in proposing a broad package of measures that are aimed at improving the population as a whole. While it is important to target interventions at groups with particular problems an evidence alcohol based policy should aim to lower total alcohol consumption as a whole. Therefore reducing alcohol related harm in the long-term requires a comprehensive approach.	Thank you for your comment.
Alcohol Health Alliance				Page 10 Page 18	We support the PDG's view that there is now consistent evidence to support population level approaches to preventing alcohol related harm. Consumption data confirms that excessive drinking is not limited to a particular social group but is widely spread across the whole of society. We fully agree with the recommendation that the Chief Medical Officer and Department of Health lead on alcohol policy across all Government Departments.	Thank you for your comment.

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Alcohol Health Alliance			Section 4	Recommendation 1 - Page 19	We absolutely agree with the PDG's recommendation that making alcohol less affordable is one of the most effective ways of reducing alcohol related harm, in particular the introduction of a minimum unit price and to increase alcohol duty with a link to inflation and earnings Evidence shows that alcohol responds to price increases like most consumer goods on the market, i.e. when other factors remain constant an increase in the price of alcohol generally leads to a decrease in consumption. [1] Alcoholic drinks in the UK have become much more affordable in recent years. In Britain, alcohol consumption rose by 121% between 1950 and 2000[2] and from 9.5 to 11.5 litres of pure alcohol per adult between 1987 and 2007[3] so that the average consumption for every person over age 15 is now 22 units (of 8 gram) per week. What the evidence also demonstrates is that changes in *per capita* consumption are reflected in changes in harm. In other words, the more alcohol a nation consumes, the greater the burden of harm it will experience and vice versa.	Thank you for your comment.

[1] World Health Organisations (2007) Second Report of the Expert Committee on Problems related to Alcohol Consumption' Technical Report Series 944
[2] Alcohol Harm Reduction Strategy for England. Cabinet Office Strategy Unit 2004
[3] HM Revenue and Customs (2008) Alcohol Factsheet http://www.uktradeinfo.com/index.cfm?task=factalcohol

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Alcohol Health Alliance			Section 4	Page 19 – (cont)	Given that the Sheffield Report[4] commissioned by the Department of Health was specifically precluded from addressing issues of alcohol duty and taxation it may be helpful for NICE to specifically commission some modelling in this area including effects not only on health but also on crime	Thank you for your comment. Unfortunately, due to limitations of time and resources it is not possible at this stage to commission additional economic modelling work. However the committee did consider issues of taxation and whilst not formally part of the recommendations it has been commented on within the considerations

[4] Meier P, et al. The independent review of the effects of alcohol pricing and promotion. Summary of evidence to accompany report on phase 1: Systematic Reviews. School of Health and Related Research , University of Sheffield, UK June 2008; 2008

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Alcohol Health Alliance			Section 4	Recommendation 2 - Page 19	We fully support the PDG's view that licensing decisions and policy should take account of public health, specifically: We are in favour of inserting an amendment to the current licensing act that would require licensing authorities in the course of managing their night time economies, to also take account of the levels of alcohol-related morbidity and mortality in their communities. Our view is that this would add substantial momentum to efforts to reduce these harms and redress an existing imbalance within the alcohol policy agenda. Assuming they would base their decisions on robust local health data a public health objective essentially would allow local authorities to judge the impact of the on and off-trades on local residents' health, and therefore provide them with a legal opportunity to maintain license levels (outlets and hours) steady, as well as provide an additional lever where crime and disorder concerns are difficult to link to particular venues.	Thank you for your comment amendments have been made to the guidance document.

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Alcohol Health Alliance					Much of the legal framework to effect this already exists. As it stands, a local authority can, using the powers in the Act, create 'saturation zones' in areas where the concentration of licensed premises is understood to be leading to problems (of crime and disorder). Once a zone is declared, although people can apply to open new premises, the assumption is that no new licences will be granted in that area[5].	Thank you for your comment. In relation to recommendation 4, the PDG is aware that much of the legal framework exists. The purpose of this recommendation is to reinforce and educate professionals about the current provisions.

[5] Alcohol Concern (2008) *Licensing Act 2003: A Lopsided Policy*. London:: Alcohol Concern

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Alcohol Health Alliance			Section 4	Recommendation 3 pg 20	We agree with the PDG's assessment that the evidence base for the effect of alcohol advertising on consumption among adults is still limited. However the evidence base for the impact on children and young people's consumption is more developed. On this basis we believe that there are a number of immediate steps that can be taken that to protect young people that should be considered: ▪ The introduction of an 'end-frame' of alcohol health information comprising one-sixth of air time or press space attached to all alcohol advertising. ▪ A ban on alcohol advertising (either branded or supermarket) from 6am through to 9pm regardless of the predicted age of audience of a programme. ▪ A major review of the voluntary broadcast advertising code to better protect young people.	Thank you for comment. As a result of the consultation process the committee have revised the recommendations. The PDG did not believe it appropriate at this time to recommend the introduction of "end frame" health information or the introduction of a watershed.

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Alcohol Health Alliance			Section 4	Recommendation 4 – Page 21	The sale of alcohol in England and Wales is currently governed by a substantial complex of laws, voluntary codes and guidelines. However, despite the proliferation of new rules and penalties (especially over the past decade), the proportion of alcohol related violent crime, as a subset of total violent crime has remained steady. The reasons for this are two-fold First, the Government has failed to provide local areas with sufficient resources or guidance to effectively tackle problem licensees using their considerable powers under the 2003 Licensing Act. For example, The Act empowers local authorities to compel licensees to adopt specific harm reduction measures when it is apparent that poor practice is evident. Secondly, new evidence has come to light suggesting that the industry-led voluntary codes that are meant to support the statutory framework are also failing to make an impact.[6] We believe that the PDG should highlight the importance of Home Office's current proposals for a national mandatory code for alcohol retailing that would tackle irresponsible promotions and retailing practices and give greater power to licensing authorities to initiate reviews and possibly give them powers to act against clusters of problem venues.	Thank you for your comment. The PDG have considered the proposed mandatory code and have commented on this within the guidance document.

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Alcohol Health Alliance				Recommendation 4 pg. 21	We believe that licensing authorities should have access to a nationally standardized collection of A&E, ambulance, hospital admissions and treatment data. This would allow local authorities the power to refuse additional licenses or extensions if local alcohol-related health harms were increasing or a matter of significant concern. We also believe that there are local partnerships that could be put in place to aid this. The recommendation around licensing has missed the importance of sharing of emergency department data about the location of assault with the police and licensing authorities. This is a low cost intervention with a reasonable evidence base. This is very effective at reducing alcohol related assaults. This is an important area as the police never know more than about a quarter of all assaults that need hospital treatment.	Thank you for your comment. Following consultation amendments have been made to the guidance document.

[6] KPMG (2008) *Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks*. London: Home Office [Accessed 01st June 2009: http://drugs.homeoffice.gov.uk/publication-search/alcohol/alcohol-industry-responsibility/alcohol-industry-vol-1?view=Binary]

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Alcohol Health Alliance			Section 4	Recommendation 5 pg 21	We fully support the recommendation that there should be better resources for brief screening and brief interventions. In particular we urge the PDG to recommend: That every acute hospital (i.e. with an A&E) should have a nominated Lead Consultant for combating Alcohol Misuse with at least one Programmed Activity (4 hours) allocated for this roll. That every acute hospital should have at least one Alcohol Nurse Specialist (and preferably more to cover extended hours – remembering problems of alcohol misuse are worse in the evenings and at week-ends). That clinicians working across primary and secondary care are properly trained about how to use early identification toolkits to assess levels of consumption and harm and utilize brief interventions which are a quick and effective means of engaging with large numbers of drinkers who are not dependent, but are still harming their health. The generally accepted verdict on brief intervention is that it has the numbers needed to treat of around 8 suggesting a 15% harm reduction but it is possible that effects diffuse into the community promoting a deeper cultural behavioural change. The detection of a problem in primary care has implications for Tiers 1-4 care, therefore resources must be provided for Tier 3 (Community Alcohol Team) and Tier 4 (Hospital care) to ensure seamless care.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations. The recommendations have been amended to acknowledge the need for a dedicated alcohol lead, training provision and an increase in tiers 2-4.

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Alcohol Health Alliance			Section 4	Recommendation 5 pg 21 (cont)	Alcohol screening and brief psychological interventions supported by alcohol nurse specialists have also been shown to be clinically effective and cost effective in reducing unscheduled alcohol related re-attendance in A&E	Thank you for your comment.
					The group may also wish to consider modelling the degree of harm reduction that could be achieved were these recommendations to be fully implemented	Thank you - we will pass this comment onto our implementation team for consideration in their work.

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Alcohol Health Alliance			Section 4	Recommendation 6 - Page 23	There is currently no mention of the involvement of parents with young children who are thought to be drinking hazardously or harmfully and it may also be helpful to have recommendations to assist in dealing with children harmed by drinking within the family.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to parental involvement. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Interventions specially aimed at dealing with children harmed by drinking within the family were outside the scope of this work. We welcome suggestions from all stakeholders on other interventions/ approaches that they consider important. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
					Under what action should be taken the second bullet point. We believe that they should add in individuals who request an screen for sexually transmitted infections or seek sexual health advice or practice unprotected sexual intercourse.	Following consultation the recommendations have been clarified.

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Alcohol Health Alliance			Section 4	Recommendation 9 – Page 26	We feel that the groups that have been identified should also include patients who have been assaulted and those that attend for sexual health advice, requests a screen for sexually transmitted infections or practice unprotected sex The third bullet point – practice unsafe sex we suggest this should be changed to: - practice unprotected sex	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to those at an increased risk.
Alcohol Health Alliance			Section 4	Recommendation 9 – Page 26 (cont)	Older people. There is very little discussion on the detection and treatment of alcohol misuse in older people. It is prevalent in up to 10% of hospital in-patients, and 50% of older patients in nursing homes. The MAST-G questionnaire can be used and the role of carers in detecting alcohol misuse should be discussed. Alcohol care should be introduced into the National Service Framework for Older People. Older people with late onset alcohol misuse can respond well to brief interventions.	Thank you for your comment. The PDG recognise that alcohol use disorders are a potential problem within many different groups. As such the recommendations are applicable to everyone aged 10 years and over and recommend the uptake of brief interventions within social care. In addition the recommendations acknowledge the need for professionals to use their professional judgement when dealing with certain at risk groups including older people.

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Alcohol Health Alliance			Section 4	Recommendation 10 – Page 28	We think that the use of the AUDIT here cannot be too exclusive, this scale is rarely used in emergency departments as it is too long. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline. We think that 'hazardous drinkers' should receive a brief intervention from a trained alcohol specialist. It has been found, through experience the experiences of our members that, that trained alcohol specialists in secondary care are more effective when supported by a Consultant and the discussion needs to reflect this.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in terms of the target group. Thank you for your comment. The recommendations do state that brief interventions should be delivered by those who have received the necessary training.
Alcohol Health Alliance			Section 4	Recommendation 11 - Page 29	We feel that the use of the AUDIT here cannot be too exclusive, this scale is rarely used in emergency departments as it is too long. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in terms of the target group.
Alcohol Health Alliance			Section 4	Recommendation 12 - Page 30	We feel that the use of the AUDIT here cannot be too exclusive. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in terms of the target group.

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Association for Family therapy and Systemic Practice (AFT)			General		Many AFT members practice with families with more than one problem, often across generations. Different levels of alcohol problems may be one of the problems in the family, regardless of the reason for the referral. The membership of AFT is multidisciplinary, some of whom are registered Family therapists with UKCP, but others use their systemic family therapy approach within their other roles. Members work in a variety of different settings across the life span, in social care, the NHS and voluntary agencies.	Thank you for your comment
Association for Family therapy and Systemic Practice (AFT)			General		Details of family therapy practice, including work with substance misuse, can be found in two articles on the AFT website: *The report on the evidence base of systemic family therapy* and *Current Practice, Future Possibilities.* www.aft.org.uk	Thank you for your comment. The public consultation on the evidence reviewed for this guidance took place during May and June 2009 when all stakeholders were invited to submit additional evidence and comment on the interpretation of the evidence. Whilst the evidence identified here was outside that period the PDG were made aware of its existence..

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Association for Family therapy and Systemic Practice (AFT)			6	32	Is Systemic family therapy an effective preventative intervention for families with teenagers where one or both parents has alcohol problems?	Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst systemic family therapy for families and teenagers was not included within the review work – the PDG recognises the importance of parental influences and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp
Association for Family therapy and Systemic Practice (AFT)			8	32	Suggest that guidelines for Antisocial Behaviour Disorders 2009 are included. This recommends various family interventions for young people with conduct problems, including substance misuse, and who may have parents who misuse alcohol or drugs - as a way of preventing antisocial behaviour disorder	Thank you for your comment. The guidance document has been appropriately amended.

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Balance			General		Balance reports into a Regional Advisory Group for Alcohol in the North East and has asked this group for comments on the office's response to this consultation exercise. Although Eileen Kaner, Nick Heather and Chris Record sit on the Regional Advisory Group, they have deliberately declined to comment on the Balance response, citing a conflict of interests, on account of their involvement in the NICE Committee. This response is therefore representative of the office's independent viewpoint, with input from key stakeholders across the region.	Thank you for your comment.
Balance			General		Balance welcomes and supports the publication of the draft guidance 'Alcohol-use disorders: preventing the development of hazardous and harmful drinking'. The document addresses a number of important issues and makes extremely valid recommendations in relation to the prevention agenda. In an increasingly challenging financial climate, Balance welcomes the emphasis upon preventative interventions and the longer-term, consolidated approach that this represents. As a whole, the guidance is practical and informative and Balance hopes it will be used to inform commissioning processes at a local level in the future.	Thank you for your comment.

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Balance			General		Feedback from Children & Young People's Substance Misuse Commissioners and Providers suggests that information about Young People's alcohol consumption is crucial – and it is particularly important to consider parental attitudes towards this. Parents often feel that alcohol consumption is a 'rite of passage' amongst children and young people and that drinking alcohol is less serious than taking drugs, for example. This reflects a lack of parental knowledge about unit levels, alcohol strengths and the risks associated with drinking alcohol for children & young people.	Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions specially aimed at parental attitudes were not included in the review work – the PDG recognises the importance of these influences on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Balance			Part 2	5	Section 2 cites data from the 'General Household Survey', which indicates that "73% of men and 57% of women in England had an alcoholic drink on at least 1 day during the previous week". Whilst this information is useful, it would also be beneficial to highlight figures for under-18s, since the document relates to children / young people as well as adults.	Thank you for your comment. This section has been amended to include figures from: Smoking, drinking and drug use among young people in England in 2008.
Balance			Part 2	5	The report notes that "levels of self-reported hazardous and harmful drinking…are highest in the north" - although it fails to clarify what is meant by "the north". There is evidence to suggest that levels of hazardous and harmful drinking are particularly high in the North West and North East 'Government Office' regions and Balance believes that it would be useful to clarify the terminology used to reference this point.	Thank you for your comment. The guidance document has been clarified.
Balance			Section on Health & Social Problems	6	The report acknowledges that alcohol-use disorders are associated with a variety of health and social problems, including relationship breakdown, poor parenting etc. Balance believes that it would also be useful to highlight the strong correlation between alcohol-use and mental-health disorders.	Thank you for your comment. The mental health issues are already covered under neurological conditions.
Balance			Section on cost of alcohol-use disorders	7	The document states that in "2007/08 there were 863,300 admissions due to alcohol-specific causes". Whilst this figure is valid and highly informative, Balance feels that it would also be useful to reference wider 'alcohol-related hospital admissions' – as measured by NI39 and taking into account 'attributable fractions' as well as alcohol-specific causes.	Thank you for your comment. The text within the document has been clarified and does include alcohol related hospital admissions.

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Balance			Section on socio-economic factors	7	The report talks briefly about the alcohol-related inequalities suffered by people living in more deprived areas of the country, in spite of evidence to suggest that more affluent groups self-report the highest levels of alcohol consumption. Balance believes that it would be useful to explore the links between socio-economic deprivation and alcohol-related harm in more detail, taking into account factors such as illegal drug use, wider health inequalities of more deprived communities etc.	Thank you for your comment. The methods and processes for developing public health guidance are based on a set of values and principles which recognise that social differences in the population are linked to patterns of mortality and morbidity. Your reflections on the issues related to alcohol related inequalities are therefore important. In addition NICE (and therefore all its committees) have a duty to comply fully will all legal obligations to promote equality and eliminate unlawful discrimination during the production of its guidance and as such have to formally assess the implications of its recommendations across all population groups prior to final publication.

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Balance			3.2	9	The report states that "each year, drinking adversely affects approximately 1.3 million children" and results in "125,000 instances of domestic violence". Balance believes that it would be useful to explain what is meant by drinking "adversely affects" this number of children – e.g. does this refer to safeguarding / child abuse issues, instances of 'Hidden Harm' etc? Presumably, the figure is calculated using official statistics and would therefore exclude un-recorded but serious examples of child / family neglect, such as emotional abuse or absence from the home environment. To summarise, Balance believes that 1.3 million is a low figure and that it would be useful to acknowledge the huge numbers of children affected by parental drinking in a variety of un-recorded, but potentially damaging ways. Similarly, Balance believes that "125,000 instances of domestic violence" per year underestimates the actual figure, taking into account the low reporting rate for this type of offence. It might be worth clarifying whether this is the 'recorded' rate for instances of domestic violence and acknowledging that the actual rate is likely to be significantly higher. It is also inaccurate to suggest that alcohol 'results' in 125,000 incidents of domestic violence per year. Whilst alcohol might be a factor in, or catalyst for, domestic violence, it is not the direct cause and domestic abuse / women's organisations are often at pains to reinforce this point.	Thank you for your comment. These statistics are quoted directly from the Chief Medical Officers report and as such it is not possible to provide any additional detail.

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Balance			3.5	10	Balance welcomes and supports the assertion that "population-level approaches are very important because they can help reduce the aggregate level of alcohol consumed and therefore lower the population's risk of alcohol-related harm." The office is keen to promote a 'population-level approach' across the North East, via a series of initiatives and interventions, including the Big Drink Debate and social marketing / communications campaigns and welcomes the synergy with the NICE approach.	Thank you for your comment.
Balance			3.6	10	Although Balance agrees that the Government adopted a population-level approach to tackling drink driving, it is worth acknowledging that the preventative aspects of the campaign were also reinforced by a strong enforcement element over a sustained period of time. Whilst Balance wholly supports the document's overall emphasis upon prevention, it is also useful to explore the potential for cross-cutting action to bring about long-term cultural change in relation to alcohol.	Thank you for your comment. The guidance document acknowledges the importance that the implementation of the majority of recommendations will require bodies at different levels to work together in order to prevent alcohol related harm.
Balance			3.7	10	Again, Balance wholeheartedly supports the document's assertion that "making alcohol less affordable appears to be the most effective way of reducing alcohol-related harm". The office is currently in the process of building up an evidence base around minimum pricing per unit and is keen to lead a national drive / lobbying function in relation to this issue.	Thank you for your comment.

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Balance			3.8	11	The document notes that those from "lower income groups" would not be disproportionately affected by the introduction of minimum pricing per unit. Balance supports this argument and there is also evidence to suggest that minimum pricing per unit would have very little economic effect upon 'moderate drinkers' – by extension, impacting more upon heavier and underage drinkers, who tend to buy the cheapest brands / highest volume of alcohol. Balance believes that it might be useful to highlight this fact, whilst also stressing some of the possible advantages of minimum pricing and cost savings to the economy – e.g. the introduction of a minimum price of 50 pence per unit would: • Reduce consumption per drinker by 6.9% on average. This would lead to 97,900 fewer hospital admissions and 10,300 fewer violent crimes per year. • Reduce consumption per 11-18 year old drinker by 7.3%, leading to 500 fewer hospital admissions and 2,200 fewer violent crimes per year for that age category.	Thank you for comment. As a result of the consultation process the committee have clarified the guidance document in relation to the effect of a minimum price and those on a low income.

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Balance			3.9	11	The report also talks about regulation of alcohol sales and Balance is aware of good practice from a number of different countries, including Australia and Sweden – which it might be worth referencing - in relation to control of alcohol sales.	Thank you for your comment. The evidence base which supports this guidance document included studies from around the world. The relevant evidence statements are detailed in the appendices and the full reports are available on the NICE website.

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Balance			3.13	12	The document notes that young people may be drinking in "unsafe environments" such as parks and street corners, where "problems are more likely to occur. Whilst this is a major issue in itself, the North East Big Drink debate also found that 66% of respondents felt that "children and young people drinking in parks and on street corners" was "a concern and one they worried about" and a further 24% highlighted it as a "concern, but not a major one". This would suggest that it is important to reduce the amount of young people drinking in "unsafe environments" - both from a point of view of their safety and from a wider perspective of public reassurance. This section only looks at children and young people who drink and it would be useful to link this in with a wider issue around children & young people whose parents drink to excess. This group often experiences emotional, economic and physical poverty as a result of their parents' drinking and are more likely to drink themselves in the future.	Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions specially aimed at reducing the number of children drinking in unsafe environments and interventions to help children whose parents drink to excess were not included in the review work – the PDG recognises the importance of this issue and took account of this in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Balance			Section on Population versus individual approach	17	The document suggests that it would be beneficial to create "an environment that supports lower risk drinking." Balance strongly agrees with this aim and is keen to explore existing work around 'social norms', which suggests that there is a gap between perception and reality in relation to alcohol consumption. For example, young people tend to believe that a higher proportion of their peers consume alcohol than is actually the case and Balance aims to facilitate a shift in social norms around alcohol, thereby creating an environment that supports lower levels of alcohol consumption.	Thank you for your comment.
Balance			Recommendation 1	19	As noted earlier in the consultation response, Balance fully supports the assertion that "making alcohol less affordable appears to be the most effective way of reducing alcohol-related harm" and is keen to drive the 'Minimum Pricing Per Unit' agenda at a regional and national level.	Thank you for your comment.
Balance			Recommendation 2	19	Balance also endorses the recommendation to make alcohol less easy to buy and to introduce public health as a mandatory consideration in approving licensing regulations. On a slightly different note, the office believes that it is essential to maximise understanding of the Licensing Laws amongst local licensing authorities and to ensure that they are used to maximum potential at a local level.	Thank you for your comment.

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Balance			Recommendation 6	23	Balance agrees that it is essential to provide appropriate support and advice for children and young people aged 10 to 15 years and welcomes the inclusion of this recommendation in the draft guidance. The document suggests that NHS / health & social care professionals should be invited to deliver interventions to this age group. Balance supports this assertion and believes that representatives of universal services could also be enlisted to screen children and young people for alcohol and to deliver brief interventions / refer to specialist services as appropriate.	Thank you for comment.
Balance			Recommendation 7	24	The guidance suggests that young people aged 16-17 should be screened in most cases, using the AUDIT screening tool. Whilst Balance acknowledges that this would be appropriate for the majority of young people in this age group, providers in this region have also developed 'youth proofed' screening tools – i.e. a more targeted adaptation of the AUDIT screening tool, using 'youth friendly' language etc. With this in mind, Balance believes that it might be worth exploring the potential for rolling-out more targeted screening tools for children and young people.	Thank you for your comment. After reviewing the evidence and studying the stakeholder comments on the guidance the PDG do believe that AUDIT should be used within this age group. However, the PDG has acknowledged that professional judgement is needed when dealing with younger people.

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Balance			Recommendation 10	29	The document suggests that it would be beneficial to "follow up on people's progress in reducing their alcohol consumption to a low-risk level (whereby they score less than 8 on the AUDIT scale)." Whilst Balance acknowledges that this type of long-term intervention is preferable, in reality, the recommendation might have significant resource implications and it might also be difficult to monitor the behaviour of more 'chaotic' individuals. With this in mind, Balance believes it would be beneficial to clarify what is meant by "following up" on people's progress (i.e. would the expectation be for a single follow-up meeting, several meetings as required etc) and to identify a suggested timescale for contact (e.g. 6 months to a year).	Thank you for your comment. The wording of this recommendation has been clarified.
Balance			Section 9 Glossary	33-36	Balance welcomes the inclusion of a comprehensive Glossary in the guidance and the clarity this provides for the targeted audience in relation to key words / terms.	Thank you for your comment.
Balance			General		Balance also welcomes the inclusion of a clear methodology, evidence base (and acknowledgement of gaps in the evidence as appropriate) and timeline for formulating the recommendations and for producing the final Guidance.	Thank you for your comment.

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British Association for Adoption and Fostering (BAAF)			General		This response is being submitted on behalf of the BAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence. Our area of concern is the particularly vulnerable group comprised of looked after and adopted children and young people, as well as those on the margins of care.	Thank you for your comment.
British Association for Adoption and Fostering (BAAF)			General	24	We welcome this guidance, and are pleased to see that looked after children (LAC) are specifically mentioned. It would be helpful for a general audience to be clearer about what LAC means i.e. by saying children looked after by the local authority, or children in the care system. However, the guidance would be considerably strengthened by addressing specific needs of vulnerable children, including LAC.	Thank you for your comment, noted, we will amend the document appropriately.

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British Association for Adoption and Fostering (BAAF)			General		An increased focus on the following is needed: - role of schools in education on responsible use of alcohol and shaping values - educating parents and professionals to be good role models	Thank you for your comment. These are important issues. NICE has previously developed, and is developing recommendations on alcohol education and these are detailed within section 7 of the guidance document. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions specially aiming to educate parents were not included in the review work – the PDG recognises the importance of these influences on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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British Association for Adoption and Fostering (BAAF)			General		There is a lack of reference to the impact on children, families and society of exposure to alcohol in utero. In recent years there has been an increasing recognition of Foetal Alcohol Spectrum Disorder (FASD) and the life long impact FASD has on children. An increasing number of children with FASD are coming into the care system, with direct financial and societal costs. There is a need for a robust campaign to increase awareness of this serious and costly public health issue, and definitive guidance that pregnant women should abstain completely, including prominent statements on all alcoholic beverage packaging and in all establishments which sell or serve alcohol.	Thank you for your comment. Unfortunately this area was outside of the scope of this guidance. However, the problems associated with drinking in pregnancy have been acknowledged within the guidance document NICE has previously issued guidance in this area: Antenatal care: routine care for the healthy pregnant woman (http://guidance.nice.org.uk/CG62)
British Association for Adoption and Fostering (BAAF)			3.16	12	It is very important to highlight the guidance noted here which is of particular relevance to vulnerable children. It would be useful to include key points from previously published guidance to make this guidance more comprehensive.	Thank you for your comment. As mentioned NICE has published guidance on a range of topics that are associated with alcohol. In order to make the guidance as clear as possible these links to these of guidance are included within the related guidance section.

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British Association for Adoption and Fostering (BAAF)			Recommendation 3: marketing	20	We would fully support a total ban on advertising of all alcohol products. Since there is strong evidence in statement 3.6 and 3.7 that exposure to alcohol advertising is associated with the onset of drinking among children and young people, this is a critical point to prevent harmful behaviour and also positively influence life style choices and values. Most advertising is aimed at normalising use of alcohol in everyday life, and promoting the value and allure of a drinking culture and it is this seductive message which is often most detrimental, contributing to peer pressure to drink, life long values which include drinking, and which is hardest to offset by education and role-modelling by parents.	Thank you for comment. As a result of the consultation process the committee have made revisions to the advertising recommendations. The committee did not believe that the current evidence base supported the introduction of a complete advertising ban.
British Association for Adoption and Fostering (BAAF)			Recommendation 4: licensing	21	We welcome the acknowledgement that 'sufficient resources' will be required to carry out this recommendation. There will be considerable need for ongoing training programmes and sufficient workforce for full implementation.	Thank you for your comment.
British Association for Adoption and Fostering (BAAF)			Recommendation 6:	23	It would be helpful to make an explicit statement that children 10 – 15 years old should not drink alchohol, while at the same time acknowledge that in reality some do and need intervention.	Noted, thank you for your comment, the guidance document has been appropriately amended.

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British Association for Adoption and Fostering (BAAF)			Recommendation 7	24	We would suggest further details, or preferably a sample, be provided for AUDIT and other screening tools mentioned.	Thank you for your comment. Unfortunately it is not possible to include sample questionnaires within the guidance document. However, it is possible that they may be included within the implementation tools that NICE will produce
British Association for Adoption and Fostering (BAAF)			Recommendation 7	24	We welcome the inclusion of LAC, those involved with child protection agencies and those accessing contraceptive services in high risk groups. We would also suggest including young people attending clinics for sexually transmitted infections, given the connection between alcohol use and sexual activity.	Thank you for your comment. Following the consultation process the recommendations have been amended to include those seeking help for STIs.
British Association for Adoption and Fostering (BAAF)			Recommendation 8:	25	Foster carers and residential care workers of LAC should specifically be included in those who should take action. They are very well placed to be aware of LAC who are engaging in high risk behaviour and influencing them to take part in brief interventions.	Thank you for your comment.. These workers are included within the “who should take action group under the broader heading of social care.

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British Association for Adoption and Fostering (BAAF)			Recommendation 9	26	We welcome the specific focus on parents whose children are involved with child protection agencies, and suggest specific inclusion of parents with LAC in this list. Research by Harwin and Forrester has shown that up to one third of children in the care system come from backgrounds of alcohol and / or substance misuse, and that recognition of alcohol misuse lags behind substance misuse. It is critical that all professionals coming into contact with these groups are able to intervene.	Thank you for your comment.
British Association for Adoption and Fostering (BAAF)			Recommendation 10	28	Further elaboration needs to be given concerning FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy).	Thank you for your comment. Additional detail has been provided within the glossary.
British Association for Adoption and Fostering (BAAF)			Recommendation 12	30	Further elaboration is needed as to the signs of moderate or severe alcohol dependence, and the glossary is insufficient.	Thank you for your comment. The glossary does provide some detail as to some of the possible signs of dependence.
British Association for Adoption and Fostering (BAAF)			Evidence statement 3.7	57	A literature review stated that there was no scientific evidence available to describe the effectiveness of self-regulation in alcohol advertising. The best answer would be to completely ban alcohol advertising.	Thank you for your comment.

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British Association for Adoption and Fostering (BAAF)			Evidence statement 7.1	62	The provision of sufficient resources is crucial to fully implement these guidelines. There are immense training needs, ranging from how to approach alcohol use in a variety of clinical settings, to use of screening tools, motivational counselling and brief interventions, as well as targeting high risk groups. There must be recognition within clinical settings of the increased time required to undertake these activities. A culture of teamwork must also be developed, if interventions by a variety of professionals in varied settings are to be effective.	Thank you for your comment. The guidance does include a recommendation that address resources and the need for training.

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British Association for Adoption and Fostering (BAAF)			General		We suggest that the following articles concerning effectiveness of preventative work with children of alcoholics would be useful. Johnson, B.A., Roache, J.D., Javors, M.A., DiClemente, C.C., Cloninger, C.R., Prihoda, T.J., Bordnick, P.S., Ait-Daoud, N., Hensler, J.: Ondansetron for reduction of drinking among biologically predisposed alcoholic patients: a randomized controlled trial. JAMA: The Journal of the American Medical Association 284 (8): 963-971, 2000. Johnson, B.A.: Serotonergic agents and alcoholism treatment: rebirth of the subtype concept – an hypothesis. Alcoholism: Clinical and Experimental Research 24 (10): 1597-1601, 2000. Johnson, B.A., Cloninger, C.R., Roache, J.D., Bordnick, P.S., Ruiz, P.: Age of onset as a discriminator between alcoholic subtypes in a treatment-seeking outpatient population. The American Journal on Addictions 9 (1): 17-27, 2000. Dawes, M.A., Johnson, B.A.: Pharmacotherapeutic trials in adolescent alcohol use disorders: opportunities and challenges. Alcohol and Alcoholism 39 (3): 166-177, 2004. Dawes, M.A., Johnson, B.A., Ait-Daoud, N., Ma, J.Z., Cornelius, J.R.: A prospective, open-label trial of ondansetron in adolescents with alcohol dependence. Addictive Behaviors 30 (6): 1077-1085, 2005. Dawes, M.A., Johnson, B.A., Ma, J.Z., Ait-Daoud, N., Thomas, S.E., Cornelius, J.R.: Reductions in and relations between 'craving' and drinking in a prospective, open-label trial of ondansetron in adolescents with alcohol	Thank you for your comment. The public consultation on the evidence reviewed for this guidance took place during May and June 2009 when all stakeholders were invited to submit additional evidence and comment on the interpretation of the evidence. Whilst the evidence identified here was outside that period the PDG were made aware of its existence.

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British Association for the Study of Liver Disease					The Programme Development Group make the very important points that drinking alcohol is never without risk and the harms from alcohol are directly proportional to overall per capita consumption and that drinking has profound adverse affects on non-drinkers, including approximately 1.3 million children each year. As such the preventive approach which is outlined in this draft guidance include both national measures needed to reduce the overall alcohol consumption 75% of which according to the Department of Health, is drunk by hazardous and harmful drinkers together with individual measures. PDG make the point that the affordability of alcohol is a key driver for consumption and that changes in the affordability of alcohol have been the key driver for increased consumption and increased harm over the last few decades in the UK. Given that poorer sections of society drink less than the most affluent but suffer between 2-5 times as much alcohol-related harm, changes in the affordability are likely to have had the most impact on those sectors of society most susceptible to the harms that alcohol causes. While recognising that affordability is the most important factor and the most amenable to change through Government policy, the PDG also take into account increasing availability of alcohol and the overwhelming evidence now showing the deleterious effect of alcohol marketing on young people.	Thank you for your comment.

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British Association for the Study of Liver Disease			**Recommendation 1, price**		We absolutely agree with the recommendation to introduce a minimum price per centilitre of alcohol (unit) and to increase alcohol duty with a link to inflation and earnings. Given that the Sheffield Report commissioned by the Department of Health was specifically precluded from addressing issues of alcohol duty and taxation it may be helpful for NICE to specifically commission some modelling in this area including effects not only on health but also on crime.	Thank you for your comment. Unfortunately, due to limitations of time and resources it is not possible at this stage to commission additional economic modelling work. However the committee did consider issues of taxation and whilst not formally part of the recommendations it has been commented on within the considerations
British Association for the Study of Liver Disease			**Recommendation 2, availability**		There is mounting evidence in favour of a complete ban on advertising as this is really the only effective option for preventing the exposure of young people to alcohol marketing in the same way as it was for tobacco. However, given the likely reluctance of governments to do this, it may be helpful for the group to address specific recommendations in terms of a 9 or 10 pm shed for media alcohol advertising and Certificate 15 or 18 classification for cinema advertising given that a robust mechanism certification of film already exists.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations. The PDG did not believe it appropriate at this time to recommend the introduction of a watershed.
British Association for the Study of Liver Disease			**Recommendation 3, marketing**		We absolutely agree with the suggestion that public health should be taken into account as a criteria in licensing regulations as it is in Scotland and consideration should be given to the availability of alcohol and in personal import allowances.	Thank you for your comment.

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British Association for the Study of Liver Disease			**Recommendation 4, licensing**		We agree with the recommendations on licensing and regret that the existing Home Office proposals on licensing appear currently in danger of being deferred as a result of lobbying by the drinks industry.	Thank you for your comment.
British Association for the Study of Liver Disease			**Recommendation 5, screening and brief intervention**		We would agree with these detailed recommendations and the group may wish to consider modelling the degree of harm reduction that could be achieved were these recommendations to be fully implemented. The generally accepted verdict on brief intervention is that it has the numbers needed to treat of around 8 suggesting a 15% harm reduction but it is possible that effects diffuse into the community promoting a deeper cultural behavioural change.	Thank you for your comment. We will pass this comment onto our implementation team for consideration in their work.

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British Association for the Study of Liver Disease			**Recommendations 6 and 7**		There is currently no mention of the involvement of parents with young children who are thought to be drinking hazardously or harmfully and it may also be helpful to have recommendations to assist in dealing with children harmed by drinking within the family.	Thank you for your comment. The guidance has been amended to include parental involvement. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions specially aimed at helping children harmed by drinking within the family were not included in the review work – the PDG recognises the importance of these influences on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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British Beer & Pub Association			2	7	The number of alcohol attributable deaths is a subjective figure. There are published figures on this issue, surely it would be prudent to use these.	Thank you for your comment. The figures provided on alcohol attributable deaths come from a published report by the North West Public Health Observatory (NWPHO). The NWPHO, report was commissioned by and commented on by the Department of Health. This has been appropriately referenced within the document.
British Beer & Pub Association				7	Under the heading "Socioeconomic factors" the guidance explains that those in the most deprived areas of the country are more likely to die either in part, or directly, due to alcohol consumption, and are more likely to be admitted to hospital due to an alcohol use disorder. The guidance goes on to say that the most deprived drinkers tend to drink less than better-off parts of society. This seems to suggest that there is no direct link between overall consumption and negative health consequences. As a result, population level interventions should not be deemed appropriate.	Thank you for your comment. This section of the guidance has been clarified.

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British Beer & Pub Association				7	Affordability is a misleading measure for this type of analysis. The increase in alcohol affordability is no different than the increase of affordability of most other goods. Consumer behaviour and economic theory relates consumption with price, not affordability. On this basis one would expect to see an increase in alcohol consumption, as alcohol is a normal good, but not a particularly large increase as alcohol is rather inelastic. A more appropriate measure is the real price of alcohol which essentially adjusts the nominal price of alcohol by the general price level. The relative alcohol index refers to the price of alcohol relative to the price of all other goods. In the case of alcohol in the UK, prices have increased by 6% more than the all items RPI, .prices in general.	Thank you for your comment.
British Beer & Pub Association				7	The report states that between 1980 and 2008 alcohol had become 75% more affordable. This is incorrect as it fails to take into account the increase in population. Using ONS data the increase in 'affordability' is just 45%. Further to this the inflation figures are skewed. They do not accurately measure the 'price' of alcohol, rather they are more a reflection of changing consumer trends, such as the increasing prevalence of drinking in the off-trade where the price is inherently lower.	Thank you for your comment. The affordability statistic is quoted directly from a document published by the NHS Information Centre. The document in question utilises data from a range of sources including the Office for National Statistics.
British Beer & Pub Association			3.1	9	"Drinking alcohol is never without risk". This statement is emotive and doesn't add anything to the guidance. Everything in life involves risk and as with other activities, drinking alcohol has benefits.	Thank you for your comment. This statement has been clarified.

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British Beer & Pub Association			3.1	9	There is not definitive evidence either way regarding overall per capita consumption and related deaths.	Thank you for your comment.
British Beer & Pub Association			3.1	9	Consumption of alcohol also has considerable societal benefits that appear not to be recognised by this guidance.	Thank you for your comment. The guidance document has been amended.
British Beer & Pub Association			3.1	10	Paragraph 3.5 talks about the benefit of population level approaches. However it fails to recognise the failings associated with a one-size fits all approach. It is not accurate to say that such interventions will "lower the whole population's risk of alcohol-related harm" as many of the population will not be affected and there may be negative externalities as a result of such approaches (illicit production, etc)	Thank you for your comment. As noted in the guidance document it is widely accepted that by reducing the overall risk it is likely to result in benefits for the population as a whole.
British Beer & Pub Association			3.1	10	We would question whether there is any consensus on the need for population level approaches.	Thank you for your comment. However, the PDG has noted several recent reports that have advocated such an approach.
British Beer & Pub Association			3.1	10	The comparison with legislation on drink-driving is not applicable as there were clear risks posed to people other than the individual that is doing the drink-driving. There is very little evidence to show that there is significant harm caused by others from moderate alcohol consumption.	Thank you for your comment. As highlighted in the Chief Medical Officers report alcohol affects not only the person drinking but those around them.
British Beer & Pub Association			3.1	11	There is no relevant evidence to show that a reduction in outlets will reduce alcohol consumption.	Thank you for your comment. The recommendations are developed from the, publically available, evidence reviews. While developing the recommendations the committee did consider evidence regarding outlet density and alcohol consumption.

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British Beer & Pub Association			3.1	11	In paragraph 3.10 the PDG claims that the increase in imports from abroad that would occur from increasing prices would only have a "small impact". Evidence from booze-cruising during the 1990s shows this to be untrue. At the time there was a significant price differential between the price of alcohol in the UK compared to France and Belgium (due to the very high duty rate in the UK, for example). It is estimated that consumption from imports from Europe accounted for approximately 8% of UK consumption in 2000. This figure excludes duty-free imports which are likely to increase the figure to closer to 10% of consumption. In certain areas of the country, for example Kent, the proportion would have been much higher.	Thank you for your comment. The guidance has been clarified.
British Beer & Pub Association			3.1	11	Restrictions in the area of alcohol advertising in the UK are amongst the strictest in the world, as set out in the Advertising Standards Authority's codes of practice. A survey published in September showed a 99% compliance rate with the ASA's codes. The Portman Group also have a code of practice on the naming, packaging and promotion of alcoholic drinks as well as a newly launched guide to 'The Responsible Marketing of Alcoholic Drinks in Digital Media'.	Thank you for your comment. The PDG are aware of the rules governing the current self-regulatory system.

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British Beer & Pub Association			4	18	It is inappropriate to give the Chief Medical Officer(s) lead responsibility for alcohol issues. The CMO is an unelected official who is unlikely to have the expertise necessary to work across all agencies of Government. Working specifically with the Department of Health removes any independence when assessing policy issues around alcohol.	Thank you for your comment. The guidance document has been clarified.
British Beer & Pub Association				19	The recommendation for a minimum price ignores issues around potential legality, the fairness of such a system and the fact it will lead to increased cross-border shopping. A recent judgement by the European Court of Justice found that minimum pricing was illegal when applied to tobacco. Although the judgement was not directly applicable to alcohol, the reasons given for rejecting the implementation of that legislation do relate to alcohol.	Thank you for your comment. The recent opinion issued by the ECJ is specific to tobacco. Therefore it has not yet been ruled that a minimum price for alcohol is a breach of European law.
British Beer & Pub Association				19	Minimum pricing penalises responsible consumers and doesn't take into account that those who misuse alcohol tend to be least sensitive to price changes.	Thank you for your comment, noted.
British Beer & Pub Association				19	Alcohol duties have increased far above the rate of inflation for the last few years and it is intended to do so for the next three years. One issue that has arisen is that this has encouraged a move towards drinking in the off-trade, effectively lowering the price of alcohol. Linking alcohol duty to earnings risks punishing the population for economic success, particularly those that have not benefited from increased earnings.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations and no longer recommend that alcohol duty is linked to inflation and earnings.

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British Beer & Pub Association				19	There is no evidence to suggest that the most recent liberalisation of the licensing laws caused higher consumption or increased crime and disorder. In fact the opposite is true, with falling alcohol consumption and a reduction in alcohol-related crime.	Thank you for your comment, it has been noted.
British Beer & Pub Association				19	Market forces determine the level of supply and falling consumption has seen a fall in the number of pubs in the UK. Such trends demonstrate that where there is oversupply it will be removed by commercial pressures.	Thank you for your comment, it has been noted.
British Beer & Pub Association				20	Public Health as a licensing objective was debated very recently, when the latest Licensing Act was being developed. It was felt that it was not appropriate for Licensing Authorities to make that decision. Nothing has changed to suggest that this decision should be reviewed.	Thank you for your comment, it has been noted.
British Beer & Pub Association				20	Altering personal import allowances is unlikely to have any impact on alcohol consumption. This sector is currently very small. The only reason this would be necessary is if excessive regulation/ taxation were imposed on the alcohol industry. It is unlikely that this allowance could be reduced without infringing European law.	Thank you for your comment, it has been noted.

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British Beer & Pub Association				20	The principle aim of alcohol marketing is to promote one brand against another, and to a lesser degree one product type against another. There is no evidence to suggest that the increasing amount of money being spent on advertising has led to an increase in the number of underage drinkers. This is in part due to the effectiveness of current industry codes of practice that prevent alcohol being targeted at minors or marketed irresponsibly.	Thank you for your comment, it has been noted.
British Beer & Pub Association				20	A ban on alcohol advertising, or further restrictions, is likely to have a major impact throughout the economy. Advertising revenue is crucial to some media outlets, to sports clubs, from the very largest to the small community teams. It is not practical to suggest that a football team cannot be sponsored by their local pub.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations regarding the introduction of a complete alcohol advertising ban.
British Beer & Pub Association				20	There are likely to be issues around access to market. If new entrants to the market are not allowed to advertise then it is very difficult to build a brand.	Thank you for comment.
British Beer & Pub Association				20	A limit of 5% of the audience under the age of 18 is likely to mean the end of any advertising in the football industry, as an example.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations. The 5% of the audience under the age of 18 has been amended
British Beer & Pub Association				21	As noted earlier in the guidance, public health is not a licensing objective and as such licensing authorities should not take this into account	Thank you for your comment, it has been noted.

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British Beer & Pub Association				21	Many of the suggestions that are proposed are already taken into account by licensing authorities. They have an in-depth knowledge of their local area and are capable of making decisions in their locality without further centralised guidance.	Thank you for your comment. The purpose of this recommendation is to highlight the current licensing provisions and reinforce current practice.
British Beer & Pub Association				21	Partnership schemes are currently being carried out throughout the country. The most effective examples are where Licensing Authorities work with industry to identify areas for improvements. Pubwatch schemes are an excellent example of where industry and relevant authorities can combine to deal with issues. The implementation of Business Improvement Districts have also provided examples of success. It would be useful to identify industry as a relevant partner within the guidance.	Thank you for your comment, it has been noted.
British Beer & Pub Association				21	Other comments generally revolve around applying the law as it currently exists.	Thank you for your comment, it has been noted.
British Beer & Pub Association				39	It is interesting to note that the Programme Development Group does not have any representation from the alcohol industry, or business generally. Such representation would have given insight into how businesses operate and how the recommendations would work at a practical level.	Thank you. Details of the process the recruitment of NICE can be found in the CPHE process manual available at : www.nice.org.uk/phprocess In addition stakeholders can consult the NICE web pages for getting involved at: http://www.nice.org.uk/getinvolved/

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British Liver Trust			General		The British Liver Trust welcomes this comprehensive set of guidance presented by NICE. We would like to specifically submit our comments on the following areas: price, availability, marketing, licensing and screening for adults. The Trust firmly believes that prevention methods are fundamental to the reduction of alcohol related health harms. The guidance laid out for consultation clearly harnesses the key areas which need to be addressed by multi-agencies to achieve progress in reducing alcohol health harms. The Trust believes that there is need for a population versus individual approach to reducing consumption and subsequently the harm it may cause. Additionally there is a need for a national policy change across all departments in government to reduce the confused messages of safe drinking messages against 24-hour drinking policies. The introduction of a minimum price per unit would be an important component in reducing alcohol consumption. The Trust believes the Sheffield study provides evidence sufficient to make that decision. A mandatory code is required from drinks retailers to ensure that good practice is maintained and also improved. The Trust would like more emphasis on the health impact of alcohol, particularly in health information at point of sales, a change in the way in which drinks are measured and promoted and how premises are licensed.	Thank you for your comments.

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British Liver Trust			Recommendation 1: Price	19	The British Liver Trust firmly believes that the introduction of a minimum price per unit would reduce alcohol-related health harm. There is now strong evidence to support a minimum price for alcohol in order to reduce alcohol consumption. A minimum price per unit would ensure the risk of health harms (liver disease) to the most vulnerable like liver damage (alcoholics, chronic drinkers and the young) would be reduced. Price is a key factor in the consumption of alcohol and needs to be examined and addressed in order to reduce consumption of alcohol. The Trust does not believe that linking alcohol duty to inflation and earnings would result in the same impact as a minimum price of alcohol. Rates of duty vary and have not been devised to protect vulnerable drinkers from health harm, nor do they deter consumption when linked with disorder.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations. The recommendations have been revised and no longer link alcohol duty to inflation and earnings.

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British Liver Trust			Recommendation 2: Availability	19-20	The availability of alcohol is widespread in the UK. With the relaxation of the licensing laws people are now able to purchase alcohol around the clock. Additionally, availability in shops and supermarkets needs to be addressed where alcohol is stacked high and available throughout the store, rather than being restricted to one specific area. Alcohol is also promoted and available next to food. The Trust is also concerned that offers such as £10 'meal deal' promotions run by several supermarkets normalises alcohol and encourages couples (the package is for two people) to share a bottle of wine over dinner, which encourages people to consume above the recommended unit consumption for both genders. The British Liver Trust wholeheartedly agrees with all the guidance put forward by NICE and would like licensing legislation revised to ensure it takes into account the link between the availability of alcohol and alcohol related health harms including the collateral caused by crime and disorder.	Thank you for your comment.
British Liver Trust			Recommendation 3: Marketing	20	The British Liver Trust agrees with all guidance put forward by NICE on marketing and alcohol. It is important to note that there is evidence that suggests that those who drink at a young age have an increased chance of developing alcoholism later in life therefore any restrictions put on advertising will help to reduce this.	Thank you for your comment.

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British Liver Trust			Recommendation 4: Licensing	20	The British Liver Trust agrees with all the guidance by NICE on licensing. The Trust would like to add to point two within the guidance, "Ensure sufficient resources are available to prevent underage sales, sales to people intoxicated, non-compliance with any other alcohol license condition and illegal imports of alcohol." We believe that health information needs to be displayed prominently in both on and off trade premises. Health information provided at point of sale is very important and by providing information on serious health consequences, both short and long-term, of exceeding the drinking guidelines, it would be rational to assume that informed customers would more frequently choose not to drink to excess.	Thank you for your comment. Following the consultation process amendments have been made to recommendation 4. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst the provision of information was not included in the review work – the PDG recognises the importance of this on drinking harmful and hazardous amounts across the whole population and took account of this in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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British Liver Trust			Recommendation 5: resources for screening and brief interventions	21-22	The British Liver Trust fully supports and agrees with the recommendations made in this section.	Thank you.
British Liver Trust			Recommendation 6: Supporting children and young people aged 10-15 years	23		
British Liver Trust			Recommendation 7: screening young people aged 16-17 years	24	The British Liver Trust fully supports and agrees with the recommendations made in this section.	Thank you.
British Liver Trust			Recommendation 8: Motivational counselling with young people aged 16-17 years	25	The British Liver Trust fully supports and agrees with the recommendations made in this section.	Thank you.

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British Liver Trust			Recommendation 9: Screening adults	26		
British Liver Trust			Recommendation 10: Brief advice for adults	27		
British Liver Trust			Recommendation 11: motivational counselling for adults	29	The British Liver Trust fully supports and agrees with the recommendations made in this section.	Thank you.
British Liver Trust			Recommendation 12: Referral	30	The British Liver Trust fully supports and agrees with the recommendations made in this section.	Thank you.
British Medical Association			4	16	In tackling alcohol-related harm, the BMA supports the use of population and individual interventions that aim to lower the total alcohol consumption in the population as a whole, and provide targeted support for people facing particular problems with alcohol.	Thank you for taking the time to read and comment on the guidance document. We note your suggestions and comments and have responded where appropriate.

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British Medical Association			4	19	Price Affordability is a key determinant in the use and misuse of alcohol. The BMA supports the introduction of policies to reduce the affordability of alcohol, including: • establishing a minimum price per unit for the sale of alcohol products • increasing the level of excise duty paid on alcohol products above the rate of inflation and rationalisation of the current system of taxation so that it is accurately linked to alcoholic strength for all products • implementing legislation to prohibit irresponsible promotional activities in licensed premises and by offlicenses.	Thank you for your comments, they have been noted.

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British Medical Association			4	19-20	Availability Licensing interventions are one of the most influential measures for controlling alcohol consumption by regulating where, when and to whom alcohol can be sold. The BMA believes it is essential that public health is considered as an objective of licensing regulations. In controlling the availability of alcohol the BMA believes: • there should be a reduction in licensing hours for on- and off-licensed premises • that the density of alcohol outlets should be taken into account in planning or consideration of license applications, and where necessary, introduce legislative changes to ensure these factors are considered • there should be an assessment of the impact on public health of the changes to licensing legislation.	Thank you for your comments, they have been noted.
British Medical Association			4	20	Marketing Alcohol marketing communications have a powerful effect on young people and are independently linked with the onset, amount and continuance of their drinking, as well as reinforcing strong proalcohol social norms. The BMA believes there should be a comprehensive ban on all alcohol marketing communications that is rigorously enforced.	Thank you for your comments, they have been noted.

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British Medical Association			4	21	Licensing Active enforcement of laws regulating licensing hours andprohibiting the sale of alcohol to individuals who are intoxicated or those underage are key measures in reducing alcohol-related harm. The BMA believes: • licensing legislation in the UK should be strictly and rigorously enforced. This includes the use of penalties for breach of licence, suspension or removal of licenses, the use of test purchases to monitor underage sales, and restrictions on individuals with a history of alcohol-related crime or disorder, (eg removal or suspension of licence and limiting opening hours) • enforcement agencies should be adequately funded and resourced so that they can effectively carry out their duties. Consideration should be given to the establishment of a dedicated alcohol licensing and inspection service.	Thank you for your comments, they have been noted.

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British Medical Association			4	21-23	Resources for screening and brief interventions Preventing alcohol-related harm requires the accurate identification of individuals who misuse alcohol and the implementation of evidence-based interventions to reduce alcohol consumption. The BMA believes that: • the detection and management of alcohol misuse should be adequately funded and resourced component of primary and secondary care in the UK to include: o formal screening for alcohol misuse o referral for brief interventions and specialist alcohol treatment services as appropriate o follow-up care and assessment at regular intervals • comprehensive training and guidance should be provided to all relevant healthcare professionals on the identification and management of alcohol misuse funding for specialist alcohol treatment should be significantly increased and ring-fenced to ensure all individuals who are identified as having severe alcohol problems or who are alcohol dependent are offered referral to specialised alcohol treatment services at the earliest possible stage • there should be continual assessment of the need for and provision of alcohol treatment services in the UK, building on the 2004 Alcohol Needs Assessment Research Project in England, and ensuring similar assessment is undertaken throughout the UK.	Thank you for your comments, they have been noted.

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British Medical Association			General		The draft guidance does not include recommendations on the following two key aspects of alcohol control: Education and health promotion The use of public information and educational programmes is a common theme for alcohol control polices in the UK and internationally. While such approaches may be effective at increasing knowledge and modifying attitudes, they have been found to be largely ineffective at reducing heavy drinking or alcohol-related problems in a population. The BMA believes that public and school-based alcohol educational programmes should only be used as part of a wider alcohol-related harm reduction strategy to support policies that have been shown to be effective at alerting drinking behaviour, to raise awareness of the adverse effects of alcohol misuse, and to promote public support for comprehensive alcohol control measures. **Cont below**	Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst education and public information interventions were not included in the review work – the PDG recognises the importance of these and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp You may also be interested in the following document: School based interventions on alcohol http://guidance.nice.org.uk/PH7

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British Medical Association			General		**Cont** - Much of the strategy to reduce alcohol-related harm in the UK focuses on recommended drinking guidelines. While the majority of people are aware of the existence of these guidelines, few can accurately recall them, understand them, or appreciate the relationship between units and glass sizes and drink strengths. Labelling of alcoholic beverage containers and the provision of information at the point of sale, including at licensed bars, is useful methods for providing explanatory guidance on recommended drinking guidelines and health warnings, as well as supporting other alcohol polices. The BMA believes that: • it should be a legal requirement to prominently display a common standard label on all alcoholic products that clearly states: o alcohol contents in units o recommended daily UK guidelines for alcohol consumption o a warning message advising that exceeding these guidelines may cause the individual and others harm it should be a legal requirement for retailers to prominently display at all points where alcoholic products are for sale: o information on recommended daily UK guidelines for alcohol consumption o a warning message advising that exceeding these guidelines may cause the individual and others harm o information to assist purchasers in assessing how many units are in an alcoholic product.	Please see previous comment.

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British Medical Association			General		International cooperation on alcohol control International cooperation on alcohol is essential for several reasons: the significant global burden of alcohol, the commonality of problems faced by different countries, trans-border factors such as global advertising and production, formal and informal trading, and smuggling, and the difficulties countries have in dealing with alcohol problems in isolation. The BMA believes there should be strong support for action at an EU-level, and supports the introduction of a Framework Convention on Alcohol Control in order to support governments in developing and implementing effective alcohol control policies, foster collaboration between countries, counter international trade agreements that restrict governments, and effectively engage non-governmental organisations.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations to acknowledge the need for action at an EU level.
College of Emergency Medicine			General	13	Throughout the guideline the College of Emergency Medicine prefers the term 'Emergency Department' to 'Accident and Emergency'	Thank you for your comment, the guidance document has been amended appropriately.
College of Emergency Medicine			Recommendation 5	22	The recommendation around licensing has missed the importance of sharing emergency department data about the location of assault with the police and licensing authorities, 'The Cardiff Model'. This is a low cost intervention. This is very effective at reducing alcohol related assaults. This is an important area as the police never know more than about a quarter of all assaults that need hospital treatment.	Thank you for your comment, the guidance document has been amended appropriately.

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College of Emergency Medicine			Recommendation 9	26	The College of Emergency Medicine feels that the groups that have been identified should also include patients who have been assaulted.	Thank you for your comment, the guidance document has been amended appropriately.

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College of Emergency Medicine			Recommendation 9	Page 27	– last paragraph should be changed to:- • The College of Emergency Medicine highlights the use of Blood Alcohol Concentrations (BACs) in the Resuscitation Room (RR) of Emergency Departments where questionnaire use is inappropriate in that frenetic noisy environment, and also not possible with the obtunded patient – but all raised BAC levels need to be fed back to the patient, with PAT/FAST/equivalent being applied once the patient has improved clinically (and left the RR). • BACs are used routinely in level 1 trauma centres in the USA where both detection and alcohol health work are now mandatory for attainment of Level 1 status (American College of Surgeons, Committee on Trauma. Resources for the optimal care of the injured patient. Chicago, Illinois: American College of Surgeons, 2006). **Cont below**	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations to acknowledge the use of BAC in certain circumstances.

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College of Emergency Medicine			Recommendation 9	Page 27	**Cont** • Note: USA – Intoxicated ED Patients: A 5-year follow-up of Morbidity and Mortality. Davidson P et al. Annals of Emergency Medicine. 1997;30:593-7. UK - Blood alcohol concentrations of patients attending an accident & emergency department. Peppiatt R et al. Resuscitation 1978;6:37-43. • The use of BACs from Emergency Department Resuscitation Rooms (RRs) for flagging up patients who should be followed up by FAST/PAT/equivalent should be the subject of further audit for outcomes (re-attendance rates) from follow up by Alcohol Nurse Specialists.	Please see above comment.

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College of Emergency Medicine			'Recommendation 10	28	The College of Emergency Medicine feels that the use of the AUDIT here cannot be too exclusive, this scale is rarely used in emergency departments as it is too long. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline. The College of Emergency Medicine believes that Hazardous Drinkers should receive a brief intervention from a trained alcohol specialist. The College has found, through experience, that trained alcohol specialists in secondary care are more effective when supported by a Consultant and the discussion needs to reflect this. The College of Emergency Medicine supports all ED staff – doctors and nurses – giving Brief Advice (1-3 minutes as guided by PAT) when indicated (i.e. possible alcohol-related attendance) to make best use of 'Teachable Moments' so that patients may contemplate change by associating their clinical problem to their alcohol consumption, to reduce ED reattendance. **Cont below**	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to the target groups. The recommendations do state that interventions should be delivered by those who have received the necessary training. The recommendations do acknowledge the use of PAT in specific situations. However, the committee felt that AUDIT should be used wherever possible.

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College of Emergency Medicine			'Recommendation 10	28	**Cont** Early Identification and Brief Advice may all that is warranted for the non-dependent intermittent young binge drinker (who may rarely visit their GP). Where judged appropriate the offer of an appointment for Brief Intervention (20-40 minutes, based on FRAMES) by an Alcohol Nurse Specialist should be offered (together with possible liaison with community alcohol services) to reduce alcohol-related ED re-attendance.	Please see previous comment.
College of Emergency Medicine			Recommendation 11	29	The College of Emergency Medicine feels that the use of the AUDIT here cannot be too exclusive, this scale is rarely used in emergency departments as it is too long. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline.	Noted, please see previous response.
College of Emergency Medicine			Recommendation 12	30	The College of Emergency Medicine feels that the use of the AUDIT here cannot be too exclusive. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline.	Noted, thank you, please see previous response

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College of Emergency Medicine			Highlighting 'potential inconsistencies' Glossary, page 34	Page 34	– The College of Emergency Medicine recommends – for consistency with the above – that **Brief Advice** *is added as a heading.* "The giving of 1-3 minutes feed-back on PAT/FAST/ equivalent application by any member of ED staff. Induction programs for all ED staff should include education on the management of alcohol misuse, early identification of misuse and use of PAT/FAST/equivalent. This education should be given by either the Alcohol Nurse Specialist, or a Consultant who acts as 'Consultant Alcohol Lead or Support'." **Brief Intervention "**Specific structured counselling – 20-40 minutes by trained members of staff (additional to ED routine staff) e.g. Alcohol Nurse Specialists, using systems based on FRAMES for motivational interviewing". **Early Identification** *(not early **intervention,** as this is confusing with the above)* – "Use PAT/FAST/equivalent) to stimulate Brief Advice by any member of ED staff to reduce alcohol-related reattendance. This is particularly aimed at the intermittent binge drinker, often young, before they become dependent. Often such patients present to EDs with falls, collapse, head injuries, assault or accidents".	Thank you for comment. As a result of the consultation process the committee have made revisions to the glossary.

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College of Emergency Medicine			With reference to: 'points or areas not covered but fall into scope of guidance' and to' Practical value of provisional recommendations'		Every acute hospital (i.e. with an A&E) should have a nominated Lead Consultant (of whatever speciality best suits an individual Trust) for combating Alcohol Misuse with time allocated in job plan (e.g. One Programmed Activity, 4 hours). This is necessary to ensure education, audit and feed-back mindful of the turn over of junior doctors (often as rapid as every four months). Mental health Trusts are separate from Acute Hospital Trusts, so there is this need for an 'alcohol Czar' from within acute hospital. It is also of note within Mental Health Trusts, alcohol and drug services are separate from general psychiatry; this means that in most acute Trusts psychiatric liaison nurses do not see patients with alcohol misuse problems. Every acute hospital has at least one Alcohol Nurse Specialist (and preferably more to cover extended hours – remembering the problems of alcohol misuse are worse in the evenings and at week-ends). Reference : The Royal College Physicians London, Alcohol – Can the NHS Afford it, 2001, www.rcplondon.ac.uk highlight web site www.alcohollearningcentre.org.uk	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in terms of the need for a dedicated alcohol lead.

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Department for Business, Innovation and Skills			General		We feel that the population-level interventions where evidence is limited and inconclusive are inconsistent with Better Regulation principles.	Thank you taking the time to read through and comment on the guidance document. The PDG recognised that empirical data alone, even from the best conducted investigation, seldom provides a sufficient basis for making recommendations. This data requires interpretation and analysis, using prior knowledge and understanding and existing models and theories. Therefore, the PDG developed its recommendations using the best available empirical data and inductive and deductive reasoning. For further information on NICE methodology please see http://www.nice.org.uk/media/4E9/6A/CPHEMethodsManual.pdf

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Department for Business, Innovation and Skills			General		It would be helpful to clarify the relationship between Evidence Statement 3 in Part One of the ScHARR report and the further evidence developed through modelling in Part Two using specific UK data to make clearer the strength of the evidence supporting judgements on the cost-effectiveness of price, availability and promotion interventions underlying the draft guidance. This needs to be articulated more clearly for a lay and policy maker audience.	Thank you for your comment. In general terms, Appendices B and C of the guidance document explain the link between the evidence commissioned (evidence reviews and economic appraisals) and specific links between evidence statements and recommendations. A link to the supporting document is provided within appendix E. For further information on NICE methodology please see http://www.nice.org.uk/media/4E9/6A/CPHEMethodsManual.pdf
Department for Business, Innovation and Skills			General		No mention has been made of evidence relating to the health benefits of some alcohol consumption – we feel that if this document is to be credible it should also identify health benefits.	Thank you for your comment the guidance has been amended appropriately.
Department for Business, Innovation and Skills			General		It would be helpful if firmness of language reflected firmness of evidence - Eg Drinking alcohol is NEVER without risk (we know that there is evidence of some benefits to low level consumption). Eg. Alcohol results in 17 million lost working days.	Thank you for your comment the guidance has been amended appropriately. Where applicable references have been inserted to support statistical statements.

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Department for Business, Innovation and Skills				7	**Socio-economic factors** This seems contradictory: '…most deprived fifth of the country are more likely to die or be admitted for alcohol related causes.' BUT '…managers and professionals self-report that they consume most alcohol.' This would seem to suggest that alcohol consumption is not the primary factor.	Thank you for your comment. The guidance has been clarified
Department for Business, Innovation and Skills			3.1	9	The guidance states '…alcohol is never without risks'. It would be helpful if you could clarify the evidence for this statement and also why the evidenced benefits are not included for consistency.	Thank you for your comment the guidance has been amended appropriately.

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Department for Business, Innovation and Skills			3.3	9	'PDG…believes interventions are likely to improve the overall well being and productivity of the population.' A clearer summary of the ScHARR evidence in this area would be helpful.	Thank you for your comment. The evidence reviews which supported the development of the guidance are available on the NICE website and appendices B and C of the guidance document highlight the relationship between evidence statements and recommendations. A link to the supporting document is provided within appendix E. For further information on NICE methodology please see http://www.nice.org.uk/media/4E9/6A/CPHEMethodsManual.pdf The statement that you refer to is from the considerations section of the document which is derived from the discussions that the PDG have when considering the evidence and draws on their expert knowledge.
Department for Business, Innovation and Skills			3.7	10	"Making alcohol less affordable appears to be the most effective way… there is sufficient evidence to justify minimum unit price." As noted already, a clearer summary of the strength of the evidence supporting judgements on the cost-effectiveness of price, availability and promotion interventions would be helpful. Some discussion of the interrelation between different policy interventions, if supported by the evidence, would also be helpful.	Thank you for your comment. See comment above for general description of NICE process on how it links evidence to recommendations. In addition the PDG have now drafted a further set of considerations relating to minimum price that should be read in conjunction with the final recommendations.

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Department for Business, Innovation and Skills			3.8	11	'…It is unlikely that those from lower-income groups would be disproportionately affected.' This is inconsistent with ScHARR evidence which states that 'Decreases in the price of alcohol contribute towards….population groups specifically affected included the older population, the unemployed and individuals with lower levels of education, social class and income"	Thank you for your comment the guidance document has been clarified.
Department for Business, Innovation and Skills			Paragraph 1	18	'Policy recommendations are based on extensive and consistent evidence….." This statement is not consistent with ScHARR's conclusions:- Recommendation 1 "LIMITED evidence suggested that minimum pricing MAY be effective." Recommendation 2 "Studies… did not demonstrate any conclusive evidence of an increase in alcohol-related attendances at A&E as a result of the Licensing Act, or regarding promotion " Recommendation 3 "The evidence for the impact of advertising bans was inconclusive "	Thank you for your comments The PDG recognised that empirical data alone, even from the best conducted investigation, seldom provides a sufficient basis for making recommendations. This data requires interpretation and analysis, using prior knowledge and understanding and existing models and theories. Therefore, the PDG developed its recommendations using the best available empirical data and inductive and deductive reasoning. For further information on NICE methodology please see http://www.nice.org.uk/media/4E9/6A/CPHEMethodsManual.pdf

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Department for Business, Innovation and Skills				49	NICE considered whether there was sufficient evidence of cost-effectiveness to form a judgement. The ScHARR cost-effectiveness review found:- Evidence of the cost effectiveness of pricing, promotion and availability interventions is scarce. As such the evidence statements based on the literature reviewed are relatively uninformative. Further economic analysis and research is very desirable in these areas. For NICE to consider that this conclusion gives them "sufficient evidence" to form a judgement is inconsistent with their decision-making principles, and Better Regulation principles.	Please see previous comment.

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Department for Culture Media and Sport			General		There are some concerns about the approach taken by NICE in regard to the development of alcohol advertising guidance for the following reasons: • We understand NICE has not actively consulted with key stakeholders with an interest in this work, including specifically the Advertising Standards Authority, Ofcom and the advertising industry. It would be helpful if you could clarify whether these organisations have been involved in the development of the guidance. • The guidance does not appear to reference or consider the existing regulatory systems in place that oversee advertising regulation - in particular the role and remit of Ofcom and the Advertising Standards Authority. • NICE does not appear to have taken into account the existence of the current advertising rules; considered the latest evidence against those rules nor the evidence that led to those rules being strengthened in 2005. • There is no reference to the current work that has been undertaken through the recent advertising code review consultations - undertaken by the Committee of Advertising Practice (CAP) and the Broadcast Committee of Advertising Practice (BCAP) - to look at the advertising codes in their entirety. This work has included specific consideration of the adequacy of the current alcohol advertising codes and the relevant evidence base including the ScHARR study. Cont Below	Thank you for taking the time to read through and comment on the guidance document. National organisations are able to register their interest in the guidance at anytime during its development. Registered stakeholders are free to comment during the specified consultation periods. The Advertising Standards Authority was involved in stakeholder consultations and whilst they were late in registering were able to input into the consultation on the economic model which took place in August 2009. They did not submit comments at draft guidance stage. For a full list of the stakeholders who registered for this piece of guidance please see: http://guidance.nice.org.uk/PHG/Wave15/1 When developing the guidance the committee did take account of the current self-regulatory structure and the recently revised rules. In addition the evidence base that informed the committee's deliberations included an examination of the revised advertising code. The committee developing the recommendations are experts within the alcohol field and as such were able to appraise the ScHARR evidence base directly when developing the recommendations.

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Department for Culture Media and Sport			General		**Cont** • We are concerned that there appears to be little or no explanation as to how NICE has arrived at its specific guidance proposals for advertising; the evidence and rationale underpinning those specific proposals; what impact the proposals would be expected to make on consumption trends and what impact they would have on the public and the Industry. We understand that key stakeholders have already expressed concern about their lack of early involvement in the NICE process and that the scoping and consultation documents NICE published did not set out the existing regulatory systems for alcohol advertising or the CAP/BCAP review of the alcohol advertising rules. The advertising regulatory system is a best practice regulator. If clear evidence emerges that brings into question the effectiveness of the current alcohol advertising rules then CAP and BCAP will consider the need for changes. In light of our concerns, it would be helpful if NICE could reconsider its draft advertising guidance in its alcohol work to reflect the current rules in place and the role of the advertising regulatory system. This is an omission that we feel should be addressed in **section 2 'Public health need practice' – pages 5-8.**	Thank you for your comment. The evidence reviews which supported the development of the guidance are available on the NICE website and appendices B and C of the guidance document highlight the relationship between evidence statements and recommendations. A link to the supporting document is provided within appendix E. See www.nice.org.uk/ph24 . National organisations are able to register their interest in the guidance at anytime during its development. Registered stakeholders are free to comment during the specified consultation periods. For a list of the stakeholders who registered for this piece of guidance please see: http://guidance.nice.org.uk/PHG/Wave15/1 Thank you for comment. As a result of the consultation process the committee have revised the recommendations to acknowledge the role of the advertising system and the current rules.

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Department for Culture Media and Sport				5	**Public health need and practice** We feel that it should be noted that HM Revenue and Customs data suggests a reduction in the overall level of alcohol consumption since the 2003 Act came into force. This is supported by other data such as the General Household Survey. This, and a similar pattern following the relaxation of licensing laws to allow all daytime opening in the 1980s suggests that there is no simple correlation between opening hours and alcohol consumption, and that it certainly is not a given that relaxing hours will necessarily result in increased consumption.	Thank you for your comment. The guidance document has been amended appropriately.
Department for Culture Media and Sport			3.7	10	**National Approach** The Government has indicated that is not currently minded to introduce a policy of minimum pricing, especially in the current economic climate. This should not therefore appear in 'National Approach.' Could you please consider renaming this section 'Suggested National Approach'.	Thank you for your comment. The guidance document has been amended to acknowledge that the final decision on whether these proposals are taken forward is the government's'.
Department for Culture Media and Sport			3.9	11	As above under National Approach, we query whether this is appropriate here. For further details on this, please see the comments below on recommendation 2 (availability).	Noted

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Department for Culture Media and Sport			3.11 & Recommendation 3 (marketing)	11 & 20,	As noted earlier, there is no detail of the existing regulatory structures in place nor is there clear consideration of the current evidence base on the impact of alcohol advertising/promotion – both in relation to children and the wider public. We feel this is a serious omission. As set out in Line 3, NICE seem to be suggesting that appropriate levels of child protection cannot be achieved without the use of extensive advertising bans. This is not the case. Government Ministers and the advertising regulators have clearly recognised the concerns about alcohol misuse in the UK and taken action to ensure that robust, evidence-based alcohol advertising rules are in place. Line 2 sets out evidence on exposure to alcohol advertising. However, it is important to recognise that the current rules were strengthened significantly in 2005 in response to the evidence on the relationship between alcohol advertising and consumption. The updated rules were designed to ensure that alcohol is promoted in a socially responsible way and the advertising codes also contain strict scheduling and placement rules for alcohol ads. Ultimately, both broadcast and non-broadcast advertising regulations must be robust and based on best evidence. If any new evidence emerged which clearly highlighted major problems caused by alcohol advertising in relation to consumer harm or protection of the vulnerable, in particular children and young people, then the independent regulators would have a duty to consider this fully and take appropriate action.	Thank you for comments, they have been noted. As a result of the consultation process the committee have revised the recommendations in terms of the introduction of a complete advertising ban. In addition the PDG did consider evidence which assessed the rule changes introduced in 2005.

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Department for Culture Media and Sport				*18*	**Recommendations for policy** 'The Chief Medical Officer should have lead responsibility for co-ordinating the broad approach across Government, supported by the Department of Health.' It should be made clear that this is in relation to the Government's Alcohol Harm Reduction Strategy.	Thank you for your comment, we will amend the document appropriately
Department for Culture Media and Sport			Introductory paragraph	18	**Recommendations for policy** The recommendations for policy on page 18 do not appear to take into account the existing regulatory structures in place and seek to extend the remit of some bodies/individuals that run contrary to the Government's Better Regulation Principles. As such we would be particularly concerned about the possibility of regulatory creep here and would seek reassurances that NICE's work - which comments specifically on the controls on alcohol advertising - should not unduly impinge on the role of the statutory/mandatory regulators (Ofcom and the ASA/CAP/BCAP) in this area.	Thank you for your comments, they have been noted. As is noted within this section any decision on whether these options are taken forward is the government's.

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Department for Culture Media and Sport			Recommendation 1 (price)	19	The evidence base behind this recommendation should be referenced more clearly. Presumably, this relates to the Sheffield Report. This however, produced limited evidence, suggesting that minimum pricing may be an effective approach in reducing alcohol consumption, and that its findings were not conclusive. The report states in its Executive Summary: *"Limited evidence suggested that minimum pricing may be an effective approach in reducing alcohol consumption."* This does not take into account the effect on minimum pricing on responsible consumers on lower incomes, who may be unfairly penalised through minimum pricing.	Thank you for your comment. The evidence reviews which supported the development of the guidance are available on the NICE website and appendices B and C of the guidance document highlight the relationship between evidence statements and recommendations. A link to the supporting document is provided within appendix E. See www.nice.org.uk/ph24 For further information on NICE methodology please see www.nice.org.uk/phmethods Thank you, the guidance document has been clarified.

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Department for Culture Media and Sport			Recommendation 2 (availability)	19	It should be noted that a central pillar of the Licensing Act is that each premises must be treated individually, and any restrictions on hours must be necessary and proportionate to the promotion of the licensing premises for that individual premises. Issues around the shaping of place and local areas are more appropriately tackled through planning policies and this should be acknowledged. As noted later in the report (page 21), the Licensing Act allows high density of premises in an area to be tackled by cumulative impact areas which can be identified in a statement of licensing policy where there is evidence of a saturation of licensed premises and any additional premises could affect the licensing objectives. These are the prevention of crime and disorder, public safety, the prevention of public nuisance and the protection of children from harm. It is also important to note that there are important differences in drinking patterns in Scotland and in England/Wales. In 2007, the pure alcohol volume of spirits sold in Scotland was almost double those sold in England and Wales (3.6 litres per capita compared with 1.8 per capita). The volumes sold of other beverages were very similar between Scotland and England and Wales. This shows that drinking behaviour is significantly different in Scotland, with a sharper emphasis on spirits. Concerning hours that alcohol is available, in our previous comments on the evidence we included information found that mortality rates from chronic liver disease and cirrhosis (ICD 571), pancreatitis (ICD 577) and alcohol dependence or psychosis (ICD 303 & ICD 291) appeared to be unaffected by the extension of opening hours.	Thank you for your comments. As you acknowledge the recommendations refer to and recommend authorities to make use of the current licensing provisions. Thank for your comments on alcohol consumption and mortality rates, they have been noted.

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Department for Culture Media and Sport				20	The question of whether health should be included as a licensing objective in England and Wales was debated thoroughly during the passage of the Licensing Act. The outcome was that Parliament decided that it should not be included. The Government is seriously concerned about the health impact of alcohol misuse but believes that these are complex issues that are more appropriately being dealt with through the national alcohol strategy. The Licensing Act is about the control and regulation of the sale of alcohol, not its consumption. Alcohol can still be consumed in hazardous quantities in ways well beyond the scope of the Act, such as at home, private parties, on the streets, etc. Licensing law cannot be used to address these health-related concerns. If Health were to become a licensing objective, there would be a requirement on all licence holders to promote public health objectives. As well as publicans and off-licence retailers, this would also include cinemas, theatres, village halls, indoor sports arenas, school parent teachers associations and others in the third sectors who hold premises licences. Licensing authorities and licence holders are required to promote all of the licensing objectives under the 2003 Act, regardless of the licensable activity. **Cont below**	Thank you for your comment. The committee is aware that the question of whether public health should be included within the Licensing Act has been previously debated. As noted within the pre-amble the committee is fully aware that the final decision on whether these policies are adopted will be determined by the government.

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Department for Culture Media and Sport				20	**Cont** Unlike in Scotland, the 2003 Act covers the provision of regulated entertainment and late night hot food and drink, as well as alcohol sales. It is therefore better to target alcohol related health objectives through other interventions. But we do wish to see licensing laws as contributing to the overall strategy to reduce harm from alcohol and our guidance to licensing authorities suggests that they should ensure their licensing policies complement the relevant national alcohol strategies for England or for Wales. It would be important to understand what would be achieved through making health a licensing objective that cannot be delivered through other legislation. For example, some of the measures in the proposed mandatory code relating to unit information will be delivered through food safety legislation. Sanctions can already be imposed on premises licences following review if they are necessary and proportionate to the licensing objectives.	Please see previous comment.

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Department for Culture Media and Sport			Recommendation 4 (licensing)	21	**Recommendations for Practice** This advises Local authorities, trading standards officers, the police and magistrates to "use local health and crime data to map the extent of local alcohol-related problems before developing or reviewing a licensing policy. If supported by the evidence, adopt a 'cumulative impact' policy to meet the objectives of the Licensing Act. If necessary, limit the number of licensed premises in a given area." Please note that, as noted above, cumulative impact areas can only be identified where there is a saturation of licensed premises and any additional premises could affect the *licensing objectives*. It is not possible for licensing policies to be based on data that does not relate to the licensing objectives, so should not be based on local health data except for where this relates to the licensing objectives – for example A&E data that helps identify premises where violent incidents have occurred or threats to public safety. This section also includes recommendations for measures that are already happening such as test purchasing. NB – the Policing and Crime Bill currently before Parliament proposes to amend the offence of selling alcohol to children on different occasions from 'three occasions' to 'two occasions'.	Thank you for your comment. The aim of this recommendation is reinforce the current provisions of the Licensing Act. The recommendation has also been clarified in relation to the 'cumulative impact' point.

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Department for Culture Media and Sport					**Evidence/Modelling Statements – general comment** All evidence should be clearly referenced. The list of evidence statements and modelling statements from page 52 are not clearly referenced. Listing the sources as Reviews 1-4 on page 41 is not clearly related to the references to evidence statements from page 52. DCMS appreciate that there is a paragraph explaining that the details can be found in Annex E, but still found this to be complicated. For readers to measure the quality of the evidence, they should be able to reference the source quickly and easily. It would be helpful for this to be done more effectively throughout the document.	Thank you for your comments about the structure of the guidance document, we note your concerns. As you acknowledge a link is provided to enable access to the full evidence reviews so that the reader may easily find the report they are most interested in.

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Department for Culture Media and Sport			**Evidence Statements 2.20-2.25** (on which Recommendation 4 is in part based)		This seems to be based on effects of extending hours in other countries which does not fully acknowledge that there are likely to be significant local, cultural and contextual differences. We commented on this in our previous response on the evidence. Any consideration needs to take account of the *full* package of measures that accompany licensing changes, including the introduction of balancing powers to control premises. Last year, a review of the impact of the Licensing Act in England and Wales was published. This showed that changes to licensing laws have not led to a widespread increase in availability – statistics indicate there are fewer premises licensed to sell alcohol under the new regime than there were ten years ago. Furthermore HM Revenue and Customs data suggests a reduction in the overall level of alcohol consumption since the 2003 Act came into force and this is supported by other data such as the General Household Survey. Although Home Office figures suggest there may have been a slight increase in some incidents in the early hours of the morning, this has been more than offset by reductions of 5% in more serious violent crime and a fall of 3% in less serious wounding in the evening and night time. Similar comments are relevant for modelling statement 54, which is also based on experiences in other countries.	Thank you for your comments. When developing the recommendations the expert committee do consider international evidence. As part of their deliberations the committee does take into account the applicability of this evidence within a UK context.

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Department for Culture Media and Sport			Evidence Statements 3.2 – 3.8 (research)		In relation to the additional research report to the NICE Public Health Programme Development Group published by the University of Sheffield - we note that the NICE commissioned work contains some updated policy modelling (version 2.0) based on the previous work undertaken by the University of Sheffield (ScHARR) in this area - to help assess the effectiveness and cost-effectiveness of public health related strategies and interventions to reduce alcohol attributable harm in England. As we understand it - and from a broad assessment by DCMS - the detail of this work is not new with regard to advertising. There do not appear to be any significant differences between the methodology and results of the ScHARR research work and that presented to NICE. Both reports have considered the same policy options and most importantly both highlight the significant limitations of the current evidence base and the disagreement in the academic research literature on the effect of advertising bans. The earlier Sheffield review indicated substantial uncertainty in the evidence on the potential impact of advertising restrictions and called for further research and this is clearly echoed in the report to NICE. As part of the Government's 2008 alcohol strategy consultation CAP and BCAP were asked by SoS for Culture, Media and Sport to make a full assessment of the DH commissioned research being undertaken by Sheffield University - as part of their wider advertising code review. **Cont below**	Thank you for your comment. The economic modelling work for this guidance is based upon the original work carried out for the Department of Health.

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Department for Culture Media and Sport			Evidence Statements 3.2 – 3.8 (research)		**Cont** CAP and BCAP have also undertaken a comprehensive analysis of the Sheffield findings, as requested by Government. CAP and BCAP extended their public consultation to allow interested parties sufficient time to respond to their analysis. In addition, as part of their code review process, CAP and BCAP will consider all the evidence submitted through their public consultation on the Sheffield research and other pieces of work that have been undertaken in this area before agreeing any final code changes. CAP and BCAP are currently in the process of analysing the consultation responses with a view to publishing their evaluation of each substantive response later this year. CAP and BCAP hope that the revised codes will come into force in the first quarter of 2010. Regulators have consistently set out that they would need to see evidence of alcohol advertising having a direct impact on harmful drinking to merit the more extensive interventions proposed in **Recommendation 3** – these proposed interventions would be disproportionate given the current evidence base. <u>*New media*</u> Recommendation 3 also explores new media marketing issues. Alcohol advertising across new media is already regulated through the CAP Code overseen by the ASA. This includes monitoring of practice. In addition, other marketing issues are covered by the Portman Group Code of Practice. The Portman Group recently published advice on 'Responsible marketing of alcoholic drinks in digital media' - setting out these regulatory regimes to remind industry of the requirements placed on them in relation to new media marketing.	The committee developing the recommendations is composed of a panel of experts from the alcohol field and will use their expertise in interpreting the evidence that has been made available to them. Thank you for your comment. Following the consultation on the guidance amendments have been made to recommendation 3.

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Department for Culture Media and Sport				76	**Economic Analysis** This states that increasing the price is likely to be a cost-effective method of reducing consumption and alcohol-related harm. It should be noted that the evidence showed mixed results, and was not as conclusive as this presents.	The PDG recognised that empirical data alone, even from the best conducted investigation, seldom provides a sufficient basis for making recommendations. This data requires interpretation and analysis, using prior knowledge and understanding and existing models and theories. Therefore, the PDG developed its recommendations using the best available empirical data and inductive and deductive reasoning.
Department of Health			General		It would be helpful to clarify the relationship between Evidence Statement 3 in Part One of the ScHARR report and the further evidence developed through modelling in Part Two using specific UK data to make clearer the strength of the evidence supporting judgements on the cost-effectiveness of price, availability and promotion interventions underlying the draft guidance. This needs to be articulated more clearly for a lay and policy maker audience.	Thank you for your comment. In order to develop the evidence base from which the recommendations are developed NICE commissions our collaborating centres to produce a series of different reviews; an effectiveness review, a cost effectiveness review and where applicable an economic model. For further information on NICE methodology please see www.nice.org.uk/phmethods

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Department of Health			General		We feel that there is little reference to accidents in the document (it briefly acknowledges the association between accidents and alcohol (page 6) for example). We suggest that a general point be made about the clear socioeconomic gradient associated with accidents.	Thank you for your comment. The guidance document does acknowledge the link between alcohol consumption and accidents. The guidance document does acknowledge the socioeconomic gradient in relation to alcohol consumption and harm.
Department of Health			General		Part 1 of the ScHARR report was a systematic review of the international evidence and found that there was limited research internationally on minimum unit price; Part 2 modelled the effects of minimum unit price and general price increases. Particularly for minimum unit price, the Sheffield review has added to the evidence base by modelling the impacts using several UK databases, including industry data, in a way not done before. A clearer summary of the strength of the evidence supporting judgements on the cost-effectiveness of price, availability and promotion interventions would be helpful.	Thank you for your comment. The evidence reviews which supported the development of the guidance are available on the NICE website and appendices B and C of the guidance document highlight the relationship between evidence statements and recommendations. A link to the supporting document is provided within appendix E. For further information on NICE methodology please see www.nice.org.uk/phmethods A link to the supporting document is provided within appendix E.

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Department of Health					It would be helpful if NICE could explain further the reasons why the current UK regulatory and self-regulatory system would or would not sufficiently limit harms from alcohol advertising, based on the evidence. It could also recognise more clearly the dilemma caused by clearer evidence on the harms from advertising and less clear evidence on the effectiveness of policy interventions. As it stands, the recommendation for a ban on advertising seems to stem from gaps in the evidence for lesser interventions, gaps which could potentially be filled. The question of proportionality should be addressed.	Thank you for comment. As a result of the consultation process the committee have revised the recommendations in relation to an advertising ban and the current regulatory system.
Department of Health			(Final paragraph)	6	'35% of all A&E attendances and ambulance costs are alcohol-use disorders" (defined as mental health problems. These include hazardous and harmful drinking).' It would be helpful if you could clarify that 35% of ambulance costs are people who have regularly consumed more than 21/14 units of alcohol a week, or how far this relates to patterns of drinking.	Thank you for your comment. The Interim Analytical Report from which the statistic is quoted states that the costs are alcohol related. The final guidance document reflects this wording.
Department of Health			3.2	9	The estimated range for children affected by parental alcohol misuse in the Strategy Unit's interim analysis was 700,000 – 1.3m. Is the 'approximately 1.3m' figure in the draft guidance from an alternative source?	Thank for your comment the guidance document has been amended appropriately.

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Department of Health			3.3	9	'PDG…believes interventions are likely to improve the overall well being and productivity of the population.' A clearer summary of the ScHARR evidence in this area would be helpful.	Thank you for your comment. The evidence reviews which supported the development of the guidance are available on the NICE website and appendices B and C of the guidance document highlight the relationship between evidence statements and recommendations. A link to the supporting document is provided within appendix E. For further information on NICE methodology please see www.nice.org.uk/phmethods The statement that you refer to is from the considerations section of the document which is derived from the discussions that the PDG have when considering the evidence and draws on their expert knowledge.

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Department of Health			3.4	9 & 10 [Part 1]	Overall, this section is at risk of being misinterpreted and we feel it would benefit from more precision – in the paragraph and in the linked glossary definitions. It references changes in DH terminology. The DH 2007 *Safe Sensible Social* alcohol strategy document defines the term 'harmful drinking' for our DH strategy and our public health policy purposes. It is similar to the definition used by NICE for this document. It was the DH strategy definition of 'harmful' use that was updated with the introduction of the public-facing terminology of lower, increasing and higher risk drinking – after research with the public supported this – not the WHO definition of harmful use. The WHO medical definition of harmful use is an established technical medical diagnostic term. The wording in 3.4 might also be misunderstood to suggest that NICE is using only the WHO diagnostic definition of harmful use when the NICE glossary makes clear that its definition includes not only the WHO diagnostic element but also a unit-based element of 'consumption' (including anyone drinking "in the absence of harm – above 35/50 units a week"). This added element of the definition – of 'risk' linked to consumption level – is clearly important in a useful definition relevant to public health responses, and not just treatment.	Thank you for your comment. Amendments have been made to the guidance document.

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Department of Health			3.4	9 & 10 [Part 2]	The concept of 'hazardous drinking' is itself technically a form of risky behaviour – and not a medical 'alcohol use disorder' but this is not entirely clear, in para 3.4 or in the glossary. In fact, the DH term 'lower risk' drinking has exactly the same meaning as the WHO concept of those drinking below 'hazardous' levels used by NICE here. We would suggest this section and glossary could be more precise on these issues. There is a danger, otherwise, that it may be misinterpreted as suggesting a fundamental discrepancy of approach that does not really exist. Consistent with the messages in this document, we recognise the importance of aiming communications in those drinking excessively to promote reduced consumption to below 'increasing risk'/'hazardous' levels. We also recognise that the public are entitled to be informed that drinkers who drink over 35 units/week (women) and 50 units/week (men) are at particularly high risk of developing harms. We fully support the medical use of established diagnostic categories of harmful use and dependence. And we also recognise that use of 'harmful drinking' here to mean both the ICD10 disorder and the NICE risk category can be entirely justified for their different respective clinical and public health purposes. There is a case for a closeness/familiarity of meaning for clinicians in using 'harmful' for both purposes (harm and risk), which is a key focus of this guidance. But we also consider there is value in using more explicit risk-based less-technical terminology such as 'higher risk drinking' as developed by the Department of Health for communicating the risks to the public. These approaches can clearly exist alongside each other.	Please see previous comment.

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Department of Health			3.7	10	"Making alcohol less affordable appears to be the most effective way… there is sufficient evidence to justify minimum unit price." As noted already, a clearer summary of the strength of the evidence supporting judgements on the cost-effectiveness of price, availability and promotion interventions would be helpful. Some discussion of the interrelation between different policy interventions, if supported by the evidence, would also be helpful.	Thank you for your comment. The evidence reviews which supported the development of the guidance are available on the NICE website and appendices B and C of the guidance document highlight the relationship between evidence statements and recommendations. A link to the supporting document is provided within appendix E. see. www.nice.org.uk/ph24 For further information on NICE methodology please see www.nice.org.uk/phmethods
Department of Health			3.20	13	Last sentence – It is not clear why those with a 'drinking problem' is mentioned here (possibly meaning excessive drinker instead). It does not appear the intention is to suggest that the evidence is strong enough (just from the A&E and primary care research) to support screening and a population level approach for this wider group. But the reference does appear to suggest that brief advice to those 'individuals' identified to be excessive drinkers is being supported by NICE in this wider group. And if so, this could be made more explicit.	Thank you for your comment. The guidance document has been clarified.

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Department of Health				*18*	**Recommendations for policy** 'The Chief Medical Officer should have lead responsibility for co-ordinating the broad approach across Government, supported by the Department of Health.' It should be made clear that this is in relation to the Government's Alcohol Harm Reduction Strategy.	Thank you for your comment. Amendments have been made to the guidance document.
Department of Health			Section 4, recommendation 5	22	'What action should they take?" We suggest that the second bullet includes a specific reference to hard to reach/disadvantaged groups.	Thank you for your comment. Amendments have been made to the guidance document.
Department of Health			Section 4, recommendation 5	22	'What action should they take?' Reference to alcohol services uses incorrect terminology as there are actually no Tier 3 or Tier 4 services. We suggest it could read '…services providing Tier 3 or Tier 4 structured alcohol treatment interventions.'	Thank you for your comment. Amendments have been made to the guidance document.
Department of Health			Section 4, recommendation 7	24	'Who is the target population?' The words 'thought to be' could be removed, as this appears to be clearly aimed at all 16-17 year-olds when feasible, in order to target those who are drinking at hazardous or harmful levels.	Thank you for your comment. The PDG have decided to retain the original wording as the purpose of the recommendation was not to advocate universal assessment.
Department of Health			Section 4, recommendation 8	25	It is not easy to identify in the background evidence statements, the evidence base used for suggesting progressing directly from screening of 16-17-year-olds to 'motivational counselling' and why this might not include structured brief advice before offering motivational counselling. It would be helpful just to make clearer here the thinking of the expert group.	Thank you for your comments. The guidance document has been clarified.

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Department of Health			Section 4, recommendation 9	26	"What action they should take" 2nd para 1st indent before the word 'physical' it might be helpful to insert the word 'relevant' 2nd indent – before the word 'mental health' it might be helpful to insert the word 'relevant'	Thank you for your comment. Amendments have been made to the guidance document.
Department of Health			Section 4, Recommendation 10	Page 28	"Who is the target population?" We suggest that reference be made to the socioeconomic gradient and for the need to target people with hazardous drinking in disadvantaged groups.	Thank you for your comment. The original wording of the recommendations has been retained. However, additional reference to the socioeconomic gradient and the need to help this group has been made elsewhere in the guidance document.
Department of Health			Section 4, Recommendation 11	Page 29	"Who is the target population?" We suggest that reference be made to the socioeconomic gradient and for the need to target people in disadvantaged groups.	Please see previous comment.
Department of Health			9	33	**Glossary – Alcohol use disorders.** As noted above, 'hazardous drinking' is not a medical disorder per se, so this may need slight amending. It is often treated as such in certain contexts because of the use of public health interventions to reduce harm that mirrors interventions used to treat disorders. However, the glossary for such a key document probably needs to be precise. The Babor/WHO manual for AUDIT refers more precisely to hazardous drinking as a form of alcohol 'misuse' rather than a disorder, for example.	Thank you for your comment. The guidance document has been clarified.

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Department of Health			9	35	**Glossary – Harmful drinking**. This NICE definition combines the WHO definition of the 'disorder' of harmful use with an additional measure of consumption. This is quite acceptable but is not clearly reflected in the text of the document – as noted above.	Thank you for your comment. The guidance document has been clarified.
Department of Health			9	35	**Glossary - Motivational Counselling** We would suggest replace the words 'giving them' with the word 'identifying' given that most motivational approaches would help the individual to elicit their own reasons for making changes.	Thank you for your comment. The guidance document has been clarified.
Department of Health			9	35	**Glossary - UK Government drinking Guidelines** The sentence '… are recommended to have some alcohol-free days' is not accurate. Whilst this is commonly recommended for those who have decided they wish to reduce their consumption, the general Government guidance on alcohol-free days has referred to abstinence after a period of heavy drinking.	Thank you for your comment. The guidance document has been clarified.

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Department of Health					Since 1995, Government guidelines have provided advice on drinking in terms of daily limits for regular drinking rather than weekly: The guidelines recommend that • men should not regularly drink more than 3-4 units a day and women should not regularly drink more that 2-3 units a day • Pregnant women or women trying to conceive should avoid drinking alcohol. If they do choose to drink, to minimise the risk to the baby, they should not drink more than one to two units of alcohol once or twice a week and should not get drunk. **Lower-risk** For men: not regularly drinking > 3-4 units per day For women: not regularly drinking > 2-3 units per day **Increasing-risk** For men: regularly exceeding 3-4 units per day – but not drinking at levels incurring the highest risk For women: regularly exceeding 2-3 units per day but not drinking at levels incurring the highest risk **Higher-risk** For men: regularly drinking > 50 units per week (or regularly drinking > 8 units per day) For women: regularly drinking greater than 35 units per week (or regularly drinking > 6 units per day.	Thank you for your comment. The guidance document has been clarified.

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HM Treasury			**Section 4**	Page 19	recommends that alcohol duty should be linked to earnings and inflation. It is worth pointing out to NICE that government policy already links the rates of alcohol duty to inflation. Budget 2008 announced that alcohol duty would increase by 2 per cent above inflation up to and including 2013."	Thank you for comment. As a result of the consultation process the committee have revised the recommendation on price and removed the linking of alcohol duty to inflation and earnings..
IBA – the Voice of British Advertisers			**Alcohol-use disorders: preventing the development of hazardous and harmful drinking: draft**	2	As the UK representative body we would have expected to have been formally consulted about a matter on which we have both specialist knowledge and a representative role. At this late stage we are unable offer a detailed review, we do however include some comments below which should be read in conjunction with comments from the UK Advertising Association, the industry tripartite and our independent regulator the Advertising Standards Authority.	Thank you for your comment. We do try to notify all organisations that may have an interest in a guidance topic. Unfortunately we cannot guarantee to contact all. As such potential stakeholders are strongly encouraged to check regularly the list of public health guidance in development so that they may contribute to the guidance development process. In addition, we also rely on our existing stakeholders to alert others who may have an interest in particular topics and who may not be familiar with our processes.

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IBA – the Voice of British Advertisers			Report scope	2	Clearly alcohol misuse disorders are matters for concern for us as a body and to us and our members as citizens. The alcohol industry supports the Portman Group and the Drink Aware Trust both of which have programmes for addressing alcohol related harm. For a public body , such as NICE, to be recommending interventions outside their normal competency there would have to be demonstrated systematic failure of the recognised bodies and procedures. We fail to see any such evidence in this report.	Thank you for your comment. Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. The aim of NICE public health guidance is make recommendations on what is known from research and practice about the effectiveness and cost effectiveness of interventions and broader programmes that may address the areas set out in the scope document. As such, advertising was felt to be important area that warranted investigation. For further information on NICE methodology please see www.nice.org.uk/phmethods

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IBA – the Voice of British Advertisers			Recommendation 3; Marketing	20	The recommended intervention into the consumer products market, UK business, and social acceptance of drinking alcohol are far reaching. ISBA does not accept that NICE has produced any evidence to support the recommendation. We do however recognise the views expressed in the recommendation as those of campaigners in the media not as the findings of a public body charged with developing evidence based public policy .	Thank you for your comment. The evidence base which supports this guidance document included studies from around the world. The relevant evidence statements are detailed in the appendices and the full reports are available on the NICE website. The members of the committee are experts within the alcohol field and as such are ideally placed to appraise the extensive evidence base and produce evidence based recommendations.
IBA – the Voice of British Advertisers				20	The ban on tobacco advertising is cited as supporting the argument that advertising bans result in reduced consumption, yet we can find no evidence to support this assertion. The ban may have other public goods but that is not the same as a causal relationship.	Thank you for your comment. The guidance document has been clarified.

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Joint Action Group on Alcohol in London			General		The Joint Action Group for Alcohol in London (JAG) was established in January 2009 to deliver London's 'Regional Statement of Priorities for Alcohol'. The group is made up of experts from a range of organisations, including Primary Care Trusts, London Probation, MPS, London boroughs and the voluntary sector. The Greater London Alcohol and Drugs Alliance (GLADA) acts as the Strategic Delivery Board for the JAG. We would be pleased to link the NICE alcohol guidance team up with local agencies, groups or forums. The JAG has held two Alcohol Practitioner's Forums at City Hall this year, one in March on 'Reducing Alcohol Related Harm for Children and Young People', and the second in September on 'Community Engagement and the Night Time Economy'. These forums included presentations on innovative alcohol work from across the country, which can be accessed at www.ldan.org.uk. Both forums were attended by over 80 practitioners from alcohol or related fields, and produced a wide-ranging body of information that is relevant to the current NICE 'Alcohol-use disorders (prevention) draft guidance'. In response to recommendations 1-4 in the draft guidelines, on the price, availability, marketing and licensing of alcohol, I would like to highlight the group work feedback from the workshops on 'managing the night time economy' at the September alcohol practitioner's forum:	Thank you for taking the time to read and comment on the guidance and your helpful offer. We will pass your information to our implementation team. Thank you for your helpful comments and suggestions, these and others below are duly noted. Please note that as a result of the consultation process the committee have made some revisions to recommendations 1 to 4.

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Joint Action Group on Alcohol in London			Section 4 Recommendation 1	19	The practitioners attending the September forum highlighted that licensed shops or premises need to be encouraged to look at more responsible price promotions, for example, cutting down on 'happy hours'. There was a suggestion that supermarkets were a particular concern in relation to slashed prices and easily accessible alcohol.	Thank you, noted.
Joint Action Group on Alcohol in London			Section 4 Recommendation 2	19	Practitioners suggested that overall there was a need for better regulation of high percentage alcohol products and large measures. They felt there was a particular need to engage with nightclubs about reducing alcohol-related harm. Practitioners noted that off sales can create high levels of concern to residents in terms of underage drinking and even allowing people to buy drink on credit. In particular, attendees were keen to see work with off sales to restrict the supply of super strength alcohol.	Thank you, noted.
Joint Action Group on Alcohol in London			Section 4 Recommendation 3	20	Practitioners agreed that there was a need for more responsible advertising for alcohol products, as this does have an influence on consumers, and in particular young people.	Thank you, noted.

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Joint Action Group on Alcohol in London			Section 4 Recommendation 4	21	Practitioners had particular concerns about the licensing of late night food outlets, as these are areas that often generate violence. The attendees also felt that current legislations and enforcement could be used more effectively, for example by issuing fines for premises when anti social behavior or crime and disorder is connected to them. There was also a suggestion that there needs to be more training for the licensing trade and bar staff, including legal requirements and social responsibilities.	Thank you, noted. The recommendations do address issues over the current licensing provisions and the need for enforcement.
Joint Action Group on Alcohol in London			Section 4 Recommendations 6-8	23-25	In response to recommendations 6, 7 and 8 in the draft guidelines, which relate to working with children and young people, I would like to highlight that the JAG has also set up a working group to produce a new pan-London guidance document on young people and alcohol. Feedback from the March alcohol practitioners' forum suggested that there was a need for greater consistency in approach to this issue across London boroughs. There was also a call for a pan-London screening tool for young people to be developed, allowing boroughs to compare results and workers to move between services more easily.	Thank you, noted.

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Joint Action Group on Alcohol in London			Section 4 Recommendations 7	24	With particular relevance to recommendation 7 on alcohol screening, the first JAG working group suggested that screening tools are a useful way to support engagement and initiate conversations with young people. They highlighted that these tools need to be sensitive to different cultures and demographics, and focus on issues that have particular relevance to young people, such as personal safety, body image and peer influence. They stressed the importance of clear guidance to accompany any screening tool to aid consistent implementation.	Thank you, for your comment. This issue was considered by the committee. The committee felt that it was essential that professionals were made aware of these issues but that they should use their professional judgement as to how best to deal with them. .

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Lundbeck			General		We commented during the evidence consultation that the evidence base includes numerous outcome measures for measuring reduction in alcohol consumption. And that we believe it would be helpful if the GDG recommends as part of the public health guidance, a small number of specific validated alcohol consumption measures for use in **future evaluation work**. These clinically validated measures should be able to be used as part of a treatment monitoring strategy in individuals as well as being an assessment tool. A suitable validated outcome measure is for example the 'Timeline Follow Back' method which is one of the most applicable measures for meeting these criteria (Sobell, L. C., and M. B. Sobell, 1992, Timeline follow-back: a technique for assessing self-reported alcohol consumption., in R Littten and J Allen eds., Measuring alcohol consumption: Humana Press). The GDG responded in the stakeholder response table by stating 'Thank you for your comment. When developing their recommendations the committee will identify gaps in the evidence base and make recommendations for research'. We want to clarify that our reference above to 'future evaluation work' was not intended to suggest that there are gaps in the evidence base. The intention was to suggest that the GDG recommend a small number of validated alcohol consumption measures, selected based on the existing evidence base, for guideline users to incorporate into their work on alcohol use disorder management. *(comment continues on next page/)*	Thank you for your comment. As set out in the scope document the aim of this guidance was to assess which tools were the most effective and cost effective at initially identifying those with an alcohol use-disorder. As such the assessment of a small number of validated alcohol consumption measures to determine which are effective and cost effective at monitoring an identified individual's consumption, was outside the scope of this work. However, the committee have noted the potential benefit of biochemical measures in assessing the severity and progress of an established alcohol-related problem within the recommendation You may be interested to note that another piece of NICE guidance is being developed on alcohol dependence. http://guidance.nice.org.uk/CG/Wave17/1 However, if you would like NICE to consider developing guidance on these types of approaches please see the topic referral weblink. Stakeholders can suggest future topics for consideration at http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Lundbeck			General (same point continued)		*(/comment continued from previous page)* Also, this was in the context of the second part of our previous evidence consultation comment i.e. we believe it would be helpful if the GDG recommends as part of the public health guidance, a small number of specific validated alcohol consumption measures which would facilitate overall assessment and evaluation by allowing individual patient level data to be audited to support other national measures for reduction in alcohol consumption (e.g. WHO risk thresholds; World Health Organisation. 2000. International Guide for Monitoring Alcohol Consumption and Related Harm. 2000).	Please see previous comment.

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National Heart Forum			General		The National Heart Forum (NHF) welcomes the opportunity to comment on the NICE consultation on the Public Health draft guidance on 'Alcohol-use disorders: preventing the development of hazardous and harmful drinking' consultation. As an alliance of 60 organisations working to reduce the risk of avoidable chronic diseases including coronary heart disease, stroke, cancer and diabetes, the NHF restricts its comments to those aspects of the public health guidance where we recognise a public health impact. The NHF highly commends NICE on this public health draft guidance aiming to prevent hazardous and harmful drinking of alcohol in particular its recommendations for policy makers and for practice. We believe that these recommendations represent crucial new evidence which should be considered by all stakeholders involved such as government, the industry and the National Health Service (NHS). The views expressed in this submission do not necessarily reflect the views of all individual members of the NHF.	Thank you for taking the time to read through and comment on the guidance document. You may already be aware but other guidance may be of interest: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1 Alcohol Clinical Alcohol use disorders – clinical management http://guidance.nice.org.uk/CG/Wave15/77 School based interventions on alcohol http://guidance.nice.org.uk/PH7 Interventions to reduce substance misuse among vulnerable young people http://guidance.nice.org.uk/PH4

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National Heart Forum			Section 4	Page 16	Population versus individual approach The NHF strongly agrees that both population-level and individual approaches are needed as part of a combined approach to reducing alcohol-related harm that will benefit society as a whole. As a public health expert body, the NHF agrees that population-level approaches will create an environment that supports lower risk drinking preventing alcohol-related harm. Therefore, the NHF strongly supports NICE's recommendation calling for policy changes at a national level.	Thank you for your comments.
National Heart Forum			Section 4	Page 18	Recommendations for policy The NHF agrees that the Chief Medical Officer should have lead responsibility for the coordination of a cross-government and inter-departmental implementation of this public health guidance.	Thank you for your comment.
National Heart Forum			Section 4	Page 19	Recommendation 1: price The NHF supports recommendation 1 to introduce a minimum price per unit which is an effective policy measure helping to tackle irresponsible and harmful drinking patterns.	Thank you.
National Heart Forum			Section 4	Page 19	Recommendation 2: availability The NHF agrees that restricting the 24/7 availability of alcohol by reducing the number of outlets and the days and hours when alcohol can be sold is another effective way of reducing alcohol related harm.	Thank you for your comment.

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National Heart Forum			Section 4	Page 20	Recommendation 3: marketing The NHF agrees with recommendation 3 in particular that exposure to alcohol advertising is associated with the onset of drinking among children and young people as well as increased consumption amongst those who already drink. Therefore we support the suggested action to consider introducing a regulatory system which covers all forms of non-broadcast marketing, including web-based channels for example.	Thank you.
National Heart Forum			Section 4	Page 21	Recommendation 4: licensing We welcome NICE's recommendation with regard to the licensing policy especially the use of local health data (including liver disease, obesity rates and alcohol related A&E attendances) and crime data (including domestic violence) to map the extent of local alcohol-related problems before developing or reviewing a licensing policy. We believe these changes to how licensing policy is developed will help prevent alcohol-related harm.	Thank you for your comments.

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National Heart Forum			Section 4	Page 21 - 30	Recommendations 5 – 12 While the NHF's expertise concentrates on the prevention of chronic diseases, we agree with NICE's recommendation 5 – 12 detailing screening and brief interventions to offer treatment to people at risk of alcohol-related problems and those whose health is being damaged by drinking. Further, we believe that the list of those particularly at risk and therefore for targeted screening and for brief advice should include 16-18 yr olds and adults who are obese as alcohol is a significant source of calories. Overall, we believe that better and adequate resources for screening and brief interventions are needed.	Thank you for comment. Please note that 16 and 17 year olds are covered within recommendations 7 and 8..In terms of those who are obese the recommendations do state that those with a related physical condition are an at-risk group.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			General		Colleagues across County Durham and Darlington and in my role as sexual health and alcohol advisor at DH, we welcome the draft guidance 'Alcohol-use disorders: preventing the development of hazardous and harmful drinking' and is grateful for the opportunity to comment. We also support the submission from Balance – the North East Regional Alcohol Office.	Thank you for taking the time to read through and comment on the guidance document. You may already be aware but other guidance may be of interest: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1 Alcohol Clinical Alcohol use disorders – clinical management http://guidance.nice.org.uk/CG/Wave15/77 Interventions to reduce substance misuse among vulnerable young people http://guidance.nice.org.uk/PH4
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			2 – First Paragraph	5	Please specify if the General Household Survey relates only to adults; it would be useful to include specific information on children and young people too.	Thank you for your comment. Amendments have been made to the guidance document.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			2	6	*In addition, alcohol-use disorders are associated with…domestic violence and aggression.*.The terminology should be altered to domestic abuse as alcohol plays a factor in other forms of domestic abuse including emotional and sexual abuse. Violence and aggression implies it is only physical abuse.	Thank you for this helpful suggestion, we will amend the document where appropriate.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.1	9	We welcome the first statement to frame the considerations that drinking is never without risk.	Thank you.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.2	9	We believe a distinction should be made between the number of children and young people affected by living with parents/guardians who misuse alcohol (Hidden Harm) and the number of children/young people who misuse alcohol themselves. We believe there is some evidence linking the two and could be included within the document.	Thank you for your comment. These statistics were taken directly from the CMO's annual report. Therefore it is not possible to distinguish between the two.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.6	10	We are supportive of the public health approach to addressing alcohol related-harm at a population level.	Thank you.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.7 & 3.8	10	We are very supportive of the approach to introduce minimum pricing per unit and believe these paragraphs should be expanded to include references to success in other countries e.g. Ireland and Australia of the impact of price on health, crime, domestic abuse and rape.	Thank you for your comment. The guidance has been amended to highlight that there is international evidence to support the introduction of a minimum price per unit.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.9	11	We welcome the approach to prevent alcohol being so accessible and available; we believe the guidance should make specific reference to the good practice in Scandinavian countries where there is greater control of alcohol sales through dedicated stores and trained personnel.	Thank you for your comment. The guidance has been amended to highlight the fact that international evidence supports the variations on the licensing regime. The evidence reviews which supported the development of the guidance are available on the NICE website and appendices B and C of the guidance document highlight the relationship between evidence statements and recommendations. A link to the supporting document is provided within appendix E. For further information on NICE methodology please see http://www.nice.org.uk/media/4E9/6A/CPHEMethodsManual.pdf
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.9	11	We believe specific reference should be made regarding the sale of alcohol in petrol stations as an outlet as it gives a contradictory message regarding drink driving.	Thank you for your suggestion. The committee did consider referring to specific types of businesses but felt it was inappropriate to do so.

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Guidance consultation – stakeholder response table
13 October – 10 November 2009

Stakeholder Organisation	Evidence submitted	Document Name & Number	Section Number	Page Number	Comments Please insert each new comment in a new row.	Response Please respond to each comment
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.13	12	Whilst we acknowledge that young people may be drinking in 'unsafe' environments or 'unsupervised' situations – parks and street corners, we would also like to see the recognition of unsafe environments or unsupervised situations also being in homes or friends homes where young people get access to alcohol.	Thank you for your comment. The guidance has been clarified to acknowledge that the two are distinct.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.15	12	We welcome the recognition of the role of parents/guardians in alcohol interventions for young people and that more explicit reference to the family or home environment should be articulated.	Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions within the home environment were outside the scope of this work – the PDG recognises the importance of these on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.16	13	We believe the NICE guidance on 'school based interventions on alcohol' provides a simpler message and one less open to misinterpretation than the CMO guidance included in the national consultation on Children, Young People and Alcohol.	Thank you for your comment. The NICE guidance on 'school based interventions on alcohol' is referenced within the document.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.17	13	We support the approach to extrapolate evidence on brief interventions to 16 and 17 year olds in health and social care settings, in particular for those services working across age ranges e.g. primary care, sexual health services and pharmacies.	Thank you for your comment.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.20	13-14	We would like to see the inclusion of the term statutory and non-statutory provision rather than simply looking at other public services. This would recognise the valuable role that the voluntary and community sector plays in supporting vulnerable individuals and families very often addressing their holistic needs.	Thank you for your comment. The valuable role of community and voluntary sector services has been clarified within the document.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			3.24-3.26	15	We believe specific reference should be made to LGBT communities	Thank you for your comment. The methods and processes for developing public health guidance are based on a set of values and principles which recognise that social differences in the population are linked to patterns of mortality and morbidity. Your reflections on the issues related to alcohol related inequalities are therefore important. In addition NICE (and therefore all its committees) have a duty to comply fully will all legal obligations to promote equality and eliminate unlawful discrimination during the production of its guidance and as such have to formally assess the implications of its recommendations across all population groups prior to final publication.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4 - Recommendation 2	19	As outlined above a specific reference to petrol stations being prevented from selling alcohol would be useful.	Thank you for your suggestion. The committee did consider referring to specific types of businesses but felt it was inappropriate to do so.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4 - Recommendation 2	20	We welcome the inclusion of '*protection of the public's health as part of the licensing objectives'*	Thank you.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4 - Recommendation 3	20	Can we also include music sponsorship as part of the bullet point on banning all forms of alcohol marketing and advertising as this is primarily aimed at young people.	Thank you for your suggestion. As a result the consultation process the PDG has revised the advertising recommendation pertaining to a total advertising ban; as such it is not possible to include this element.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4 - Recommendation 4	21	We would like to see the inclusion of proxy-sales as well as under age sales and sales to people who are intoxicated.	Thank you for this suggestion, the document will be amended appropriately.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4 - Recommendation 6	23	Target Population – if this is a prevention framework should it also include those who are at risk of becoming hazardous and harmful drinkers rather than just those who are 'thought to be' drinking a hazardous or harmful amount?	Thank you for your suggestion. However, the committee felt that the original wording should be retained.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4- Recommendation 7	24	Groups that may be at risk of alcohol related harm – please can you add 'who request contraceptive advice including emergency contraception', 'those who are screened for a sexually transmitted infections' and 'those accessing Termination of Pregnancy Services'	Thank you for your suggestion. As a result the consultation process the PDG has revised the recommendations to include those regularly seeking emergency contraception
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4- Recommendation 9	26	Please also include in the section on NHS professionals routinely carrying out alcohol screening as part of their practice ….managing chronic disease, particularly as part of medicine reviews	Thank you for your suggestion, the document will be amended appropriately.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4-Recommendation 9	26	Screening adults – can we also include those who practice unsafe sex or who are screened for a Sexually Transmitted Infection for NHS professionals too (second bullet point)	Thank you for your suggestion, the document will be amended appropriately.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4-Recommendation 9	26	For non-NHS professionals it would be useful to include those experiencing or at risk of domestic abuse	Thank you for your suggestion, the document will be amended appropriately.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4-Recommendation 10	28	Brief Advice for Adults – reference needs to be made to voluntary, community, public and private sector agencies who are commissioned to deliver a range of health services as these may also be appropriate settings and staff who can deliver brief advice.	Thank you for your comment. The guidance document will be clarified.

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NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			4-Recommendation 12	30	If this is aimed at those aged 10 years and over should the screening thresholds be lowered for the younger age group?	Thank you for your comment. The guidance document has been clarified.
NHS County Durham, NHS Darlington, County Durham Alcohol Harm Reduction Group, Darlington DAAT and the Sexual Health Policy Team (Department of Health)			General		We believe reference should be made to the need for systematic data recording through the Screening Tools in order to gain a better picture of need, ideally this needs to be electronic in order to extract data.	Noted, thank you. The importance of carrying out needs assessment and evaluation has been noted within the guidance document.

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NHS Health Scotland			4	28	There is no mention of Antenatal Care settings as a target population for brief advice in adults in the list provided on page 28. In the supporting evidence documents to the draft guidance there is an acknowledgment that screening for maternal alcohol consumption and referral to necessary treatment is of particular importance in the prevention of foetal alcohol spectrum disorders and that T-ACE and TWEAK were shown to be appropriate in identifying alcohol misuse in pregnant women but beyond that there is nothing specific to this target group in the actual draft guidance. NICE CG62 'Antenatal care: routine care for the healthy pregnant woman' also has no reference to screening and/or brief interventions, its recommendations mainly focus around providing women with information on the safe drinking limits during pregnancy (i.e. to avoid alcohol), the dangers of binge drinking and the need for more research into the effects of alcohol consumption during pregnancy. There is some reference to the effectiveness evidence of' basic information and advice' at first visit to the antenatal clinic but nothing specifically in the any of the recommendations about routine screening and/or BI. Despite a limited evidence base for brief interventions in this setting (as there is with many of the target populations listed on page 28) there is significant plausible theory as to why they could be effective in this setting for not only the mother, but also for the unborn foetus. In Scotland, a national clinical guideline (SIGN 74) was published in 2003 recommending the delivery of ABIs for harmful and hazardous drinkers in primary care and also highlighting the potential for delivery in A&E and Antenatal Care settings. Were Antenatal Care settings considered when drafting the guidance and, if they were, is there a particular reason they were not identified in the target population?	Thank you for your comment. The guidance document has been amended appropriately. Please note that ante natal settings are covered by the reference to health sector professionals. However, specific reference to this setting has been made within the document. Upon reviewing the evidence the committee felt that AUDIT was the most appropriate tool for the assessment of alcohol use disorders, but that professionals should use their judgement when screening certain groups, such as pregnant women. In addition other guidance in development may be of interest: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1 Alcohol Clinical Alcohol use disorders – clinical management http://guidance.nice.org.uk/CG/Wave15/77

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NHS KIRKLEES			General		It is considered positive that a wide range of factors impacting upon alcohol-related harm are addressed, and the need for a cultural shift is identified rather than just focusing on individual behaviour change. However the commitment to address these social norms around alcohol consumption must be addressed at the highest level and require a cross-party agreement to make what will need to be significant, long-term changes.	Thank you for your comment, your concerns are noted.
NHS KIRKLEES			General		Although acknowledged as not necessarily an issue for NICE, there are clearly cost-implications for many of the recommendations whether in terms of actual costs or in-kind costs. In these times of decreasing budgets there is an ever-increasing need to be able to demonstrate the cost-effectiveness & cost-benefit of the various activities. Will such supporting information be made available?	Thank you for your comment. All NICE guidance considers the cost effectiveness and cost benefits when recommendations are drafted. The reviews and modelling reports may be found on the NICE website and a link to the supporting documents is provided within appendix E. NICE also produces a series of costing tools that may be of interest to your organisation, these will be made available following publication of the guidance.

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NHS KIRKLEES			General		There is limited reference to parents/carers & friends/peers- it is strongly felt that there is a need to highlight the impact that they have, their roles, & their influence over children & young people's drinking attitudes, expectations & behaviours. There is a need to more effectively educate/inform parents/carers as well as young people generally around responsible drinking. (as per Joseph Rowntree Foundation report Nov 2009).	Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions specially aiming to address the social influences were not included in the review work – the PDG recognises the importance of these influences on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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NHS KIRKLEES			General		Whilst the draft document considers the impact of the marketing activity of the alcohol industry there is a gap around the marketing/social marketing of sensible/safer/responsible drinking messages which is clearly an issue which needs to be addressed- is this something that NICE will comment on?	Please see previous comment
NHS KIRKLEES			General		Suggest support for the original proposed mandatory code of practice for licensed retails – which covers price, promotion & availability. For example, prevention of loss-leading wine/beer promotions; availability of smaller (125ml) wine glasses; mandatory training for all involved in the selling of alcohol; improved labelling on all alcohol – consider including risks as with tobacco; enforcement of proof of age schemes;	Thank you for your comment. The committee have made reference to the mandatory code within the guidance document.
NHS KIRKLEES			1 Price	19	Significant research has been undertaken to evidence the positive impact of increasing price on reducing consumption levels (SHAAP 2007, BMA 2008). Given the strength of this evidence we support the recommendations around pricing, & wonder if they could go further, including not only minimum price per unit but also increases in alcohol excise/taxation- with a subsequent commitment to utilising the resulting funding to support the social & economic costs of alcohol.	x Thank you for your comment. As a result the consultation process the PDG have made some revisions to the recommendations. However based on the evidence the PDG did not feel they could go further.

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NHS KIRKLEES			2 Availability & 4 Licensing	19, 21	Consider review & regulation of 24hr alcohol delivery services.	Thank you for your comment. Any review of the licensing legislation, as detailed in recommendation 2, may include this aspect.
NHS KIRKLEES			3 Marketing	20	Both the BMA (2009) "Under the Influence- the damaging effect of alcohol marketing on young people" & Joseph Rowntree Foundation (2009) " Influences on how children & young people learn about and behave towards alcohol" highlight the significant impact that all forms of alcohol marketing/advertising (direct, indirect, sponsorship, & new media such as social networking sites & viral campaigns) have on young people's attitudes, perceptions & expectations around alcohol. It is felt therefore that the proposed recommendations around marketing & advertising could be stronger. Given the vast promotional campaigns within the UK alcohol industry – approx £800million annually, there is clearly disparity between this and the amount spent on promoting safer, more responsible drinking targeting specific population groups/types of drinker; and ensuring the effectiveness of these through thorough & robust evaluation.	Thank you for your comment, your concerns are duly noted. Following the consultation on the guidance the advertising recommendations have been amended. The committee did not feel that the recommendations should be strengthened in this instance.

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NHS KIRKLEES			4 Licensing	21	Consideration should be given to where alcohol may by displayed, and the type of alcohol which may be displayed, e.g. cheap alcohol stacked up in shop (e.g. newsagent) windows, also consider explicit reference to proxy purchases	Thank you for your suggestions. This recommendation has focussed on the current provisions of the licensing act and the awarding and enforcement of licenses. As such it is not possible to comment on how the alcohol is displayed.
NHS KIRKLEES			5 Resources for screening & brief interventions; 7 screening for young people; 8 motivational counselling for young people	21,24, 25	Whilst the limited evidence of effectiveness of brief interventions for children & young people is noted, the document then goes on to extrapolate that structured brief intervention and motivational counselling are the way forward for 16+. We feel that there is a need to stress that tools are adapted where possible so that questions, information discussed & provided are more relevant to the age-group, and that it's clear that some motivational approaches probably work better with young people than others – e.g. solution-focused approaches.	Thank you for your comment and your concerns are noted. The PDG debated this issue at length considering the lack of effectiveness evidence you rightly highlight and the particular risks for this group. The guidance does highlight the need to ensure that when dealing with young people the interventions are sensitive to their needs. Given the lack of research in this area it was also felt that a recommendation for robust research should be made in this area.

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NHS KIRKLEES			5 Resources for screening & brief interventions; 7 screening for young people; 8 motivational counselling for young people; 9 screening adults; 10 brief advice adults; 11 motivational counselling adults.	21,24, 25, 26, 28, 29	Whilst we welcome a commitment to, & belief in, the roll-out of screening/identification, brief advice, & motivational counselling/brief intervention, we feel it would be useful to provide an outline or list of suggested staff groups or roles that are best placed to undertake this kind of activity (especially for non-NHS staff groups). Alcohol screening, advice & counselling is not necessarily something that all staff groups could or should be undertaking.	Thank you for your comment and your concerns. The PDG did not feel it was necessary to be too prescriptive as to the type of professional that should be delivering screening and brief interventions. However as detailed within document interventions should be carried out by appropriately trained staff and resources should be made available for this training.
NHS KIRKLEES			7 Screening for young people	24	Consider the need for pre-CAF checklist/ CAF albeit for 16-17 year olds	Thank you for your helpful suggestion. It was considered by the committee, but they did not feel it appropriate for this age group.

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NHS KIRKLEES			10 Brief advice adults & 11 Motivational counselling adults	28, 29	Concern around the capacity of existing services to manage the workload, given the high number of adults that could potentially be in need of brief advice &/or motivational counselling.	Thank you, your concern is noted and this point addressed within the guidance document. All of recommendations are made with due consideration to effectiveness and cost effectiveness. Implementing the recommendations will reduce harm in the long term.
NHS KIRKLEES			12 Referral	30	Emphasise the need for pre-CAF checklist/ CAF – it would be very concerning if 10-13 yr was alcohol dependent & would struggle to see a situation where using a pre CAF checklist wouldn't be appropriate.	Thank you for your comment. The guidance document has been clarified following the consultation process in relation to CAF.

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NHS Leeds			1 Price	19	We would totally endorse minimum unit price as the key action – but if this were to prove politically difficult, then the next best option might be to link taxation to alcohol content. At present low or none alcoholic beer carries the same rate of tax as premium beers. This move would encourage both production and consumption of lower strength drinks. Also the tax break should be removed from Cider industry – especially in the case of white cider, which probably should not even be classified as cider, and which causes particular harm amongst young people and dependant street drinkers.	Thank you for your comments.
NHS Leeds			2 Availability	20	We would particularly endorse the proposal for a fifth licensing objective – To protect the public health. This would give far greater potential scope to restrict the number and type of licence, which is beyond the scope of the current public disorder related objectives.	Thank you for your comments.

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NHS Leeds			3 Marketing	20	▪ Whilst we would endorse the long term aim to remove alcohol advertising, this is unrealistic in the short term due to the fact that it would not just impact on the alcohol industry, but also the advertising industry together with sports and culture which derive so much of their current income from alcohol. A sensible staging post would be to introduce a watershed ban on TV advertising. Alcohol Concern research 2006 showed a spike in alcohol adverts shown from 3pm to 5pm - the time when most children return from school. The 5% audience limit for children under 18 seems a very blunt instrument when millions of children might be watching a programme such as X Factor, though they might be below the percentage threshold. The same could be true for cinema advertising. ▪ We would support an 'end-frame' of alcohol health information comprising one sixth of air time or press space attached to all alcohol advertising. To have no warning or health messages within alcohol adverts is at odds with the harm alcohol causes.	Thank you for comment. As a result the consultation process the PDG have made some revisions to the advertising recommendation. The PDG did not believe it appropriate at this time to recommend the introduction of "end frame" health information or the introduction of a watershed.

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NHS Leeds			4	21	▪ It is easy to state that we will prevent sales to people who are intoxicated – but this law is completely ignored – and if it were enforced – nearly all night time licensees would be liable to prosecution. There needs to be practical discussion about how this law can me made to be enforceable before it can be enforced. ▪ Test purchasing needs to take place in the 'real world', where children are allowed to lie about their age, and electronic recording devices can be used in court as evidence rather than needing an adult to be present – who might act as a warning sign to vendor.	Thank you for your comments, your concerns are duly noted. However, the committee felt it necessary to reinforce the current provisions of the Licensing Act.
NHS Leeds			5	21	▪ This advice sits strangely a long way away from Rec. 10 ▪ Resource allocation for treatment provision has been a major problem in recent years, and has to compete against other drug treatment provision. Local commissioners should have freedom to balance provision far all substance treatment services. ▪ Validated screening tools are specified in other sections – why not here? ▪ Amongst those who should take action – the police should be included here.	Thank you for your comments. The aim of this recommendation is to ensure appropriate levels of investment within NHS commissioned alcohol services. The recommendation has been clarified in respect to screening questionnaires.

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NHS Leeds			8	27	We endorse the need to revise Audit scores downwards for over 65s – but there is need for specified national advice on what these levels should be.	Thank you for your comment. There is limited evidence on what level the scores should be revised to. As such the committee felt that professionals should use their judgement when screening this age group.
NHS Leeds			11	30	Agencies for referral for specialist treatment should include AA and AlAnon. In practice AA supports far larger numbers than all other services put together, but they are often missing from the picture presented by statutory services. AlAnon could potentially provide far greater support than it does for families of dependant drinkers, but awareness is very low among professionals and the public. Consideration should be given for how these groups can be encouraged, supported and promoted more widely.	Thank you for your comments and suggestion. Comment on which specific services dependent drinkers should be referred to is outside the scope of this guidance. Please see: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1
North Somerset Community Safety Drug Action Team			Recommendation 1	19	A minimum price should be introduced in conjunction with a progressive taxation (duty) policy. Policies to limit demand will be more effective than targeting supply.	Thank you for your comment. Following consultation the recommendations have been amended in terms of regularly reviewing alcohol duties.

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North Somerset Community Safety Drug Action Team			Recommendation 1	19	This should target young people, binge drinkers and harmful drinkers.	Thank you for your comment, we note your concerns. The PDG debated this issue at length and considered that minimum price per unit would effectively impact this group as a matter of course.
North Somerset Community Safety Drug Action Team			Recommendation 1	19	Minimum price per unit to be not less than 40p.	Thank you for your comment. The committee only considered the effectiveness of a minimum pricing policy, they did not consider at what level any minimum price should be set at.
North Somerset Community Safety Drug Action Team			Recommendation 1	19	Duty should be raised above earnings/inflation as a means of restricting demand.	Thank you for comment. As a result the consultation process the PDG have revised the point relating to inflation and earnings. In this instance the PDG did not feel that duty should be raised above inflation and earnings.
North Somerset Community Safety Drug Action Team			Recommendation 10	28	The funding issue is key. I agree with the action to be taken, the difficulty is funding it.	Noted, thank you.
North Somerset Community Safety Drug Action Team			Recommendation 11	29	The funding issue is key. I agree with the action to be taken, the difficulty is funding it.	Noted, thank you.
North Somerset Community Safety Drug Action Team			Recommendation 2	19	Alcohol is an addictive substance. Restricting outlets through licensing may not stop people who are determined to buy alcohol.	Thank you for your comment, your concern is noted.

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North Somerset Community Safety Drug Action Team			Recommendation 2	19	There might be a legal challenge if outlets are excluded when licenses are granted. It would be difficult to establish criteria that reduced competition in an area.	Thank you for your comment.
North Somerset Community Safety Drug Action Team			Recommendation 2	20	Enhanced powers to licensing departments would assist in tackling those outlets that fail to comply.	Noted, thank you
North Somerset Community Safety Drug Action Team			Recommendation 2	20	Without the resources to police borders to prevent illegal drugs entering the country, is there not a danger that cutting allowances could increase alcohol smuggling and increase the black market trade?	Thank you for your comment. The committee did discuss this issue and have made reference to it within the document.
North Somerset Community Safety Drug Action Team			Recommendation 3	20	Tobacco wasn't linked with active sports such as Football and Rugby prior to the advertising ban. Football and Rugby enjoy extensive youth participation, which encourages fitness and avoidance of anti social behaviour and crime. There would need to be a cost benefit analysis where the Sport in question provides social benefits from the Alcohol advertising.	Thank you for comment. As a result the consultation process the PDG have made some revisions to the recommendations.
North Somerset Community Safety Drug Action Team			Recommendation 3	20	Broadly in favour of media bans not withstanding comments above about active sports and social impact.	Your concerns noted, thank you.
North Somerset Community Safety Drug Action Team			Recommendation 4	21	Unsure how feasible it is to remove licenses once issued in order to restrict licensed premises in an area.	Thank you for your comment. The guidance document has been clarified.
North Somerset Community Safety Drug Action Team			Recommendation 4	21	Licensing currently dealt with by local authority that face severe budget pressures. Ensuring sufficient resources may be difficult.	Noted, thank you.

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North Somerset Community Safety Drug Action Team			Recommendation 5	22	Without designated national funding there aren't the resources to deliver the required treatment. We are keen to deliver more treatment but resources aren't available. The Drug treatment funding model should be replicated for Alcohol.	Thank you for your comments, The issue of limited resources has been addressed within the guidance document.
Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust			1.1 Glossary	13, line 26	Alcohol Dependence – Withdrawal symptoms need to be added as a key indicator for diagnosing dependence under ICD10 or DSMIV in addition to the ones mentioned.	Thank you for taking the time to read and commenting on the guidance. We note your concerns and this was considered by the PDG. It was felt that any diagnosis would be best made by professionals with particular expertise. The aim of this guidance is not diagnose dependence but to identify those who may be dependent. The diagnosis of dependence is to be covered by additional NICE guideline which is currently under development Please see: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1

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Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust			1.1 Glossary	14, line 18	Brief Advice or Counseling – 'Brief Interventions (which I believe this is trying to describe)' is a recognized evidence-based psychotherapy for the treatment of addictive behaviors and as such shouldn't be referred to as 'Brief Advice'. Carrying out 'Brief Interventions' would also usually require some level of training in this form of psychotherapy.	Thank you for your comment. The guidance document does set out the need for individuals to be trained. Following consultation the guidance document has been clarified.
Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust			1.1 Glossary	16, line 4	Could be made clearer 'A state of functional impairment, in this case caused by Alcohol'. Obviously intoxication can happen with number substances so it needs to be clear not to suggest this term just applies to Alcohol.	Thank you for your comment. However, please note that there was no such reference within the public health guidance document that was consulted upon.
Oxfordshire & Buckinghamshire Mental Health NHS Foundation Trust			1.1 Glossary	17, line 25	Better wording inclusive of all aspects of common treatment methods would be: "a program designed to: assess, minimize harm, reduce or stop alcohol misuse or dependence, and or related problems."	Thank you for your comment. However, please note that there was no such reference within the public health guidance document that was consulted upon.

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Quaker Action on Alcohol and Drugs (QAAD)			Section 3.5, recommendations 1-2	Page 19	We agree with the PDG's cogent summary of the evidence relating to price and availability. We strongly support all its recommendations relating to price and availability, and all the actions it suggests. A minimum price per unit of alcohol is the only effective method of tackling the problems of over consumption and misuse. There is strong likelihood of displacement to other cheap beverages if partial measures are adopted. A harm-indexed method of pricing across all beverages is necessary if regular consumption over health guidelines is to be tackled. Current figures suggest that numbers so affected are around 10 million. We believe it is particularly critical for the law to be amended to include a public health objective in decisions relating to licensing and outlets. This enables effective decisions to limit harm that are locally sensitive. It also places the availability of alcohol in its proper policy context as a health issue, rather than centering it in DCMS and crime and disorder agendas.	Thank you for taking the time to read and comment on the guidance. .

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Quaker Action on Alcohol and Drugs (QAAD)			Section 3.11.	Page 20	We strongly agree with Recommendation 4 as regards limitations on alcohol advertising. However, we would go further and endorse Alcohol Concern's proposal that pre-watershed advertising of alcohol no longer take place on television. We believe the associative evidence between children's recognition of advertising and use is sufficiently strong to take a precautionary approach.	Thank you for your comment. Following the consultation process the advertising recommendation has been revised. The PDG did not believe it appropriate at this time to recommend the introduction of a watershed.
Quaker Action on Alcohol and Drugs (QAAD)				Page 21	We agree with both the recommended and the actions on the conditions for licensing. We further agree that policies relating to preventing under-age sales need to be appropriately resourced if they are to be successful.	Thank you for your comment.
Quaker Action on Alcohol and Drugs (QAAD)				Page 21-22	We agree with these recommendations regarding interventions at all tiers of need. Given the extent of under-assessment and unmet need at present, resourcing will once again be an issue. We would recommend that benchmarking and progress towards goals be part of the commission plan. We would also recommend ring-fenced and/or priming funding, given that alcohol tends to be subordinated to other health needs.	Thank you for your comments and suggestions.
Quaker Action on Alcohol and Drugs (QAAD)				Page 22-23	We agree with the recommendations for support to 10-15 year olds. We are aware of a paucity of specialist provision for children with high needs and would like to see piloting work developed to support this vulnerable group.	Thank you.
Quaker Action on Alcohol and Drugs (QAAD)				Page 23	We welcome the recommendations 7 and 8 for screening and appropriate support for 16-17 year olds.	Thank you.

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Quaker Action on Alcohol and Drugs (QAAD)			Recommendations 10-12	Pages 28-30	We support the recommendations and actions suggested for adults as regards brief interventions and access to treatment. We concur with the evidence adduced relating to A and E, specifically that other targets (such as maximum throughput/waiting times are counter-incentives to the investigation and addressing of need, even through the use of brief interventions. This can also occur in GP or generic social care settings. As regards A and E we would like to see a dedicated nurse at times of high demand. We are also aware that in some NHS services, drinkers with an explosive/binge/intermittent pattern are held in waiting lists while those with more obvious immediate needs, i.e. physical withdrawal, are prioritised. As the former group includes many of those who present at A and E with heavily advanced liver failure, we would suggest they should have equal priority. Even though they may be seen as having some modicum of control, their medical needs are as serious. The stepped approach of Recommendation 11 for motivational counselling and follow-up is welcome.	Thank you for your comments.

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Royal College of Nursing			General	General	With a membership of over 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. The RCN welcomes this programme guidance. It is comprehensive.	Thank you.
Royal College of Nursing			General	General	We broadly support the recommendations around alcohol affecting crime and imprisonment. We agree that alcohol use disorder affects not only the health and well being of the individual but the wider society through the crime associated with it. The effects are felt by nurses in most settings, particularly in emergency care settings, prison and custody settings, these nurses all have to deal with effects of high alcohol consumption.	Thank you.

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Royal College of Nursing			General	General	The effects of alcohol misuse in the workplace should be taken into consideration. The majority of people with early alcohol misuse problems are in employment. This also affects nurses working in occupational health. They have to deal with the effects of alcohol misuse in the workplace - absenteeism, poor performance and attendance, which puts additional pressure on colleagues to take on more work whilst providing cover. This in turn causes those left to do the work to become stressed and tired.	Thank you for your comment. When considering the evidence the committee did consider the workplace setting. However, it was felt that the settings detailed within the recommendations would adequately address alcohol related harm.

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Royal College of Nursing			General	General	The RCN is a member of the Alcohol Health Alliance (AHA) UK who will be responding separately to this guidance. The RCN supports the AHA's response particularly with respect to the following: • The need for a population versus individual approach to reducing consumption of alcohol and also harm associated with alcohol misuse • The need for policy change at a national level that is coordinated across government departments • That there is now strong evidence pointing to the impact that a minimum price per unit for alcohol would have on consumption levels • The need to address irresponsible promotions and selling practices through a national mandatory retailing code • The need to introduce changes to how licensing policy is developed - Specifically introducing a public health objective into the licensing act as has been demonstrated in Scotland • Better resources for screening and brief interventions	Thank you, your comments are noted.

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Royal College of Paediatrics and Child Health			Appendix D – Evidence tables	77	The College notes that there is almost no evidence available on the incidence of babies affected by alcohol in pregnancy.	Thank you for your comment. The effect of alcohol on the developing foetus was outside the scope of this current guidance. Please see: Ante natal care guideline http://guidance.nice.org.uk/CG62
Royal College of Paediatrics and Child Health			Draft guidance - Recommendation 6: supporting children	23	The College notes that young people who drink may be unlikely to want to attend a specialist CAMHS service or specialist drug and alcohol misuse service. A Common Assessment Framework (CAF) meeting may be a useful way of sharing concerns with other involved professionals, but does not necessarily achieve much on its own. Interventions by the professional who first comes into contact with the young person concerned may be beneficial; however, it is far from clear what interventions are likely to be effective for this age group: We were hoping that this guideline would tell us, but it doesn't. For instance, does FRAMES-type advice work in this age-group? It is possible that simple education about the effects of alcohol might help, but it might simply make the young person want to stop listening. It is also possible that some front-line professionals could learn some motivational interviewing techniques (see next comment).	Thank you for your comment. The PDG debated these issues at length, unfortunately there is little or no effectiveness evidence of benefits for particular interventions either alone or in comparison for this particular group. Research recommendations have been made and adjustments to the guidance were made where appropriate.

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Royal College of Paediatrics and Child Health			Draft guidance - Recommendation 8: motivational counselling with young people	25	The dilemma here is that a young person is likely to accept referral to a specialist service only if he or she is motivated, and is likely to be motivated only if he or she receives some help to enhance his or her desire to change. One possible way out of this dilemma might be for front-line professionals to receive training in motivational interviewing techniques.	Thank you for comment. The recommendations do state that where there is a need professional's should receive the appropriate training.
Royal College of Paediatrics and Child Health			Draft guidance - Recommendation 9: screening adults	26	The College notes that the guidance makes no mention of screening pregnant women who are making contact with health services. Fetal alcohol spectrum disorder occurring as a result of exposure to alcohol during pregnancy is a theoretically preventable condition. The impact on the baby is for life, and can result in increased demands for health and social care services. The "booking" visit early in pregnancy allows an opportunity for screening which has been well-validated, and an opportunity for intervention at an early stage to reduce/stop alcohol consumption.	Thank you for comment. As a result of the consultation process the committee have made some revisions to the recommendation on screening to include ante natal appointments

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Royal College of Physicians/British Society of Gastroenterology			General – Introduction		The Royal College of Physicians and the British Society of Gastroenterology are grateful for the opportunity to comment on the draft guideline.	Thank you for taking the time to read and comment on the guidance. Two other pieces of work underway at NICE may be of interest. Please see: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1 Alcohol Clinical Alcohol use disorders – clinical management http://guidance.nice.org.uk/CG/Wave15/77
Royal College of Physicians/British Society of Gastroenterology			2 Public health need and practice	Section 3.1 Page 9	We support overall the approach taken by the PDG in proposing a broad package of measures that are aimed at improving the population as a whole. While it is important to target interventions at groups with particular problems an evidence alcohol based policy should aim to lower total alcohol consumption as a whole. Therefore reducing alcohol related harm in the long-term requires a comprehensive approach.	Thank you for your comment, noted.

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Royal College of Physicians/British Society of Gastroenterology				Section 3.5 Page 10 Page 18	We support the PDG's view that there is now consistent evidence to support population level approaches to preventing alcohol related harm. Consumption data confirms that excessive drinking is not limited to a particular social group but is widely spread across the whole of society. We fully agree with the recommendation that the Chief Medical Officer and Department of Health lead on alcohol policy across all Government Departments.	Thank you for your comment.

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 1 - Page 19	We absolutely agree with the PDG's recommendation that making alcohol less affordable is one of the most effective ways of reducing alcohol related harm, in particular the introduction of a minimum unit price and to increase alcohol duty with a link to inflation and earnings Evidence shows that alcohol responds to price increases like most consumer goods on the market, i.e. when other factors remain constant an increase in the price of alcohol generally leads to a decrease in consumption. [7] Alcoholic drinks in the UK have become much more affordable in recent years. In Britain, alcohol consumption rose by 121% between 1950 and 2000[8] and from 9.5 to 11.5 litres of pure alcohol per adult between 1987 and 2007[9] so that the average consumption for every person over age 15 is now 22 units (of 8 gram) per week. What the evidence also demonstrates is that changes in *per capita* consumption are reflected in changes in harm. In other words, the more alcohol a nation consumes, the greater the burden of harm it will experience and vice versa.	Thank you for your comment.

[7] World Health Organisations (2007) Second Report of the Expert Committee on Problems related to Alcohol Consumption' Technical Report Series 944
[8] Alcohol Harm Reduction Strategy for England. Cabinet Office Strategy Unit 2004
[9] HM Revenue and Customs (2008) Alcohol Factsheet http://www.uktradeinfo.com/index.cfm?task=factalcohol

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Royal College of Physicians/British Society of Gastroenterology					Given that the Sheffield Report[10] commissioned by the Department of Health was specifically precluded from addressing issues of alcohol duty and taxation it may be helpful for NICE to specifically commission some modelling in this area including effects not only on health but also on crime	Thank you for your comment. Unfortunately, due to limitations of time and resources it is not possible at this stage to commission additional economic modelling work. However the committee did consider issues of taxation and whilst not formally part of the recommendations it has been commented on within the considerations.

[10] Meier P, et al. The independent review of the effects of alcohol pricing and promotion. Summary of evidence to accompany report on phase 1: Systematic Reviews. School of Health and Related Research , University of Sheffield, UK June 2008; 2008

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 2 - Page 19	We fully support the PDG's view that licensing decisions and policy should take account of public health, specifically: We are in favour of inserting an amendment to the current licensing act that would require licensing authorities in the course of managing their night time economies, to also take account of the levels of alcohol-related morbidity and mortality in their communities. Our view is that this would add substantial momentum to efforts to reduce these harms and redress an existing imbalance within the alcohol policy agenda. Assuming they would base their decisions on robust local health data a public health objective essentially would allow local authorities to judge the impact of the on and off-trades on local residents' health, and therefore provide them with a legal opportunity to maintain license levels (outlets and hours) steady, as well as provide an additional lever where crime and disorder concerns are difficult to link to particular venues. Much of the legal framework to effect this already exists. As it stands, a local authority can, using the powers in the Act, create 'saturation zones' in areas where the concentration of licensed premises is understood to be leading to problems (of crime and disorder). Once a zone is declared, although people can apply to open new premises, the assumption is that no new licences will be granted in that area.[11]	Thank you for your comments.

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 3 pg 20	We agree with the PDG's assessment that the evidence base for the effect of alcohol advertising on consumption among adults is still limited. However the evidence base for the impact on children and young people's consumption is more developed. On this basis we believe that there are a number of immediate steps that can be taken that to protect young people that should be considered: ▪ The introduction of an 'end-frame' of alcohol health information comprising one-sixth of air time or press space attached to all alcohol advertising. ▪ A ban on alcohol advertising (either branded or supermarket) from 6am through to 9pm regardless of the predicted age of audience of a programme. ▪ A major review of the voluntary broadcast advertising code to better protect young people.	Thank you for comment. As a result of the consultation process the committee have made some revisions to the recommendations. The PDG did not believe it appropriate at this time to recommend the introduction of "end frame" health information or the introduction of a watershed.

[11] Alcohol Concern (2008) *Licensing Act 2003: A Lopsided Policy*. London:: Alcohol Concern

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 4 – Page 21	The sale of alcohol in England and Wales is currently governed by a substantial complex of laws, voluntary codes and guidelines. However, despite the proliferation of new rules and penalties (especially over the past decade), the proportion of alcohol related violent crime, as a subset of total violent crime has remained steady. The reasons for this are two-fold First, the Government has failed to provide local areas with sufficient resources or guidance to effectively tackle problem licensees using their considerable powers under the 2003 Licensing Act. For example, The Act empowers local authorities to compel licensees to adopt specific harm reduction measures when it is apparent that poor practice is evident. Secondly, new evidence has come to light suggesting that the industry-led voluntary codes that are meant to support the statutory framework are also failing to make an impact.[12] We believe that the PDG should highlight the importance of Home Office's current proposals for a national mandatory code for alcohol retailing that would tackle irresponsible promotions and retailing practices and give greater power to licensing authorities to initiate reviews and possibly give them powers to act against clusters of problem venues.	Thank you for your comment. The committee has noted the importance of the proposed mandatory code within the guidance document.

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 4 pg. 21	We believe that licensing authorities should have access to a nationally standardized collection of A&E, ambulance, hospital admissions and treatment data. This would allow local authorities the power to refuse additional licenses or extensions if local alcohol-related health harms were increasing or a matter of significant concern. We also believe that there are local partnerships that could be put in place to aid this. The recommendation around licensing has missed the importance of sharing of emergency department data about the location of assault with the police and licensing authorities. This is a low cost intervention with a reasonable evidence base . This is very effective at reducing alcohol related assaults. This is an important area as the police never know more than about a quarter of all assaults that need hospital treatment.	Thank you for your comment. Within the guidance document the PDG have commented on the importance of using appropriate emergency data within the limits of the current licensing provisions; and the potential benefit of widening the scope of health data that could be used in awarding licenses.

[12] KPMG (2008) *Review of the Social Responsibility Standards for the production and sale of Alcoholic Drinks*. London: Home Office [Accessed 01st June 2009: http://drugs.homeoffice.gov.uk/publication-search/alcohol/alcohol-industry-responsibility/alcohol-industry-vol-1?view=Binary]

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 5 pg 21	We fully support the recommendation that there should be better resources for brief screening and brief interventions. In particular we urge the PDG to recommend: That every acute hospital (i.e. with an A&E) should have a nominated Lead Consultant for combating Alcohol Misuse with 5 Programmed Activity (20 hours) allocated for this role. That every acute hospital should have two Alcohol Nurse Specialist (to cover extended hours – remembering problems of alcohol misuse are worse in the evenings and at week-ends). That clinicians working across primary and secondary care are properly trained about how to use early identification toolkits to assess levels of consumption and harm and utilize brief interventions which are a quick and effective means of engaging with large numbers of drinkers who are not dependent, but are still harming their health. The generally accepted verdict on brief intervention is that it has the numbers needed to treat of around 8 suggesting a 15% harm reduction but it is possible that effects diffuse into the community promoting a deeper cultural behavioural change. The detection of a problem in primary care has implications for Tiers 1-4 care, therefore resources must be provided for Tier 3 (Community Alcohol Team) and Tier 4 (Hospital care) to ensure seamless care.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to resources, training and dedicated alcohol leads.

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Royal College of Physicians/British Society of Gastroenterology					Alcohol screening and brief psychological interventions supported by alcohol nurse specialists have also been shown to be clinically effective and cost effective in reducing unscheduled alcohol related re-attendance in A&E The group may also wish to consider modelling the degree of harm reduction that could be achieved were these recommendations to be fully implemented	Thank you for your comment. Unfortunately it is not possible at this stage of development to commission additional economic modelling work.

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 6 - Page 23	There is currently no mention of the involvement of parents with young children who are thought to be drinking hazardously or harmfully and it may also be helpful to have recommendations to assist in dealing with children harmed by drinking within the family. Under what action should be taken the second bullet point. We believe that they should add in individuals who request an screen for sexually transmitted infections or seek sexual health advice or practice unprotected sexual intercourse.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to parental involvement. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions specially aimed at dealing with children harmed by drinking within the family were not included in the review work – the PDG recognises the importance of this and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 9 – Page 26	We feel that the groups that have been identified should also include patients who have been assaulted and those that attend for sexual health advice, requests a screen for sexually transmitted infections or practice unprotected sex The third bullet point – practice unsafe sex we suggest this should be changed to: - practice unprotected sex	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to those who are at risk.
Royal College of Physicians/British Society of Gastroenterology					Older people. There is very little discussion on the detection and treatment of alcohol misuse in older people. It is prevalent in up to 10% of hospital in-patients, and 50% of older patients in nursing homes. The MAST-G questionnaire can be used and the role of carers in detecting alcohol misuse should be discussed. Alcohol care should be introduced into the National Service Framework for Older People. Older people with late onset alcohol misuse can respond well to brief interventions.	Thank you for your comment. The PDG recognise that alcohol use disorders are a potential problem within many different groups. As such the recommendations are applicable to everyone aged 10 years and over and recommend the uptake of brief interventions within social care. In addition the recommendations acknowledge the need for professionals to use their professional judgement when dealing with certain at risk groups including older people. However, the committee believe that AUDIT should be used wherever possible.

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Royal College of Physicians/British Society of Gastroenterology				Recommendation 10 – Page 28	We think that the use of the AUDIT here cannot be too exclusive, this scale is rarely used in emergency departments as it is too long. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline. We think that 'hazardous drinkers' should receive a brief intervention from a trained alcohol specialist. It has been found, through experience the experiences of our members that, that trained alcohol specialists in secondary care are more effective when supported by a Consultant and the discussion needs to reflect this.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to the target groups. Thank you for your comment. The recommendations do state that brief interventions should be delivered by those who have received the necessary training.
Royal College of Physicians/British Society of Gastroenterology				Recommendation 11 - Page 29	We feel that the use of the AUDIT here cannot be too exclusive, this scale is rarely used in emergency departments as it is too long. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to the target groups.
Royal College of Physicians/British Society of Gastroenterology				Recommendation 12 - Page 30	We feel that the use of the AUDIT here cannot be too exclusive. The previous recommendations have acknowledged the use of the PAT and the FAST in emergency departments and this should be consistent throughout the guideline.	Thank you for comment. As a result of the consultation process the committee have made revisions to the recommendations in relation to the target groups.

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SCAN (Specialist Clinical Addiction Network)			General		Informative, user friendly and useful guidance. Well structured discussion of population and individual approaches with the use of a glossary. Clear recommendations are described for different patient groups with further evidence and modelling statements to add further detail. Practical appraisal of potential difficulties such as the perceived potential for feeling stigmatised from clients at the screening stage and need for appropriate resources and support for the implementation of recommendations. The appendix D is useful to identify where gaps in evidence exist.	Thank you for taking the time to read and comment on the guidance. Two other pieces of work underway at NICE may be of interest. Please see: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1 Alcohol Clinical Alcohol use disorders – clinical management http://guidance.nice.org.uk/CG/Wave15/77
SCAN (Specialist Clinical Addiction Network)			Section 2 and Appendix C	Page 5 also Page 76	Noted on page 5, the description that an increase in the strength of alcohol consumed has occurred over time. It could be useful to examine this change further and whether any steps would be helpful in counteracting this development, for example collaboration with the drinks industry or promotion of lower percentage strength drinks. Examination of any evidence for graded pricing on alcohol according to strength would be interesting here especially as the economic analysis on page 76 indicates that various pricing measures could be examined including a possible price per unit of alcohol but no further detail is discussed.	Thank you for your comment. The guidance document recommends the introduction of a minimum price per unit and the potential effect of this intervention on the strength of alcoholic drinks is commented on within the guidance document.

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SCAN (Specialist Clinical Addiction Network)			Section 4	Page 20	Possible legislation on limiting personal import allowances is considered here. However is there any evidence to support the idea that the personal importation of alcohol contributes significantly to increased consumption?	Thank you for your comment. The committee discussed this aspect and felt that in order to support the introduction of a minimum price per unit consideration should be given to the revision of personal import allowances.
Scottish Government			Recommendation 3	20	The Scottish Government agrees that the impact of alcohol advertising on young people could and should be reduced and an approach to advertising which unequivocally protects children from exposure to alcohol advertising should be introduced at a UK level. Scottish Government consider that a precautionary approach to the protection of young people in relation to alcohol advertising is justified given that evidence is mounting in relation to: • the considerable harms which excessive alcohol consumption can cause; • indications that early introduction to alcohol can lead to misuse in later life; and • the influence which exposure to alcohol advertising has on young people's consumption. Scottish Government considers that this precautionary approach should apply not just to the content of adverts, but also crucially to the overall exposure of young people to alcohol advertising.	Thank you for taking the time to read and comment on the guidance. Two other pieces of work underway at NICE may be of interest. Please see: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1 Alcohol Clinical Alcohol use disorders – clinical management http://guidance.nice.org.uk/CG/Wave15/77

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Scottish Government			Recommendation 3	20	Because much of the legislation governing advertising is reserved to Westminster, the Scottish Government are continuing to press the UK Government to develop a UK-wide approach to advertising, whether on television, on line, or in the cinema. We particularly support a ban on television advertising before the 9pm watershed. We would also welcome the development of a co-regulatory approach to on line advertising, involving the industry, UK Government and advertising regulatory bodies.	Thank you for your comments. At this time the committee did not consider the introduction of a watershed to be appropriate.

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Scottish Government			3.12	12	Scottish Government believe that alcohol product labelling could be significantly improved and is fully supportive of measures which deliver improved alcohol product labelling. It would be preferable to implement one system of product labelling and information across the UK. and we are discussing with the UK Government how this could be taken forward".	Thank you for your comment. The scope for this work which outlined the parameters of the work for this guidance was consulted on in April 2008 and finalised in July 2008. Whilst interventions on product labelling were not included in the review work – the PDG recognises the importance of this and took account of these in the context of the interventions that were included in the scope. We welcome suggestions from all stakeholders on other interventions / approaches that they consider important for reducing harmful and hazardous drinking for consideration for our topic selection panels. Please see the NICE website for details of how you can submit your suggestions: http://www.nice.org.uk/getinvolved/suggestatopic/suggest_a_topic.jsp .
Scottish Government			General		Lack of guidance on interventions within an antenatal setting – guidance mentions women, various other healthcare settings but not antenatal. This is one of the 3 priority settings within Scottish Government HEAT target, was looking for some additional guidance within this doc.	Thank you for your comment. The guidance document has been amended to acknowledge ante-natal settings.
Scottish Government			Section 4: Recommendation 5	Page 21	This is in line with Scottish Government and SIGN 74 guidance.	Thank you.

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Scottish Government			Section 4: Recommendation 9	Page 26	Is there a requirement to spell out the professionals who should be aimed at delivering screening etc rather than just 'NHS and non-NHS professionals'. Also no mention of antenatal settings.	Thank you, for your comment. The committee felt that a range of professionals, following training, would be able to deliver screening and brief interventions. As such it was not felt necessary to produce a definitive list which may result in some professional groups not applying the recommendations. Please see our previous response.
Scottish Government			Section 4: Recommendation 9	Page 27	Query guidance around professional revising AUDIT scores downwards for certain groups – rationale for why this is only for these groups, and the potential impact of that.	Thank you for your comment. The evidence presented to the committee suggested that for certain groups it may be necessary to lower the AUDIT thresholds. The committee felt it necessary to highlight this to professionals and recommend that they use their professional judgement when dealing with these groups. The rationale behind this decision is detailed within the considerations section.

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Scottish Government			Section 4: Recommendation 11	Page 24	Query as to why brief advice/intervention is not offered to individuals who have screened as harmful/hazardous aged 16/17 years of age. Brief advice is only guided as an option for 'adults'. Also inconsistent with page 21 which outline brief interventions for 16+. Scottish Government in line with SIGN 74 has outlined brief interventions should be delivered to anyone over 16 who screens (using a setting appropriate screening tool) as harmful or hazardous.	Thank you for raising this issue. The rationale behind this recommendation is contained within the considerations section of the guidance document. Noted, thank you.
Scottish Government			Recommendation 1	19	The Scottish Government agrees that addressing the affordability of alcohol appears to be the most effective way of reducing alcohol related harm. The Scottish Government's preferred response is to introduce a minimum price per unit of alcohol. A Bill to introduce minimum pricing will be submitted to the Scottish Parliament before the end of 2009.	Thank you for bringing this to our attention. Your comments are duly noted.

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Scottish Government			Recommendation 2	19	The Scottish Government agrees that overprovision of licensed premises should be a consideration when any new licence applications are submitted. The Licensing (Scotland) Act 2005 which came fully into force on 1 September 2009 includes "protecting and improving public health" and a licensing objective and provides powers for licensing boards to refuse application on the grounds of overprovision. Licensing Boards also have an enforcement role as they are able to impose a range of sanctions on premises operating contrary to licence conditions or the licensing objectives. The sanctions available range from written warnings through the suspension of revocation of the licence.	Noted, thank you.
Scottish Government			Recommendation 4	21	The recommendation is consistent with the current position in Scotland where licensing boards, licensing standards officers, and the police carry out the action suggested, including test purchasing.	Thank you for your comment.

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Scottish Government			General		There are a number of instances (particularly in section 3) where assertions are made but no references are provided. It would he helpful if either references could be provided or it was made clear that the views being expressed were those of the PDG.	Thank you for your comment. The evidence reviews which supported the development of the guidance are available on the NICE website and appendices B and C of the guidance document highlight the relationship between evidence statements and recommendations. A link to the supporting document is provided within appendix E. (www.nice.org.uk/ph24) For further information on NICE methodology please see www.nice.org.uk/phmethods Section 3 of the guidance document 'considerations' represent a summary of the discussions that took place in PDG during the development of the guidance – they are in the main therefore expert opinion.
Scottish Government			Section 2	5	More recent consumption estimates are available from the General Household Survey. Given the revised unit conversion factors have been used for some time, do the old and new 2006 estimates need to be shown given the potential for confusion.	Thank you for your comment. The guidance document has been clarified.
Scottish Government			Section 2	6	More recent estimates of consumption among schoolchildren are available.	Thank you for your comment. The guidance has been clarified.
Scottish Government			Section 2	6	The estimated cost of £27 billion quoted on page 6 is incorrect. The referenced document provides an estimate of between £17.7 billion and £25.1 billion a year.	Thank you for your comment. The guidance document has been clarified.

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Scottish Government			Section 4, recommendation 6	23	The target population for this recommendation is given as 'children aged 10 to 15 who are thought to be drinking at hazardous or harmful levels'. The terms hazardous and harmful are not commonly used in reference to children as young as 10, given the difficulty in establishing levels of risk. NICE is asked to consider the appropriateness of these terms in relation to this recommendation, especially as they are defined in terms of units consumed per week in the glossary.	Thank you for your comment. The guidance document has been clarified.
Scottish Government			Section 4, recommendation 9	26	Reference is made under 'what action should be taken' to 'screening for other conditions'. It is queried whether this recommendation should explicitly refer to presentations that may be partly or wholly attributable to alcohol.	Noted, thank you The document will be amended where appropriate.
Scottish Government			Section 4, recommendation 10	28	The Scottish Government queries the exclusion of antenatal settings under 'target population'.	Thank you for your comment. The guidance document has been amended appropriately.

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South Asian Health Foundation			2	5	Although the survey shows the prevalence of alcohol consumption, The South Asian Health Foundation feels it may miss some high-risk groups ('the ecological fallacy'). As well as age and gender, ethnicity is another neglected risk factor for alcohol related harms. (Examples include Fisher et al. BMJ 2002 and Bhala et al. JPH 2009 for excess alcohol-related mortality in Scottish, Irish and Indian men in England and Wales). Furthermore, lessons for cultural and consumptive trends can be learnt from some of the ethnic minority groups already living in the UK, who are more prone to abstinence (Pannu et al. BMJ 2009).	Thank you for taking the time to read and comment on the guidance. The General Household Survey statistics quoted within the introductory section have been used to show the overall pattern of alcohol consumption within the country. It unfortunately does not provide a consumption breakdown by ethnic group. However, the guidance document has been amended to reflect the differences in mortality by country of birth. When developing the recommendations the PDG were conscious of the need to ensure that the needs of ethnic minorities were addressed. As such the guidance document recommends professionals to use their judgement when assessing individuals and at all times ensuring their discussions are sensitive to the individual's culture and faith.
South Asian Health Foundation			2	6	Although alcohol consumption is linked with many major chronic conditions, often focussing on mental health and liver disease, the majority of deaths attributable to alcohol are actually related to heart disease, strokes and cancer, hence needing to be considered in the other National Service Frameworks etc.	Thank you for your comment, noted.

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South Asian Health Foundation			2	6	The South Asian Health Foundation agrees that the costs of alcohol-related disorders are huge and mounting, and warrant consideration. Can data be presented on the money made by the alcohol industry and its contribution to earning to put these figures in perspective?	Thank you for your comment. Unfortunately it is not possible to include this within the document.
South Asian Health Foundation			2	7	As with other chronic diseases, the South Asian Health Foundation agrees that there is a socio-economic gradient in outcomes. This is particularly likely to affect ethnic minority groups.	Thank you for your comment. The socioeconomic differences in alcohol related harm are noted within the guidance document.
South Asian Health Foundation			2	7	The South Asian Health Foundation feels that the lack of action from some of the previous government reports, as well as the conflicting nature of their recommendations compared to scientific bodies, does not come across.	Thank you, we note your concerns.
South Asian Health Foundation			3.1	9	Whilst we agree that excess alcohol consumption is harmful, we think the statement “drinking alcohol is never without risk” is not evidence-based at the individual or population level (and should be revised).	Thank you for your comment. The guidance document has been clarified.
South Asian Health Foundation			3.3	9	The South Asian Health Foundation wholeheartedly agrees with the need to tackle alcohol-related harm at the individual level, as well as reducing inequalities.	Thank you for your comment.
South Asian Health Foundation			3.7-9	10	The South Asian Health Foundation agrees that the introduction of minimum price costing is likely to have an effect, and would not be ineffective in low income groups (or ethnic minority communities.	Thank you for your comment, noted.
South Asian Health Foundation			3.10	11	The South Asian Health Foundation agrees that the effect of foreign alcohol being imported, whilst it needs to be considered, is unlikely to have an effect at the population level.	Thank you for your comment, noted.

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South Asian Health Foundation			3.11	11	The South Asian Health Foundation agrees that the introduction of minimum price costing is likely to have an effect, and would not be ineffective in low income groups.	Thank you for your comment.
South Asian Health Foundation			3.11	11	The South Asian Health Foundation agrees that the many of the lessons from tackling tobacco also need to be implemented, including advertising bans and labelling.	Thank you for your comment.
South Asian Health Foundation			3.13-17	12-13	The South Asian Health Foundation also agrees that younger groups (eg, second generations) require additional protection from harms.	Thank you for your comment,
South Asian Health Foundation			3.18-26	13-15	The South Asian Health Foundation also agrees that brief interventions and counselling are evidence-based methods of treating the population. As well as advocating resource and education for their role, culturally aware interventions need to be applied (point 24). We also feel it is clear that alcohol services for both prevention and treatment have been hitherto neglected in the UK and require additional resources.	Thank you for your comment.
South Asian Health Foundation			3.27	16	As well as support services, clear communication and logistical support for primary and secondary medical care for alcohol-related disorders are also neglected and require attention.	Thank you for your comment, your concern is noted.

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South Asian Health Foundation			4	16	Population versus individual approach Whilst the South Asian Health Foundation approves of a population-wide approach, we also feel methods to identify (and hence, treat) individuals at higher risk within the wider population would be worthwhile as a policy programme to tackle alcohol-related harm. An environment that supports lower risk drinking is therefore a necessity.	Thank you for your comment and raising this issue. Please note that the recommendations for practice do recommend the assessment becomes an integral part of practice and where this is not possible the targeting of those who are at a greater risk.
South Asian Health Foundation			4	18	Recommendations for policy The South Asian Health Foundation also concurs that the Chief Medical Officer should have the overall lead for coordination of a cross-governmental body to tackle alcohol-related harms. Furthermore, we feel that such a body should make clear about any conflicts of interest, and should not be susceptible to external political influences. There could also be an argument for involving some of the key stakeholder groups as observers. As well as social scientists and anthropologists being involved (Pannu et al, BMJ 2009), responsible media reporting is a must.	Thank you for your comments, noted.
South Asian Health Foundation			4.1	19	The South Asian Health Foundation agrees with the evidence-based recommendation to introduce a minimum price per unit of alcohol.	Thank you for your comment.
South Asian Health Foundation			4.2	19	The South Asian Health Foundation agrees that not allowing 24/7 availability of alcohol is another effective measure to reduce alcohol-related harm.	Thank you
South Asian Health Foundation			4.3	20	The South Asian Health Foundation agrees that exposure to alcohol marketing has an effect on younger and older audiences. Hence, we also agree with this recommendation.	Thank you

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South Asian Health Foundation			4.4	21	The South Asian Health Foundation agrees that the selling of alcohol from unlicensed vendors should be prohibited, as well as stopping under-age purchasing.	Thank you, noted.
South Asian Health Foundation			4.5	22	The South Asian Health Foundation agrees that resources for screening and brief interventions needs to be radically improved in the UK for both the general population and ethnic minority groups.	Thank you for your comments, your concerns are duly noted.
South Asian Health Foundation			4.6-8	23	The South Asian Health Foundation agrees that screening younger people when in contact with medical personnel (and then referring and treating) for common harms such as alcohol and tobacco is worthwhile, but should be culturally aware.	Thank you for your comment. The guidance has been amended appropriately
South Asian Health Foundation			4.9	27	The South Asian Health Foundation agrees that screening adults when in contact with medical personnel for common harms such as alcohol and tobacco is worthwhile, but should be culturally aware. Furthermore, the risk factors for high-risk groups requires a more thorough evidence base.	Thank you for your comment. The guidance has been amended appropriately
South Asian Health Foundation			4.10-12	28	The South Asian Health Foundation agrees that treating younger people when in contact with medical personnel for common harms such as alcohol and tobacco is worthwhile, but should be culturally aware as well as adequately trained and resourced.	Thank you for your comment. The guidance has been amended appropriately

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South Asian Health Foundation			General		The South Asian Health Foundation agrees that alcohol-related harms need tackling, and commend this document. As well as needing to be aware for culturally sensitive interventions, we believe that much can be learnt from the examples of ethnic minority groups in the UK. Furthermore, alcohol is a leading risk factor for the global burden of disease, and many of these implementations can draw lessons and facilitate usage in other countries – we hope NICE International can utilise these studies in such a way. Congratulations again to the Development Group.	Thank you for your helpful comments and suggestions. We will pass on your suggestions to NICE international.

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The Gin and Vodka Association			General	1	**Consultation with stakeholders**: The draft guidance refers to industry as being a stakeholder, but there is a risk that industry's voice will not be heard in this consultation. According to the list of stages to be followed in producing the guidance, this consultation forms Stage 11. Stage 2 was a stakeholder meeting. It would be interesting to know the level of involvement of industry at Stage 2 and indeed since. The development of the guidance does not seem to have been widely known amongst industry. We would welcome clearer detail of how the guidance is intended to be used and industry's role in this.	Thank you for taking the time to read and comment on the guidance. National organisations are able to register their interest in the guidance at anytime during its development. Registered stakeholders are free to comment during the specified consultation periods. For a list of the stakeholders who registered for this piece of guidance please see: http://guidance.nice.org.uk/PHG/Wave15/1 The process and methods which are used in the development of public health guidance can be found at: www.nice.org.uk/phmethods www.nice.org.org.uk/phprocess
The Gin and Vodka Association				2	Will the second draft of the guidance be open for stakeholder input?	Thank you for your comment, this is the final consultation on the guidance document.
The Gin and Vodka Association				2	The consultation closes on 10 November, leaving only one day for review of responses before the next meeting of the PDG on 12 November. This does not appear to leave adequate time for a thorough assessment of responses.	Thank you, In addition to the meeting on the 12th of November the PDG met on the 15th & 16th of December allowing a period of about 4-5 weeks to fully consider comments of stakeholders.

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The Gin and Vodka Association			2. Public Health Need and Practice	5	14.9 units = 119 g of alcohol not 199g	Thank you for your comment. The guidance document has been amended appropriately.
The Gin and Vodka Association			3.7	10	The statement that "Making alcohol less affordable appears to be the most effective way of reducing alcohol-related harm" is supported in the draft guidance by reference to the findings of the ScHARR study. Other reports, eg The Affordability of Alcohol, RAND Europe 2009 draw different conclusions that price measures are ineffective to reduce per capita consumption. It is also not clear how such a measure would effectively target the 24% of people identified as being hazardous or harmful drinkers.	Thank you for your comment. The evidence review conducted by ScHARR included the RAND report you refer to. The full evidence reviews are available on the NICE website and a link to these reviews are provided within appendix E fo the guidance document.

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The Gin and Vodka Association			3.8	11	There is a justification put forward as to why those in lower income groups would not be disproportionately impacted if minimum pricing was introduced as they spend less per week on alcohol. There are three points: 1. What impact is there on hazardous and harmful drinkers in low income groups in that such individuals are more motivated to consume alcohol as they see it as part of their lifestyle? 2. Higher income groups spend more money alcohol; they also have more money to spend on alcohol. Pricing by default must therefore be less of an issue for hazardous and harmful drinkers in higher incomes groups. 3. We understand the Department of Health has commissioned further research from ScHARR on the impact on different socio economic groups.	Thank you for your comment. The guidance document has been clarified.

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The Gin and Vodka Association			3.10	11	States 'increasing price of alcohol, or reducing its accessibility, may lead to an increase in the amount of alcohol imported (both legally and illegally, however, the PDG judges that this would have a small impact on alcohol consumption of the population as a whole.' Can you clarify how the PDG came to this conclusion? As this guidance is aimed at preventing hazardous and harmful drinking it is unclear what the impact on those drinking at those levels would be. What assessment of the impact of unintended consequences has been undertaken? Both the ScHARR review and a report prepared by SHAAP[1] recognise there is a range of unintended consequences of increasing price – illicit production, smuggling and cross border trading as well as the impact on families where alcohol is already a problem may continue to consume excessive amount at higher prices with detrimental effects on the family budget. ([1]Minimum Pricing of Alcohol – An Economic Perspective, Scottish Health Action on Alcohol Problems, November 2008,)	thank you for your comment this consideration has now been revised and can be found at 3.17 in the guidance document: www.nice.org.uk/ph24 .

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The Gin and Vodka Association			3.11	11	It states the evidence is much stronger in relation to how alcohol advertising affects consumption in relation to children and young people. Can you clarify what is meant by 'much stronger'?	Thank you for your comment. The consideration section has now been revised. The consideration is now 3.19 and can be found at: www.nice.org.uk/ph24. In general the considerations section presents a summary of the issues that the PDG considered in developing the recommendations. In this instance they are based on the findings produced by ScHARR available at: http://www.nice.org.uk/guidance/index.jsp?action=folder&o=44249 For further information on NICE methodology please see 9in particular section 7.5 on considerations www.nice.org.uk/phmethods
The Gin and Vodka Association			4. recommendations	16	Discusses population versus individual approach. Population clearly refers to the whole population. Is the individual approach only aimed at an individual as opposed to a targeted approach which may be aimed at specific groups within a population?	Thank you for your comment. Individual interventions refer to intervening with an individual person on a one to one basis.

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The Gin and Vodka Association			Recommendation 1: price	19	Consider the introduction of a minimum price per unit. It does not appear feasible to make such a recommendation without some indication as to what that price would be. Without stating a price there is no way to assess potential intended or unintended consequences. Clearly no assessment has been made of the legality of introducing such a policy which we believe to be contrary to both EU and WTO trade rules. The European Court of Justice has consistently ruled against the setting of minimum prices. Most recently the Advocate General issued an opinion in relation to three cases brought by the European Commission against Austria, France and Ireland for violation of EU rules in trying to impose national minimum prices for tobacco. The Advocate General stated that minimum pricing was not necessary in order to protect public health and it is a distortion of competition.[2] ([2]See European Commission v. France (Case C-197/08), European Commission v. Austria (Case C-198/08), and European Commission v. Ireland (Case C-221/08). The Advocate-General's opinion was issued on 22 October 2009). In a paper by Baumberg and Anderson[3] concluded in relation to EU law that it seemed strongly likely that minimum pricing for alcohol would not be seen as permissible. ([3] Baumberg *et al* Health, alcohol and EU law: understanding the impact of European single market law on alcohol policies. European Journal of Public health, 18(4) 392-398).	Thank you for your comment. The aim of the guidance was to assess the effectiveness of a minimum price policy. The committee did not consider at what price a minimum price should be set. The potential legality of a minimum price was considered by the committee. However, as you note the recent opinion by the advocate general case law concerns a specific tobacco directive concerning the ability of a manufacturer to set a maximum price for their product. It is therefore unlikely to be directly applicable to alcohol.

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The Gin and Vodka Association					The report by Rabinovich *et a*l also highlight that minimum pricing could be in contravention of EU law. The authors suggested a possible effective alternative would be a ban on sales below cost which are not trade-restrictive. They also suggested there is legal scope for statutory and self-regulation in restricting alcohol sales below cost. ([4]Rabinovich *et al* The affordability of alcoholic beverages in the European Union, RAND Europe 2009. We would also note this report states that alcoholic beverages became more affordable in most Member States, but also observed that overall per capita consumption declined across the EU). Was there any consideration given to banning sales below the level of excise duty plus the VAT on that duty? With regard to the recommendation 'Linking alcohol duty to inflation and earnings'. We would note the UK has in place a policy to increase duty by inflation plus 2%. On the issue of earnings would this relate to average earnings? If yes then this would clearly penalise those on below average earnings.	Thank you, noted. Please see our response above. Thank you for comment. As a result of the consultation process the committee have revised the recommendation concerning linking alcohol duty to inflation.

The publication of comments received during the consultation process on the NICE website is made in the interests of openness and transparency in the development of our guidance recommendations. It does not imply they are endorsed by the National Institute for Health and Clinical Excellence or its officers or its advisory committees

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The Gin and Vodka Association			Recommendation 2: Availability	19	We would suggest the statement in relation to Scotland is checked for accuracy. The objective of the Licensing (Scotland) Act 2005 is to control availability. However, protection of public health is one of five licensing objectives included within in the Act and no one license objective takes precedent over another.	Thank you for raising this issue. We have clarified the recommendation.
The Gin and Vodka Association			Recommendation 2: Availability – bullet point relating to personal imports.	20	What evidence is there to indicate that current levels of personal import allowances are causing problems in relation to alcohol related harm in England?	Thank you for your comment. Increasing the price of alcohol, or reducing its accessibility, may lead to an increase in the amount of alcohol imported from abroad (both legal and illegal imports). The PDG considered that the current personal alcohol import allowance could undermine the introduction of a minimum price per unit for alcohol. This rationale is provided within the considerations section of the guidance document. The considerations section represent a summary of the discussions that took place in PDG during the development of the guidance – they are in the main therefore expert opinion.

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The Gin and Vodka Association			Recommendation 3: marketing	20	Whilst acknowledging the evidence on an advertising ban is inconclusive, the document goes on to state 'However, a tobacco advertising ban has helped reduce the prevalence of smoking' there are two points: 1. There appears to be no evidence in the background document to support this claim. 2. In relation to tobacco the objective is to encourage consumers to stop. That is not the case in relation to alcohol consumption. Moderate, responsible consumption can be part of a healthy lifestyle. This guidance is aimed at preventing the development of hazardous and harmful drinking not drinking *per se*. as is the case with tobacco.	Thank you for your comment.. The recommendation has now been revised and we no longer refer to the tobacco.
The Gin and Vodka Association			Recommendation 3: marketing. What action could be taken, first bullet point	20	What is the justification for this recommendation? The UK operates an effective co-regulatory system which includes monitoring. The ASA Compliance Survey Report 2009 on Alcohol advertising revealed a 99% compliance rate.	Thank you for your comment. Following the consultation process the recommendation has been revised.

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The Gin and Vodka Association			Recommendation 3: marketing. What action could be taken, second bullet point	20	Can you explain how the 5% threshold was arrived at as it is not clear from the evidence statements presented.	Thank you for comment. Following the consultation process the recommendation has been revised in relation to the 5% threshold.
The Gin and Vodka Association			Recommendation 3: marketing. What action could be taken, fourth bullet point	20	If, as is noted, the evidence is inconclusive as to the impact an advertising ban would have on consumption. Indeed the ScHARR review notes one impact reported from some studies is an increase in consumption. It is therefore unclear how this recommendation has been arrived at. Please can you clarify	Thank you for your comment. Following the consultation process the recommendation pertaining to a ban on alcohol advertising has been amended. However, please note that NICE public health recommendations are based on both empirical data and reasoning. Empirical data on its own, even from the best conducted investigation, is not sufficient. It has to be interpreted and analysed to provide answers for policy makers, practitioners and guidance producers. NICE's independent advisory committees use both inductive reasoning (based on the best available empirical data) and deductive reasoning (based on prior knowledge and understanding), along with existing models and theories.

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The Gin and Vodka Association			UK government drinking guidelines	35	In relation to the sensible drinking guidelines for men and women a sentence is included stating 'Both are recommended to have some alcohol free days.' The Sensible Drinking Report, Department of Health 1995 para 9.9 and 10.21 both discuss drink free days, but I can find no reference to the above statement. Can you clarify, please, where this statement originates from?	Thank you for your comment The guidance document has been clarified
The Gin and Vodka Association			Key questions: Q4	44	In relation to children and young people, what assessment was made of the influences peer pressure and family have on their alcohol consumption? We note the " Statistics on Alcohol: England 2009" Report notes the proportion of 11-15 year olds who have never drunk alcohol is increasing - 39% in 2003 to 46% in 2007.	Thank you for your comment. Whilst interventions specially aiming to address the social influences on were not included in the review work – the PDG recognises the importance of these influences on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were developed. These statistics are noted within the guidance document. The PDG were of the opinion that this was still a serious issue that needed to be addressed.

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The National Treatment Agency for Substance Misuse (NTA)			General		The NTA comments refer to recommendations 5 to 12 only	Thank you for taking the time to read and comment on the guidance. Two other pieces of work underway at NICE may be of interest. Please see: Alcohol dependence and harmful use http://guidance.nice.org.uk/CG/Wave17/1 Alcohol Clinical Alcohol use disorders – clinical management http://guidance.nice.org.uk/CG/Wave15/77

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The National Treatment Agency for Substance Misuse (NTA)			General		The draft NICE guidance raises the possibility of 3 different types of approaches to assess the risk of harmful drinking among young people: one approach for 10-15 year olds; one for 16-17 year olds and another for over 18s. This, coupled with the use of the Common Assessment Framework (CAF) for 10-15 year olds; and AUDIT, AUDIT-C, AUDIT-PC, SASQ or FAST screening tools for 16 years and above may cause confusion among workers in generic young people's services, where it is not un-common to treat young people up to the age of 21 (i.e. looked after children or those with co-morbid mental health issues). The NTA is concerned about implementation since, without greater clarification about the appropriate use of screening tools and approaches for different age groups, workers are not likely to feel confident in their assessments.	Thank you for comment. As a result of the consultation process the committee have made some revisions to the recommendations. Due to the different vulnerabilities of individuals of different ages the committee felt that a one size fits all approach was not believed to be practical for everyone over the age of 10 years.
The National Treatment Agency for Substance Misuse (NTA)			General		The NTA would welcome a clear statement from NICE about the importance of local care pathways between generic health and social care services and specialist alcohol and drug treatment services. These should ideally be in place, before a wider roll-out of alcohol assessments to help avoid the potential unplanned referrals overwhelming specialist services as the use of screening tools in more generic settings increases.	Thank you for your comment, your concerns are duly noted. The PDG considered this issue and the complexity and importance of multi-agency working and forward planning. The guidance document has been amended appropriately.

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The National Treatment Agency for Substance Misuse (NTA)			Recommendation 6	23	The NTA would welcome clarification on (1) how the Common Assessment Framework (CAF), a generic questionnaire with only one behavioural question (which touches on a young person's drug and alcohol use), would be used to establish if 10 to 15 year olds are at risk of harm from their drinking, and (2) at what threshold workers should consider referral to child and adolescent mental health services, social care or to young people's drug and alcohol services for treatment The NTA is concerned that untrained workers using the CAF may miss underlying young person's drug and alcohol misuse	The committee debated this issue at length and following consultation the guidance document has been amended. However, the PDG did feel that the provision of specific thresholds was not appropriate within this age group and that professionals needed to use their professional judgement when dealing with children and young people. Given the lack of research in this area it was also felt that a recommendation for robust research should be made especially when considering the effectiveness of specific interventions.
The National Treatment Agency for Substance Misuse (NTA)			Recommendation 8	25	The NTA was unsure about whether all the less detailed, 'quicker' screening tools: AUDIT-C, AUDIT-PC, SASQ or FAST (endorsed in recommendation 7) would provide the equivalent of a 20+ AUDIT score (the threshold at which Recommendation 8 suggests that workers should consider referring 16 and 17 year olds into specialist treatment). If not, the NTA would welcome clarification on which screening tools produce the equivalent of a 20+ AUDIT score, so that services / workers use the appropriate tool with a young person they suspect is drinking at harmful levels	Thank you, for your comment. The guidance has been amended appropriately.

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The National Treatment Agency for Substance Misuse (NTA)			Recommendation 9	26	There is clear evidence that alcohol plays a large contributory role in many drug related deaths recorded in the UK. According to the ONS, nearly a third (31%, n= 908) of 2008's drug-related deaths in England and Wales mentioned alcohol, the number of such deaths is up 20% since the 2004 figure (n= 756). The NTA would encourage that the guidance includes poly-drug and alcohol using/dependent clients, especially those not already in contact with structured drug treatment as an important at-risk target group for alcohol screening in generic services. If, following assessment, such clients are identified as drinking harmfully they should be referred to / or encouraged to attend their local structured drug and/or alcohol treatment service. Or at a minimum, given overdose prevention advice and information. Free, up to date, overdose information and prevention advice are available at: http://www.harmreductionworks.org.uk/overdose.html	Thank you for your comment. The guidance has been amended to acknowledge those who use drugs as an at risk group.

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The Portman Group			2	5	Your use of General Household Survey (GHS) and HM Revenue and Customs data in the second and third paragraphs implies that alcohol consumption is increasing when the evidence shows that the opposite is true. In its General Household Survey (GHS) 2006 survey, the Office for National Statistics decided to revise its methodology for estimating consumption to reflect the fact that over recent years wines, and to a lesser extent other drinks, had gradually become stronger and on-trade wine servings larger. This was causing an underestimation of consumption which had gradually become more significant. The use of the updated methodology in the 2006 survey corrected this underestimation and, unsurprisingly, resulted in an apparent increase in the amount of alcohol consumed in Britain compared with 2005. The 2006 GHS report itself acknowledged, however, that: "It should be noted, however, that changing the way in which alcohol consumption trends are determined does not in itself reflect a real change in drinking among the adult population." Continued on next page…	Thank you for your comment. The guidance document has been clarified.

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The Portman Group			2	5	This renders any comparison between 2006 GHS data using the updated methodology and previous GHS data using the old methodology misleading. For trend data, we must therefore refer to HM Revenue and Customs figures. You state that according to HM Revenue and Customs, consumption has risen from 1986/7 to 2007/8. This is true but it overlooks the fact that consumption reached a peak in 2004 and has since declined by approximately 5%, as shown below: UK consumption of alcohol - litres per head of 100% alcohol 2004 9.4 2005 9.2 2006 9.0 2007 9.2 2008 8.9 (source: BBPA and HM Revenue and Customs, BBPA Statistical Handbook 2009). The BBPA's figures for the first 6 months of 2009 suggest that this decline is increasing (3.81 litres compared with 4.15 litres in first 6 months of 2008).	

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The Portman Group			2	6	The claim that “alcohol consumption is associated with many chronic health problems …” etc. should be qualified by the prefix “excessive”. Moderate drinking is not associated with these problems. You have overlooked evidence in the British Crime Survey on the number of alcohol-related crimes. The actual number of offences where the offender is believed to be under the influence of alcohol has dropped by about a third since 1995. ("Safe: Sensible; Social: Next steps in the national alcohol strategy", HM Government 2007)	Thank you for your comments. This wording was chosen in order to take into account the overarching framework of alcohol consumption (hazardous and harmful consumption) that the guidance is addressing. Thank you for your comment. However the PDG felt that there was although the number offences has decreased that more work still needed to be done.

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The Portman Group			3.5/3.6	10	We strongly believe the focus should be on reducing alcohol misuse. It is possible, indeed very probable, that reducing alcohol misuse will actually result in a net decrease in the nation's alcohol consumption but that doesn't mean that reducing overall consumption is an appropriate goal in itself. Furthermore, the overall alcohol consumption figure masks complex and sometimes contradictory drinking patterns and trends among subgroups. It is quite possible that while a nation's per capita consumption is falling, certain sections of society will be drinking more and vice versa. Measures to tackle alcohol misuse through reducing overall consumption are therefore likely to be ineffective. Indeed, such an approach has been widely discredited in research studies. For example: Rose, G (1992) *The Strategy of preventive medicine*. Oxford University Press. Oxford. Tuck, M (1980) *Alcoholism and Social Policy. Are we on the right lines?* Home Office Research Study No 65. HMSO. London Duffy, JC (1993) *Alcohol Consumption and Control Policy*. Journal of Royal Statistical Association. Series A (Statistics in Society)	Thank you for your comment, your concerns are noted. The overall framework taken to produce this guidance followed the population approach described by Rose. The public consultation on the evidence reviewed for this guidance took place during May and June 2009 when all stakeholders were invited to submit additional evidence and comment on the interpretation of the evidence. Whilst the evidence identified here was outside that period the PDG were made aware of its existence.

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The Portman Group			3.6	10	The comparison with drink-driving in paragraph 3.6 is interesting. The success in combating drink-driving was achieved through strong law enforcement targeted against those who were drink-driving combined with effective education designed to alter attitudes among the general public. It was not achieved through getting everyone either to drink less or to drive less. We therefore do not understand how this example can serve as evidence in favour of a population-level approach to tackle the problem of alcohol misuse.	Thank you for your comment. The consideration does not aim to draw parallels with the method which was employed but the initial supporting evidence base for that intervention.
The Portman Group			3.11	11/20	You note that there is only limited evidence on how alcohol advertising affects consumption among the population as a whole and that the evidence on whether or not an alcohol advertising ban would be effective is inconclusive. Despite this, you then appear to support a ban on alcohol advertising on page 20 “in the longer-term, banning all forms of alcohol advertising and marketing….” You should have acknowledged that the University of Sheffield’s report into the relationship between alcohol promotion and harm did not support an advertising ban and recognised that such a ban could actually cause increased harm because suppliers would instead compete for market share on the basis of price. (p163 Independent Review of the Effects of Alcohol Pricing and Promotion, ScHARR report, 2007)	Thank you for comment. As a result of the consultation process the committee have revised the recommendation on a total advertising ban.

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The Portman Group			Recommendation 3	20	The first bullet point implies there is a lack of regulation in the UK. All drinks producers' marketing activity, however, including digital marketing, is subject to the same strict, comprehensive and mandatory standards of regulation. This includes rigorous monitoring of practice. For historical reasons, three regulators are involved: Ofcom, the Advertising Standards Authority (ASA) and the Portman Group. The different regulatory systems, however, while they operate independently of one another, adopt similar standards and complement one another to ensure strict supervision of all drinks producer marketing activity. With regard to digital marketing specifically, all paid-for advertising on the internet is regulated by the ASA's CAP Code. All other drinks producer marketing on the internet, including brand websites, is regulated by the Portman Group. There are no gaps in regulation.	Thank you for comment. The guidance document has been amended to further acknowledge the self-regulatory structure within the UK.

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The Portman Group			Recommendation 3	20	The effectiveness of the Portman Group's regulatory work has been recognised by several respected and independent bodies. The Better Regulation Taskforce described our Code as a good example of a Code that works well, demonstrating how effective self-regulation can be. Furthermore, The International Harm Reduction Association (IHRA) included the latest edition of the Code in its "50 Best Collection on Alcohol Harm Reduction", published in May 2008	Thank you for your comment,
The Portman Group			Recommendation 3	20	The Advertising Standards Authority (ASA) is the independent regulator for all advertisements across all media. Its role is to enforce the mandatory UK Advertising Codes. It is highly regarded and it should be made aware and consider any evidence that you may have to justify the tightening of the alcohol advertising rules.	Thank you for your comment, The evidence which the recommendations are based on is freely available on the NICE website and a link to the supporting documents is available with Appendix E of the guidance document.
The Portman Group			Recommendation 3	20	With regard to the second bullet point, as previously noted, you acknowledge that the evidence on the effect of an advertising ban is inconclusive yet you call for a ban on advertising from all media outlets where more than 5% of the audience is under the age of 18 years. This would effectively ban the vast majority of existing advertising, including all outdoor, all internet, most TV and radio, and much print. You provide no evidence as to why a majority ban is likely to be more effective than a complete ban.	Thank you for comment. As a result of the consultation process the committee have revised the recommendation on advertising and the 5% threshold.

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The Scotch Whisky Association			Introduction	1	After reviewing the NICE website we understand the work on developing this guidance has been underway for sometime. We would have thought that as industry is one of the stakeholders the guidance is aimed at there would have been a more transparent method for seeking input from the industry, more akin to the approach adopted by the World Health Organisation (WHO) when developing its strategy to reduce the harmful use of alcohol where industry is a stakeholder with which WHO consults. The first three recommendations relate to policy and are clearly aimed at Government as they are macro policies. The remaining recommendations relate to practice. Can you clarify how industry would be expected to use this guidance?	Thank you for your comments. Potential stakeholders are alerted to new guidance referrals via: a press release; posting the topic on the NICE website with details of how to register as a stakeholder; contacts stakeholder organisations that registered for previous guidance. We do try our best to identify new stakeholders who have not been involved before and also rely On existing stakeholders (for example Government Departments who are automatically notified through the Department of Health) to alert others who may have an interest in particular topics and who may not be familiar with our processes. As stated within the recommendations it is for government to implement any policies and that parties, such as alcohol producers, should be consulted on any changes.
The Scotch Whisky Association				2	We assume that field work will be conducted in relation to the policy recommendations on practice, please clarify.	The policy recommendations were also subject to the fieldwork process and industry representatives were invited and attended the meetings.
The Scotch Whisky Association				2	Will the second draft of the guidance be open to consultation?	Thank you for your comment, this is a consultation on the draft guidance and following this consultation the guidance will be finalised.

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The Scotch Whisky Association				2	The consultation closes on 10 November, but the next meeting of the PDG takes place on 12 November this does not leave much time for assessment of responses.	Thank you for your comment, the PDG met again on the 15th & 16th of December to consider the comments of stakeholders, which gave the committee over 4 weeks to consider the comments.
The Scotch Whisky Association			2. Public Health Need and Practice	5	14.9 units = 119 g of alcohol not 199g	Thank you. The guidance document has been clarified.
The Scotch Whisky Association				5	The levels of self-reported hazardous and harmful drinking are lowest in central and eastern regions of England. They are highest in the North. Is there an explanation as to these variations especially as price, availability and advertising are not different across the regions?	Thank you for your comment and raising these issues. This guidance did not examine the reasons as to why there are regional differences in alcohol consumption.
The Scotch Whisky Association			3.7	11	Makes a passing mention of preventing selling alcohol below cost price. What assessment was made of a ban on below cost sales as a policy measure?	Thank you for your comment. Below cost selling was not assessed. However the PDG did comment on this issue within the considerations section.

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The Scotch Whisky Association			3.8	11	There is a justification put forward as to why those in lower income groups would not be disproportionately impacted if minimum pricing was introduced as they spend less per week on alcohol. There are three points: 1. What impact is there on hazardous and harmful drinkers in low income groups in that such individuals are more motivated to consume alcohol as they see it as part of their lifestyle? 2. Higher income groups spend more money alcohol; they also have more money to spend on alcohol. Pricing by default must therefore be less of an issue for hazardous and harmful drinkers in higher incomes groups. 3. We understand the Department of Health has commissioned further research from ScHARR on the impact on different socio economic groups.	Thank you for your comment. The guidance document has been clarified.

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The Scotch Whisky Association			3.10	11	States 'increasing price of alcohol, or reducing its accessibility, may lead to an increase in the amount of alcohol imported (both legally and illegally, however, the PDG judges that this would have a small impact on alcohol consumption of the population as a whole.' Can you clarify how the PDG came to this conclusion? As this guidance is aimed at preventing hazardous and harmful drinking it is unclear what the impact on those drinking at those levels would be. What assessment has been undertaken of the impact of unintended consequences? Both the ScHARR review and a report prepared by SHAAP[1] recognise there is a range of unintended consequences of increasing price – illicit production, smuggling and cross border trading as well as the impact on families where alcohol is already a problem may continue to consume excessive amount at higher prices with detrimental effects on the family budget. ([1]Minimum Pricing of Alcohol – An Economic Perspective, Scottish Health Action on Alcohol Problems, November 2008,)	Thank you for your comment. The guidance document has been clarified.

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The Scotch Whisky Association			3.11	11	It states the evidence is much stronger in relation to how alcohol advertising affects consumption in relation to children and young people. Can you clarify what is meant by 'much stronger'?	Thank you for your comment. The consideration section has now been revised. The consideration is now 3.19 and can be found at: www.nice.org.uk/ph24. In general the considerations section presents a summary of the issues that the PDG considered in developing the recommendations. In this instance they are based on the findings produced by ScHARR available at: http://www.nice.org.uk/guidance/index.jsp?action=folder&o=44249 For further information on NICE methodology please see 9in particular section 7.5 on considerations www.nice.org.uk/phmethods
The Scotch Whisky Association			4. recommendations	16	Discusses population versus individual approach. Population clearly refers to the whole population. Is the individual approach only aimed an individual as opposed to a targeted approach which may be aimed at specific groups within a population? What is the evidence for the claim that a population approach halts people commencing hazardous and harmful drinking?	Thank you for your comment. Individual interventions refer to intervening with an individual person on a one to one basis. This population approach is based on the Rose hypothesis which is referenced within the guidance document.

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The Scotch Whisky Association			Recommendation 1: price	19	Consider introducing a minimum price per unit. The evidence base for minimum pricing appears to be sparse. It does not appear feasible to make such a recommendation without some indication as to what that price would be. Without stating a price there is no way to assess potential intended or unintended consequences. **Cont below**	Thank you for your comment. The aim of the guidance was to assess the effectiveness of a minimum price policy. The committee did not consider a price a minimum price should be set.

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The Scotch Whisky Association			Recommendation 1: price	19	**Cont** Clearly no assessment has been made of the legality of introducing such a policy which we believe to be contrary to both EU and WTO trade rules. The European Court of Justice has consistently ruled against the setting of minimum prices. Most recently the Advocate General issued an opinion in relation to three cases brought by the European Commission against Austria, France and Ireland for violation of EU rules in trying to impose national minimum prices for tobacco. The Advocate General stated that minimum pricing was not necessary in order to protect public health and it is a distortion of competition.[2] ([2]See European Commission v. France (Case C-197/08), European Commission v. Austria (Case C-198/08), and European Commission v. Ireland (Case C-221/08). The Advocate-General's opinion was issued on 22 October 2009). A paper by Baumberg and Anderson[3] concluded, in relation to EU law, that it seemed strongly likely that minimum pricing for alcohol would not be seen as permissible. ([3] Baumberg *et al* Health, alcohol and EU law: understanding the impact of European single market law on alcohol policies. European Journal of Public health, 18(4) 392-398).	The potential legality of a minimum price was considered by the committee. However, as you note the recent opinion by the advocate general concerns a specific tobacco directive concerning the ability of a manufacturer to set a maximum price for their product. It is therefore unlikely to be directly applicable to alcohol.

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The Scotch Whisky Association					The report by Rabinovich *et al*[4] also highlight that minimum pricing could be in contravention of EU law. The authors suggested a possible effective alternative would be a ban on sales below cost which are not trade-restrictive. They also suggested there is legal scope for statutory and self-regulation in restricting alcohol sales below cost. ([4]Rabinovich *et al* The affordability of alcoholic beverages in the European Union, RAND Europe 2009. We would also note this report states that alcoholic beverages became more affordable in most Member States, but also observed that overall per capita consumption declined across the EU). Was there any consideration given to banning sales below cost or applying excise duty to all products on a % alcohol by volume basis? With regard to the recommendation 'Linking alcohol duty to inflation and earnings'. We would note the UK has in place a policy to increase duty by inflation plus 2%. On the issue of earnings would this relate to average earnings? If yes then this would clearly penalise those on below average earnings.	Thank you for comment. As a result of the consultation process the committee have revised this aspect of the price recommendation.

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The Scotch Whisky Association			Recommendation 2: Availability	19	We would suggest the statement in relation to Scotland is checked for accuracy. The objective of the Licensing (Scotland) Act 2005 is to control availability. However, protection of public health is one of five licensing objectives included within in the Act and no one license objective takes priority over another.	Thank you for raising this issue. We have clarified the recommendation.
The Scotch Whisky Association			Recommendation 2: Availability – bullet point relating to personal imports.	20	What evidence is there to indicate that current levels of personal import allowances are causing problems in relation to alcohol related harm in England?	Thank you for your comment. Increasing the price of alcohol, or reducing its accessibility, may lead to an increase in the amount of alcohol imported from abroad (both legal and illegal imports). The PDG considered that the current personal alcohol import allowance could undermine the introduction of a minimum price per unit for alcohol. This rationale is provided within the considerations section of the guidance document. The considerations section represents a summary of the discussions that took place in PDG during the development of the guidance – they are in the main therefore expert opinion.

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The Scotch Whisky Association			Recommendation 3: marketing	20	With reference to young people and children what assessment was made of the impact of other factors that may influence their drinking? Studies have shown that the principal influences on youth drinking are parents and peers and that alcohol expectancies, family history, peer influence and personality characteristics may act as confounders in the relationship between exposure to advertising and subsequent alcohol use[5,6]. ([5]Donovan, J.E. 2004. Adolescent alcohol initiation: a review of psychosocial risk factors. Journal of Adolescent Health, 35(6):529.e7-18. [6]Smith L. A. and Foxcroft D. R. 2009. The effect of alcohol advertising, marketing and portrayal on drinking behaviour in young, BMC Public Health)	Thank you for your comment Whilst interventions specially aiming to address the social influences on were not included in the review work – the PDG recognises the importance of these influences on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were developed.

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The Scotch Whisky Association			Recommendation 3: marketing	20	Whilst acknowledging the evidence on an advertising ban is inconclusive. The document goes on to state 'However, a tobacco advertising ban has helped reduce the prevalence of smoking' there are two points: 1. There appears to be no evidence in the background document to support this claim. 2. In relation to tobacco the objective is to encourage consumers to stop. That is not the case in relation to alcohol consumption. Moderate, responsible consumption can be part of a healthy lifestyle. This guidance is aimed at preventing the development of hazardous and harmful drinking not consumption *per se* as is the case with tobacco.	Thank you for comment. The guidance document has been clarified.
The Scotch Whisky Association			Recommendation 3: marketing. What action could be taken, first bullet point	20	What is the justification for this recommendation? The UK operates an effective co-regulatory system which includes monitoring. Full details were set out in the ASA submission and commented on in the submission from DCMS. The ASA Compliance Survey Report 2009 on Alcohol advertising revealed a 99% compliance rate.	Thank you for your comment. This recommendation has now been revised.

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The Scotch Whisky Association			Recommendation 3: marketing. What action could be taken, second bullet point	20	Can you explain how the 5% threshold was arrived at as it is not clear from the evidence statements presented.	Thank you for comment. As a result of the consultation process the committee have revised this element of the advertising recommendation.
The Scotch Whisky Association			Recommendation 3: marketing. What action could be taken, fourth bullet point	20	The evidence is inconclusive as to the impact an advertising ban would have on consumption. Indeed the ScHARR review notes an increase in consumption is reported by some studies. It is therefore unclear how this recommendation has been arrived at. Please can you clarify?	Thank you for your comment. Following the consultation process the recommendation pertaining to advertising has been revised, including the bullet regarding the introduction of an alcohol advertising ban. NICE public health recommendations are based on both empirical data and reasoning. Empirical data on its own, even from the best conducted investigation, is not sufficient. It has to be interpreted and analysed to provide answers for policy makers, practitioners and guidance producers. NICE's independent advisory committees use both inductive reasoning (based on the best available empirical data) and deductive reasoning (based on prior knowledge and understanding), along with existing models and theories.

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The Scotch Whisky Association			UK governmen t drinking guidelines	35	In relation to the sensible drinking guidelines for men and women a sentence is included stating 'Both are recommended to have some alcohol free days.' The Sensible Drinking Report, Department of Health 1995, para 9.9 and 10.21 both discuss drink free days, but I can find no reference to the above statement. Can you clarify, please, where this statement originates from?	Thank you for your comment the guidance document has been clarified.
The Scotch Whisky Association			Key questions: Q4	44	In relation to children and young people what assessment was made of the influences peer pressure and family on their alcohol consumption? We note the Statistics on Alcohol: England 2009 Report notes the proportion of 11-15 year olds who have never drunk alcohol is increasing - 39% in 2003 to 46% in 2007.	Thank you for your comment. Whilst interventions specially aiming to address the social influences on were not included in the review work – the PDG recognises the importance of these influences on drinking harmful and hazardous amounts across the whole population and took account of these in the context of the interventions that were developed.
The Scotch Whisky Association			Economic modelling work	48	Can you clarify please; was the modelling report referred to peer reviewed?	Thank you for your comment. Whilst NICE evidence reviews are not subject to formal academic journal peer review, there a number of processes that subject the reports to that process, including contractor in-house review prior to submission to NICE; technical review by NICE team and importantly stakeholder review during the 4 week consultation period.

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Wine and Spirit Trade Association			2	5	Though alcohol consumption has risen compared to1986/7, Alcohol consumption peaked in 2004 and has fallen 6% to 2008 [*BBPA/HMRC].* It is also worth noting that over a longer time period, current levels of alcohol consumption are similar to 1900, when per capita consumption was 11 litres of pure alcohol *[BBPA Statistical Handbook 2009]*	Thank you for your comment. The guidance document has been clarified.
Wine and Spirit Trade Association			3.6	10	We do not believe that a population level approach to reducing alcohol consumption would be effective in reducing health and social harms and the cost resulting from them. Evidence from the past five years shows that a reduction in per capita alcohol consumption has occurred at the same time as rising harms and costs. What is needed are interventions targeted at those who misuse alcohol, rather than the whole population.	Thank you for your comment. The guidance document also addresses dealing with alcohol use disorders at an individual level.
Wine and Spirit Trade Association			3.7	10	We would dispute that there is enough evidence of the effect of minimum pricing, given that it has never been carried out on a national basis with the aim of reducing alcohol misuse. Aside from concerns about whether small price rises would discourage harmful drinkers rather than just reduce consumption across the population, the economic modelling from ScHARR, Sheffield University purports to show significant reductions in the cost of health and social harms from reductions in per capita alcohol consumption, yet per capita consumption has declined 6% since 2004 (which according to the model should have reduced costs by £2.3bn) and these costs are rising.	Thank you for your comment.

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Wine and Spirit Trade Association			3.8	11	Do lower levels of spending amongst low income groups show that they would not be affected by minimum pricing? It is more likely that low income groups spend less per week on alcohol because they buy lower priced products which are in fact more likely to be affected by price intervention.	Thank you for your comment. The guidance document has been clarified.
Wine and Spirit Trade Association			3.9		Availability of alcohol both in terms of price and number of outlets, is highly restricted in Norway and Sweden. However both these countries, along with Britain, rank highly in ESPAD studies in terms of number of teenagers who binge drink *[Hibell et al, 1995-2009*], suggesting that while availability may reduce consumption among some drinkers, it does not prevent harmful patterns of drinking.	Thank you for your comment.

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Wine and Spirit Trade Association			3.10		It is worth noting that at its height, booze-cruising during the 1990s made up a significant proportion of UK consumption. At the time there was a significant price differential between the price of alcohol in the UK compared to France and Belgium. It is estimated that consumption from imports from Europe accounted for approximately 8% of UK consumption in 2000. This figure excludes duty-free imports which are likely to increase the figure to closer to 10% of consumption. More recently, tax rises and exchange rates have created a gulf between prices in the Republic of Ireland and Northern Ireland. This led to 7% fall off in alcohol sales in the Republic and a 30% increase in off trade sales in Northern Ireland (to August 2009) *[Nielsen Ireland]* . This shows the effect of price differentials between neighbour countries.	Thank you for your comment. The guidance document has been clarified in relation to alcohol imports.
Wine and Spirit Trade Association				18	Chief Medical Officer is an advisory rather than an executive role and giving this unelected individual charge of a cross cutting policy area would entail Ministers giving up a large amount of control over policy making. The CMO is also unlikely to have the expertise necessary to work across all agencies of Government. Working specifically with the Department of Health furthermore strips the position of independence when assessing policy issues around alcohol.	Thank you for your comment. The guidance document has been clarified.

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Wine and Spirit Trade Association				18	On the point that national interventions are more likely to be effective and cost effective than local interventions, it should be pointed out that the licensing regime is devolved to Local Authorities and therefore national policy changes would entail changes by every individual local authority, creating a significant amount of public sector cost and upheaval. Likewise, any measures on price and advertising would need a corresponding enforcement regime at a local level.	Thank you for your comment, your concerns have been noted.
Wine and Spirit Trade Association				19	There are issues of legality around minimum pricing. The ECJ has recently ruled that the measure is illegal for cigarettes where it has been imposed in Ireland, Austria and France- making it unlikely that it would be allowable for alcohol.	Thank you for your comment. The case you refer applies to a tobacco specific directive and therefore is not directly applicable to alcohol.
Wine and Spirit Trade Association				19	Alcohol duties have risen above inflation for a number of years and the Government has announced an above inflation escalator for the next three years. Duty on wine has risen 20% since March 2008.	Thank you for comment. As a result of the consultation process the committee have revised this aspect of the recommendations.
Wine and Spirit Trade Association				20	We are unsure what is meant by Licensing Departments having an enforcement roll. They are currently judges of licensing applications and reviews and work closely with trading standards and police on enforcement.	Thank you for your comment. The guidance has been clarified.
Wine and Spirit Trade Association				19	Licensing legislation already takes account of crime and disorder when a new application is made or when reviewing an existing one.	Thank you for your comment. The purpose of this recommendation is to reinforce the current provisions of the licensing act.

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Wine and Spirit Trade Association					Evidence statements 2.19- 2.225 give very equivocal evidence on the effect of outlet density on alcohol related harm, especially in a UK context, making it surprising that such strong recommendations have been made on this point.	Thank you for your comment. NICE public health recommendations are based on both empirical data and reasoning. Empirical data on its own, even from the best conducted investigation, is not sufficient. It has to be interpreted and analysed to provide answers for policy makers, practitioners and guidance producers. NICE's independent advisory committees use both inductive reasoning (based on the best available empirical data) and deductive reasoning (based on prior knowledge and understanding), along with existing models and theories.
Wine and Spirit Trade Association				20	Public Health as a licensing objective was debated very recently, when the latest Licensing Act was being developed. It was felt that it was not appropriate for Licensing Authorities to interpret population level guidance on public health, especially as their interest and expertise lies in local law and order issues. Nothing has changed to suggest that this decision should be reviewed.	Thank you for your comment. The PDG was aware of the recent debates.
Wine and Spirit Trade Association				20	Altering personal import allowances is unlikely to have any impact on alcohol consumption. This sector is currently very small. The only reason this would be necessary is if excessive regulation/ taxation were imposed on the alcohol industry. It is unlikely that this allowance could be reduced without infringing European law.	Thank you for your comment. The committee discussed this aspect and felt that in order to support the introduction of a minimum price per unit this consideration should be given to the revision of personal import allowances.

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Wine and Spirit Trade Association			2	20	These recommendations are very stringent, yet the reviews of effectiveness and cost effectiveness done for this work program have been unable to offer conclusive evidence that there is a link between advertising and consumption, let alone harm (evidence statement 3.8).	Thank you for your comment. As a result of the consultation process the committee have made some revisions to the recommendations. The PDG recognised that empirical data alone, even from the best conducted investigation, seldom provides a sufficient basis for making recommendations. This data requires interpretation and analysis, using prior knowledge and understanding and existing models and theories. Therefore, the PDG developed its recommendations using the best available empirical data and inductive and deductive reasoning.
Wine and Spirit Trade Association				20	The policy would have an impact on sport, media and arts funding which would be hard to correct without more Government funding for these industries *[Health Select Committee, Oral Evidence 15th October]*	Thank you for your comment. As a result of the consultation process the committee have made some revisions to the advertising recommendation.
Wine and Spirit Trade Association				20	By recommending a regulatory system, is NICE recommending bringing the work of the Advertising Standards Authority into Government?	Thank you for your comment. As a result of the consultation process the committee have made some revisions to the advertising recommendation.

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Wine and Spirit Trade Association					Given the inconclusive evidence of whether it would be effective, it is hard to see why NICE would recommend a total ban on advertising and sponsorship by alcohol companies. Loi Evin in France has had no evidence of any effect on alcohol consumption and the main justification of it is its symbolic effect *[Inst. Alcohol Studies: The 'Loi Evin': a French exception].*	Thank you for your comment. As a result of the consultation process the committee have made some revisions to the advertising recommendation.
Wine and Spirit Trade Association			4	21	NICE should consider the need to address the demand side as well as the supply side of illegal sales. This could be done through recommendations on preventing proxy purchasing and discouraging young people from attempting to buy alcohol and confiscating alcohol from young people. Of the 11-15-year-olds who drank 14 or more units in the previous week, 48 per cent claim to have been given alcohol directly by their parents [*Youth Alcohol Action Plan].* Underage sales from shops have been driven down dramatically since 2005 when they were at an unacceptable 50%. In 2007, a campaign targeted specifically on problem premises delivered a result of 15 per cent overall *[Home Office, Oct 2007*]. Retailers are focused on the problem which is already well enforced and further recommendations in this area are unlikely to add anything new to the issue.	Thank you for your comment. As a result of the consultation process the committee have made some revisions to the recommendation and acknowledge the need to address proxy purchases.

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Wine and Spirit Trade Association			4	21	Good results have been achieved where retailers (on and off trade) have been involved as partners in ensuring responsible sale of alcohol (as acknowledged in Evidence Statement 2.8) and we would argue that retailers should be included in the list of groups who take action.	Thank you for your comment.
Wine and Spirit Trade Association				39	It is interesting to note that the Programme Development Group does not have any representation from the alcohol industry, or business generally. Such representation would have given insight into how businesses operate and how the recommendations would work at a practical level.	Thank you. The PDG was appointed by open competition and all stakeholders were eligible to apply. The processes for membership of all NICE committees are open and available to all. Further details of the process of recruitment can be found at: www.nice.org.uk/phprocess
NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			General	General	In addition to the Comments forwarded on by BALANCE (North East Regional Alcohol office) which are fully supported, the NHS North of Tyne has a number of additional comments which have come in from professionals across the 3 PCO areas which are outlined below. Whilst the NHS North of Tyne supports the publication of the draft guidance 'Alcohol-use disorders: preventing the development of hazardous and harmful drinking', it would be good in the overview/intro to comment on the impact and possible consequences specific to young people including anti-social behaviour, teenage pregnancy, STIs and health consequences in relation to extensive use and immature liver.	Thank you for your comment. The introductory section of the guidance document does highlight the detrimental effects of alcohol.

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NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			General	Overall commentary	Overall, the guidance appears more focussed around health and criminal justice and should be more inclusive of education and other partners. We need to be more transparent about inferences derived from the evidence but not be reticent about using this in practice, as we can be fairly sure that the benefits of using brief interventions with younger people and in a range of settings will be more likely to have positive effects and at the very least, will do no harm, alongside the usual course of action. Therefore, the undertaking of a brief advice approach in a range of settings with a range of age-groups need to be supported, providing it is underpinned by training and support at a local level.	Thank you for your comment. NICE has already developed guidance relating to the education sector: School-based interventions on alcohol http://guidance.nice.org.uk/PH7 . And is developing guidance on: Personal, social and health education focusing on sex and relationships and alcohol education http://guidance.nice.org.uk/PHG/Wave12/77
NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Section on cost of alcohol-use disorders	7	It would be helpful to view NI39 data in the context of adults and young people	Thank you for your comment.
NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Section on cost of alcohol-use disorders	7	There needs to be an improved understanding of 'hot spots' which can be masked by data reporting at whole county level and does not clearly identify those areas with significant alcohol related health and social harms	Thank you for your comment.

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NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			3	9	Feedback from our working groups suggests people relate more to the term “increasing risk” and “higher risk”	Thank you for your comment. The guidance document has been clarified.
NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			3	13	The wording of this point may be misleading, there is limited evidence on the basis that there have been limited studies in this area, not that studies have been undertaken which have failed to prove efficacy. It would be good to see more commissioned research in these areas, rather than perpetuate the research around health and criminal justice settings.	Thank you for your comment. The guidance document has been clarified.
NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Recommendation 5	21	We need to be more pragmatic than say just 16 and above, many young people are drinking at increasing and higher risk levels and, in the absence of high levels of specialist capacity to refer all to, professionals in universal settings need the tools to start to address issues around young people’s alcohol use	Thank you for your comment. Following the consultation process the recommendations pertaining to those under the age of 16 (recommendation6) has been amended. As such it was felt appropriate to widen the scope of recommendation 5.

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NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Recommendation 6	23	Not sure what "Routinely assess the ability of these children and young people to consent to alcohol related interventions and treatment" means. Does this mean we can offer a brief advice? We need to know what alcohol related interventions means, but this would suggest it is not brief intervention as that term has not been used. This needs to be clearer and needs to encompass a wider group of professionals. Does not adequately support local needs in managing young people's drinking as the amount of young people drinking at these levels potentially far outweighs the capacity to refer to specialist services or CAF, if we do not engage with the young person using a brief interventions approach, we will potentially miss an opportunity for early intervention, this does not suggest onward referral, CAF etc will not also be used alongside, but will ensure the young person has had the opportunity to discuss their drinking and the non specialist worker is clear about the amount and impact this is having. CAF does not screen for drinking and should only be used if there is a need for CAF. Technically, these guidelines are suggesting that anyone under 16 drinking outside the CMO guidelines should have a CAF, realistically, we know that there is a huge percentage locally of young people between 10 and 16 are drinking at varying levels and that onward referral or CAF for all of these would simply swamp the system.	Thank you for your comment. The PDG debated these issues at length; unfortunately there is little or no effectiveness evidence of benefits for particular interventions either alone or in comparison for this particular group. The PDG felt that there was a need for professional judgement in determining the appropriate course of action. Research recommendations have been made and adjustments to the guidance have been made where appropriate.

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NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Recommendation 6	23	We also know that many of these young people will initially be identified in non health or social care settings therefore we need to ensure that areas such as education, have the knowledge to identify the triggers and the confidence to manage the issue in the first instance. Young people under 16 will regularly appear in tutorials, school health drop-ins etc where the issue which brought them there may not be alcohol, but may be related to alcohol use, it is remiss not to use an IBA approach at this point. Recommendation 6 states that the evidence base is IDE (Inference Derived from the Evidence), is this then clear that we can do brief interventions with under 16's? Perhaps we need to be mindful of recommendation 9 which states "work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns." This needs to be the same for young people and is certainly what local practitioners and professionals are asking for. IBA gives the worker in any universal setting the opportunity to discuss alcohol in a structured way and will potentially allow the worker to screen more effectively in order to make onward referrals. We need to not take a blanket approach to saying that IBA should not happen with under 16s as this potentially leaves many workers, pastoral staff, teachers, educational welfare etc with limited knowledge of how to deal with these issues in the first instance, reducing the opportunity to impact early.	Please see previous comment.

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NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Recommendation 6	23	IBA training for this group needs to be sensitive to the fact the person is under 16 but will give workers knowledge and confidence to screen, provide early brief advice and understand referral pathways, alongside their usual course of action. This recommendation should add a brief advice session to the list of what to do. ***School Based Interventions on Alcohol*** also gives, under **recommendation 2**, the guidance to offer one – one brief advice in schools, therefore , this guidance should compliment that advice and offering one-one brief advice should be in the actions, and education settings should be in the section "who should take action"	Thank you for comment. As a result of the consultation process the committee have made some revisions to the recommendations.
NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Recommendation 7	24	This misses an opportunity to include higher education and other professional who will have direct contact with this group. Needs to cite education staff as a key group, and could cite attainment as a concern area. There would be of course a need to robustly evaluate to measure impact.	Thank you for your comment.

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NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Recommendation 9	26	This is limited in its target group, we could include other professionals such as housing and tenancy staff, fire services, Gym staff etc – can we not now be at the point of training any universal staff group where alcohol may be the underlying cause of the difficulty they are trying to manage with the individual. The guidance feels that it is continuing to focus on health and criminal justice setting but we need to be wider in our approach and training of IBA in order to have a bigger impact.	Thank you for comment. As a result of the consultation process the committee have made some revisions to the "who should action" element.
NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Recommendation 12	30	This directly contradicts recommendation 6. Non NHS professionals working with those over 10 years old will only identify dependence if they have had training and support to do so. Also suggests this is the course of action if they fail to respond to brief advice, however, recommendation 6 does not recommend brief advice under 16 and does not include all non-NHS professionals in the "who should take action" section. There is also no suggestion to use AUDIT for those under 16. UK drinking guidelines – can the guidelines for young people be added here	Thank you for your comment. The guidance has been clarified. The Chief medical officer's recommendation on alcohol consumption in children has been referred to within the document.
NHS North of Tyne encompassing: Newcastle PCT, North Tyneside PCT, Northumberland Care Trust			Recommendation 9 and 10	28	We need to be more inclusive and less focussed around these settings if we want to have maximum impact and build our public health workforce.	Thank you for your comment.

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