Alcohol Use Disorders: preventing the development of hazardous or harmful drinking

NICE Public Health Intervention Guidance

Fieldwork report

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Please note that as this report was prepared to provide an account of the views and opinions of professionals in response to draft NICE guidance, data reported should not be considered to necessarily reflect the views of NICE, the meeting facilitators, or the Centre for Public Health, LJMU.

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Executive Summary

Introduction

The Department of Health requested that the Centre for Public Health Excellence (CPHE) at the National Institute for Health and Clinical Excellence (NICE) produce guidance on a public health programme aimed at the prevention and early identification of alcohol- use disorders in adults and adolescents. The guidance was developed alongside the NICE clinical guideline in the management of alcohol-use disorders in adults and adolescents. Based on the findings of an effectiveness review and economic appraisal, 12 draft recommendations were developed. The guidance is aimed at professionals and managers with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors. It is also aimed at those specifically concerned with alcohol (including those with a remit to reduce alcohol-related harm). This includes: licensing boards; retailers; the alcohol industry; criminal justice system; and policy makers. In addition, it will be of interest to community groups and other members of the public.

The National Institute for Health and Clinical excellence (NICE) commissioned the Centre for Public Health (CPH) at Liverpool John Moores University (LJMU) to conduct fieldwork to support the development of NICE guidance for alcohol-use disorders (prevention) in adults and young people. The aim of the fieldwork meetings was to elicit views on the likelihood of implementing the draft recommendations in local and national policy, practice and law enforcement. Fieldwork took place between November and December 2009.

Methodology

A total of five fieldwork meetings (Bristol, Liverpool, London, Birmingham and Leicester) were conducted to field-test the draft recommendations. In addition, an online survey was conducted to capture the views of those professionals who could not attend the fieldwork meetings but who still wished to contribute. A matrix of relevant professional roles was constructed and convenience sampling was undertaken across each of the fields, whilst ensuring that independent, voluntary and community sectors were represented.

Discussion was facilitated by CPH and independent facilitators allied to the Department. Each draft recommendation was introduced and delegates were asked to consider '*Given that the evidence suggests that a particular kind of intervention/activity has worked in the following circumstances, and that this should form the basis of a recommendation, what would need to be done to make it work in your local situation'?* A follow up prompt was '*If this would not work, why not – and what would'?* Delegates were asked to identify the possible barriers or facilitators to successfully implementing a suggested intervention/activity, solutions to these barriers, and implications of the intervention in terms of increasing equalities in health and social inclusion. Three general areas were explored; *Relevance of the draft recommendations*: What is the current practice of professionals working in the area? Are the recommendations appropriate for these professional groups? Is there evidence, from

practice or other sources, that has not been considered in developing these recommendations? *Usefulness*: How might these recommendations build on or change current practice and/or service provision? What are the implications of this? Are they accessible and clear? Are they appropriate to different client groups? Are they likely to be sustainable? *Feasibility*: What are the barriers to/opportunities for implementation? What further resources, training or support might be needed to implement them? To which other professional groups might they apply? How might the range of professional groups involved be reached? Discussions were transcribed and themes categorised within and between groups.

Findings

A summary of themes emerging from discussion of each particular recommendation is provided below. The main report contains a much more detailed consideration of each:

General

- A treatment pathway matrix should be provided which would not only visualise the stages of care that the recommendations covered, but also outlines the roles and responsibilities of different professional groups in delivering the guidance.
- Good communication was needed between NICE and organisations in non healthcare settings in order to establish alcohol at the heart of partnership working.
- NICE should work closely with the National Treatment Agency (NTA) to ensure that commissioners' concerns about lack of investment in alcohol service relative to drug service were considered.
- The use of the term *motivational counselling* should be reconsidered or clearly differentiated from other motivational approaches.
- The presentation of the guidance will contribute to its impact and likely adoption. A standard approach should be used whereby each recommendation is preceded by a short statement of the evidence and a discussion of the likely outcomes of implementing the proposed actions.
- The contribution of third sector, community and voluntary groups in responding to alcohol related harm should be acknowledged and organisations working in these sectors should be mentioned throughout the guidance.

Recommendation 1 - pricing

- The language of the recommendation was criticised. It was believed that if NICE was serious about Government implementing its recommendations then imperative forms of language should be used.
- The concept of minimum pricing would be likely to be unpopular with politicians and members of the public. It should be introduced gradually and the benefits explained. The true cost of minimum pricing to the industry and consumers should be clearly defined.

- The majority of public health professionals supported minimum pricing initiatives regardless of the opposition this might provoke. If introduced this should not be optional and a specific unit price should be provided.
- Delegates anticipated that the experiences and legal rulings on the proposed introduction of minimum pricing in Scotland would dictate policy in England.
- Some local authorities had introduced schemes which sought to control alcohol pricing through licensing conditions.
- There was a concern that decreasing the affordability of alcohol for some groups would have unintended effects such as increased illicit drug use and petty crime. This might be offset by the health service and criminal justice savings that a reduction in problematic alcohol use might bring.
- Participants had little understanding of how linking alcohol pricing to inflation and earnings might work, or how it currently worked in places such as Australia.

Recommendation 2 - availability

- The inclusion of public health objectives in licensing was welcomed.
- Local authorities already had powers to close premises that were selling alcohol irresponsibly or in a manner that might harm public health, but these powers were infrequently and inconsistently applied.
- The procedure for granting licenses should be reviewed. Health and social care representatives should be included as decision makers.
- Partnerships should be established with regional public health observatories and University departments to streamline the reporting of data to inform licensing strategies.
- Delegates were unsure whether, with respect to EU law, alcohol import allowances could be changed.

Recommendation 3 - marketing

- For consistency, print media should be included in the list of sources from which alcohol advertising should be banned.
- NICE should acknowledge that the evidence supporting this recommendation is relatively weak.
- A code of practice on the advertising of alcohol using new media such as mobile phones and the internet is required.
- Regulatory systems already exist that control the content of alcohol advertisements. These systems were thought to be successful by the alcohol industry. Some delegates wished to see these bodies granted more punitive powers (e.g. fining offenders).
- NICE may need to review its guidance if product placement in TV shows is introduced through the Department for Culture, Media and Sport.

- Banning alcohol advertisements from media outlets where more than 5% of the audience was aged under 18 was considered to be equivalent to a total ban.
- Young people learn about alcohol not just through advertisements but also how drinking, and its uses and consequences are portrayed within TV programmes and other media. NICE should consider how programme creators can be persuaded to include healthier representations of alcohol use in storylines and other content.
- The alcohol industry seeks to distance itself from the irresponsible promotion of brands on user generated and social media websites. It has little control over the content that web users choose to upload to personal sites or unofficial 'fan pages'.
- NICE needs to be clearer on what the 'facts' on alcohol should be; whether this should include a balance of positive and negative aspects, or whether they should be limited to price and alcohol content.

Recommendation 4 - licensing

- Alcohol needs assessments should have already provided a good indication of local alcohol related problems. Toolkits are available for those organisations wishing to update, or improve the quality of existing reports.
- Licensing officers already have, and use, a range of powers to control the number of licensed premises in an area or to review existing licenses. The use of cumulative impact policies meant that individual premises were not usually isolated and targetted for action. Furthermore, local authorities preferred to take more strategic action to deal with problematic alcohol use in particular geographical areas as trouble was unlikely to be restricted to a single venue and would result from a combination of structural and environmental factors.
- Test purchasing and 'mystery shopper' schemes were perceived to be valuable but did not receive sustained funding to be particularly effective. Furthermore, restrictions placed on test purchasers (e.g. unable to lie about age, carry fake ID or wear makeup) meant that they provided a poor simulation of 'real world' alcohol purchasing conditions.
- Licensing officers believed that existing laws were sufficient to control irresponsible retailing. However, these were inconsistently applied and often provided little punitive discouragement. It was suggested that harsher fines and 24 hour premises closures could be potential options for dealing with irresponsible retailers.
- The introduction of alcohol server schemes were supported. These would allow retailers to respond to signs of problematic drinking. Key features of such schemes should include training to allow recognition of intoxication, confidence building (to support refusal of service to intoxicated customers), awareness of the law, and basic health promotion skills.

Recommendation 5 – resources for screening and brief intervention

- The range of NICE guidance that will be available by the end of 2010 (including clinical guidance) should be seen as a suite of responses to alcohol misuse. Professionals should not consider one piece of guidance in isolation from others.
- World Class Commissioning would provide the framework for delivery of most of the draft recommendations.
- Standardisation in descriptors of types of alcohol misuse was required as there was the suggestion that the Department of Health prefers to express alcohol use in terms of the level of risk posed.
- There may be public resistance to an increase level of scrutiny of the role of alcohol in their lives. The purpose of screening in non-traditional settings (e.g. dentists, pharmacists) should be clearly explained and justified.
- There was the belief that alcohol services had been under resourced for many years compared with drug treatment. There needs to be a clear differentiation between drug and alcohol services, with equivalent funding, if a comprehensive public health and social welfare response is to be delivered.
- Attention needs to be paid to changes in alcohol drinking when clients move from young people to adult services. Clients often disengage when they leave services at the age of 18 and may re-present several years later with increased problematic behaviour.
- All services expected to respond to alcohol misuse would benefit from clearly defined joint commissioning. Clients would benefit due to a more integrated treatment pathway.
- Abstinence based approaches should be supported by NICE if there is the evidence to back these up.
- An increase in referrals to tier 2 and 3 services as a result of more widespread screening would worsen the current 'bottle neck' and waiting lists for people needing more specialist help.
- Existing budgets were thought to be insufficient to cope with the increase in screening and referral recommended. NICE should investigate the use of free online training courses to support skills development.
- Training for professionals should not just be alcohol specific. General competencies were important as well as modules that explored and enriched trainees attitudes to alcohol and individuals with alcohol related problems.
- There are many local examples of screening and referral schemes based on use of the AUDIT and other validated tools.

Recommendation 6 – supporting children and young people aged 10 to 15

- 'Safe' unit limits have not been established for young people. It is therefore important that the role of alcohol in the client's wider biography should be evaluated before considering further action or referral.
- Non-healthcare professionals would need encouragement and incentivisation (not necessarily financial) to deliver NICE guidance. The first step should be for NICE to identify which roles they expect to integrate the recommendations in their professional practice.
- More explicit reference needs to be made to Hidden Harm throughout the draft guidance, but in particular for this recommendation.
- Schools were usually the first place that young people's alcohol use became apparent. Earlier NICE guidance (PH7 School based interventions on alcohol) is important in this regard. NICE should be aware of, and contribute to the current DCSF consultation on its updated drugs and alcohol guidance for schools.
- The follow up and monitoring of young people presenting at A&E with alcohol related conditions needs to be improved.
- Even in non-intoxicated states young people may not be able to fully consent to receiving an intervention or referral. In some instances young people may not understand the implications of their behaviour and why support was required. In circumstances where practitioners had concerns over a young client's wellbeing, providing support was more important than establishing whether the young person had full understanding of what actions were proposed.
- The ability of local CAMHS to effectively respond to young people with alcohol related problems should be established before referral is made.

Recommendation 7 – screening young people aged 16 and 17 years

- The Common Assessment Framework should continue to be used with this age group and so should be mentioned somewhere in the text.
- As long as they had received suitable training it was appropriate for a range of non-specialists to screen young people. At a minimum, training should cover non-confrontational ways of broaching the subject of alcohol, the use of appropriate tools, and interpretation of AUDIT scores in different populations and age groups.
- Screening should be included in alcohol education components of PSHE.
- Screening should not be used to gain evidence to punish young people.
- Co-location of alcohol specialists (e.g. alcohol nurse specialist) in A&E would be a better means of screening presentations than relying on busy emergency staff.
- Other groups that delegates believed to be at particular harm, warranting specific mention in this and other recommendations, included; young people using illicit substances; teenage parents; those with mental health problems; young people in families with substance use disorders; 16-17 year olds who drink at home with parents; young people at risk of mental

illness. One group requested clarification of the meaning of someone being 'at risk' of self harm, namely whether this referred to young people who had self harmed in the past or who were likely to self harm in the future. Furthermore, self harm did not necessarily refer solely to cutting, but could also mean eating disorders and harmful sexual practices (e.g. exploitative relationships, sex work or trading sex for goods).

- Engaging minority faiths and cultures in health promotion can sometimes be challenging. NICE should be aware of factors such as collusion between problematic drinkers and gatekeepers in denying the existence of alcohol-related problems; the rejection of 'Westernised' models of intervention; and the ethical issues of changing traditional healthcare practices to accommodate more conventional types of intervention.

Recommendation 8 – motivational counselling with young people aged 16 and 17 years

- In more problematic cases, rather than repeated screening and referral, an integrated care pathway approach should be taken, whereby a young person would work with only one or two practitioners who would guide them through all the different assessments and interventions required.
- There are few specialist young person's alcohol treatment services in the UK. The majority of those that accept young people are either adult services or have adopted adult models. This should be considered when recommending referral.
- Although working according to motivational principles NICE should recognise that much of practitioners work with young people was undertaken informally as this was the only way to engage clients.
- Court mandated interventions would not require the young person's permission.
- The outcomes of training are rarely evaluated, whether in relation to the development of trainees' skills or the effects of training on public health outcomes. NICE should encourage research into the effectiveness of motivational counselling training and seek to identify how training could become standardised and/or accredited.
- More information is required on the physical and mental assessment actions in this recommendation. Detail is needed on whether this should only be undertaken by a clinician, or whether self report or assessment through the CAF is sufficient.

Recommendation 9 – screening adults

- Funding restrictions would mean that it would not be feasible to deliver this recommendation as required. It is likely that a 'watered-down' version would be put in place whereby only selected groups of NHS staff would conduct training. To support implementation, targets should be set on the amount of screening taking place each year, and (additional) payment to GPs and pharmacists could be made on the basis of the number of referrals made rather than just the number of screens.

- In a similar manner to recommendations for young people's practice it was believed that some non-healthcare roles would opt out of delivery of this recommendation if they were not specifically mentioned. Suggested roles included the fire service, educators, employment officers, and the police force and other criminal justice workers.
- Problematic drug users, smokers, those with mental illnesses, perpetrators and victims of (domestic) violence, the long term workless, and the obese were all thought to have important needs related to alcohol. Delegates believed that the draft guidance should also include specific reference to these groups.
- The reasons for revision of AUDIT scores for particular groups should be fully explained and advice given on what revised scores should be.
- It is insufficient for non-English versions of screening tools to be available. Specialist translators and interpreters should also be available to help interpret the results. Greater consideration also needs to be made on how services will work with those clients with learning disabilities and difficulties.
- There was general agreement that outside of A&E, biochemical measures weren't useful in routine practice. This was due to their expense and that they sometimes provided unhelpful, time limited results. For example a drinker who had indirectly experienced harm from their alcohol use (e.g. perpetrator/victim of violence) might show liver functioning within the normal range.

Recommendation 10 – brief advice for adults

- Current finances would not be sufficient to provide training for both healthcare and non-healthcare specialists.
- The expected outcomes and limitations of brief intervention need to be clearly stated so that professionals would understand when referral was more appropriate.
- If properly trained, non-healthcare professionals should also be given the opportunity to conduct FRAMES based interventions.
- Comprehensive data sharing protocols would be needed to ensure that the range of professionals listed would know they were working with a hazardous drinker. Alternatively, if it was expected that non-specialists would also conduct screening then it should be acknowledged that in busy commercial/professional environment it might not be feasible to offer brief advice and follow up recipients for further sessions and feedback.
- Unless directly instructed to do so it was thought unlikely that many professionals would "…*try to find time*" to conduct advice sessions as requested in action point 2.
- It should be made clearer that alcohol related harms are not just limited to those related to health. This would encourage professionals from other sectors to integrate NICE recommendations into their practice.
- An AUDIT score of 8 should not be used as the only indicator or a reduction in alcohol related harm. Alcohol related behaviours (e.g. sexual risk taking, drink driving, alcohol related

violence) should also be taken into account. As a result of public misunderstanding of meaning and quantification of alcohol units, client determined goals should not refer to them.

Recommendation 11 – motivational counselling for adults

- Motivationally based interventions were often delivered in the same services and by the same professionals as brief advice. In many cases, clients would receive brief advice before a more structured intervention. However, far fewer of the non-specialists mentioned in Recommendation 10 would be involved in delivering these types of activities as they would not have the necessary skills and training. It would be mostly tier 2 alcohol workers, with the addition of trained probation and arrest referral workers who would have responsibility for delivering this recommendation.
- Although a client might specifically request a motivationally based intervention, professional judgement should be used as to whether this is appropriate and/or an effective use of resources. Other types of intervention might be more suitable and the practitioner may believe that the client would not benefit from a motivational interview. Similarly, the decision to make on onward referral should not be made on the basis of AUDIT score alone.
- Differences in the needs and nature of the client would mean that 3 sessions lasting 20-30 minutes each may not be sufficient. It was important that funding decisions were not based solely on this model.
- NICE needs to clarify whether the absence of other types of intervention in the recommendations (e.g. family based programmes, 12 step programmes, self help) meant that they were recommending against their use.

Recommendation 12 - referral

- There was the belief that use of the AUDIT was not appropriate for children as young as 10.
- Including such as broad age range in the target population is unhelpful. Young people scoring above 20 on the AUDIT may indicate serious child protection or neglect issues and therefore the police and social services might have to be involved.
- This recommendation assumes that practitioners would have suitable specialist alcohol services to refer young people (and adults) to. Variability in the level and quality of provision suggests that this is not always the case.
- Clients showing signs of alcohol related damage would almost always be referred to specialist treatment, regardless of AUDIT score.
- NICE should refer to its (forthcoming) clinical guidance on alcohol dependence in this recommendation so that readers have a better understanding of the overall screening and treatment pathway that was proposed.

1. Introduction

The Department of Health requested that the Centre for Public Health Excellence (CHPE) at the National Institute for Health and Clinical Excellence (NICE) produce guidance on a public health programme aimed at the prevention and early identification of alcohol- use disorders in adults and adolescents. The guidance was developed alongside the NICE clinical guideline in the management of alcohol-use disorders in adults and adolescents. Based on the findings of an effectiveness review and economic appraisal, 12 draft recommendations were developed. The guidance is aimed at professionals and managers with public health as part of their remit working within the NHS, local authorities and the wider public, private, voluntary and community sectors. It is also aimed at those specifically concerned with alcohol (including those with a remit to reduce alcohol-related harm). This includes: licensing boards; retailers; the alcohol industry; criminal justice system; and policy makers. In addition, it will be of interest to community groups and other members of the public.

The National Institute for Health and Clinical excellence (NICE) commissioned the Centre for Public Health (CPH) at Liverpool John Moores University (LJMU) to conduct fieldwork to support the development of NICE guidance for alcohol-use disorders (prevention) in adults and young people. The aim of the fieldwork meetings was to elicit views on the likelihood of implementing the draft recommendations in local and national policy, practice and law enforcement. Fieldwork took place between November and December 2009. A total of five fieldwork meetings (in Bristol, Liverpool, London, Birmingham and Leicester) were conducted to field-test the draft recommendations. In addition, an online survey was conducted to capture the views of those professionals who could not attend the fieldwork meetings but who still wished to contribute.

The fieldwork (including meetings and online questionnaire) explored recommendations relating to the prevention of alcohol-use disorders in people aged 10 years and older, covering: interventions affecting the price, advertising and availability of alcohol; how best to detect alcohol misuse both in and outside primary care; and brief interventions to manage alcohol misuse in these settings. Fieldwork sought to collect views of professionals on the relevance, usefulness, and feasibility of the draft recommendations.

2. Methodology

2.1 Methods

Methods included the use of fieldwork meetings which incorporated a series of focus groups in each location. A total of 20 focus groups were conducted across five locations. Due to rescheduling of the consultation period by NICE all delegates who wished to participate in the fieldwork but were unable to attend field meetings were invited to complete an online questionnaire or take part in a semi

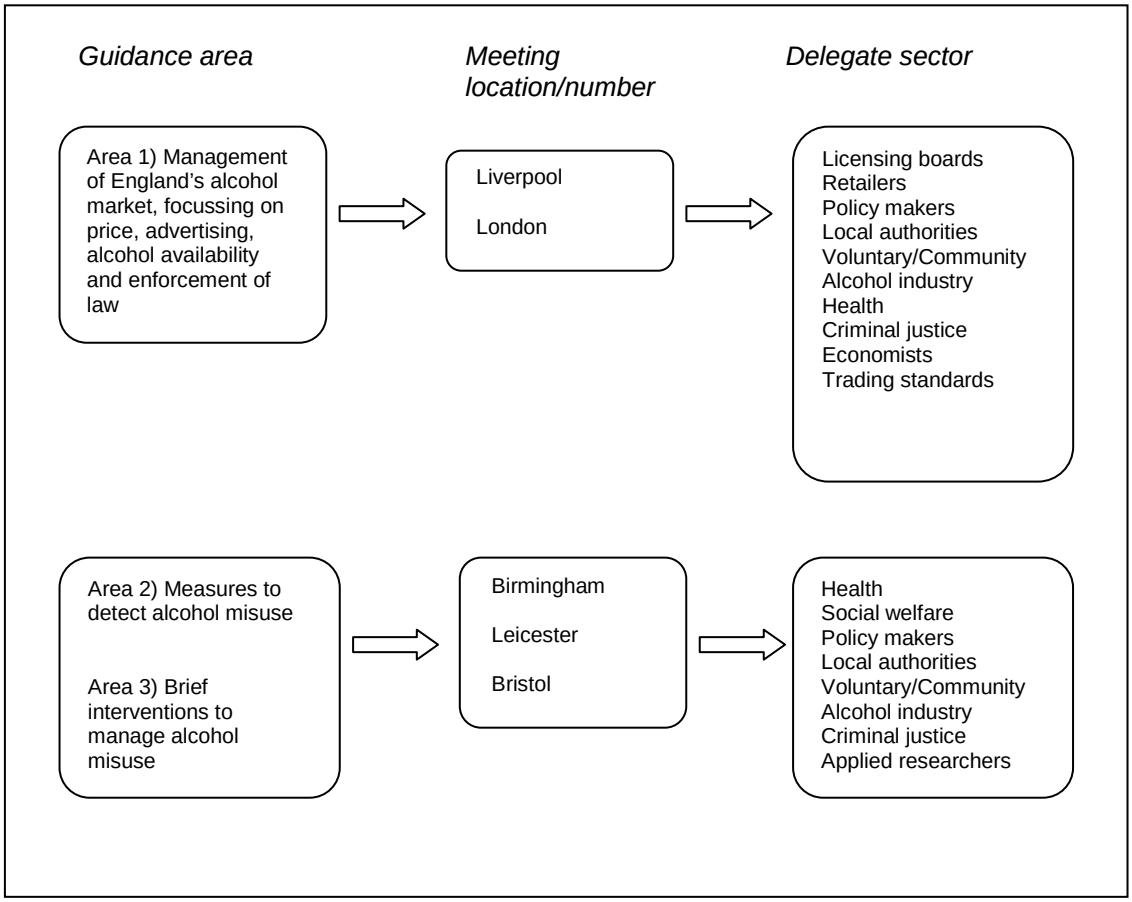
structured telephone interview. All choose to complete the online questionnaire. The fieldwork proceeded in accordance with the NICE/CPHE Methods Manual (2006; Chapter 7).

2.1.1 Fieldwork meetings

A total of five fieldwork meetings were held in the South West (Bristol), North West (Liverpool), South East (London), West Midlands (Birmingham) and East Midlands (Leicester) over a three week period. As shown in figure 1 below, the two fieldwork meetings held in London and Liverpool focussed specifically on the draft programme guidance recommendations concerning England's alcohol market (Recommendations 1-4), including price, advertising, alcohol availability and enforcement of the law (area 1). Whilst three fieldwork meetings held in Birmingham, Bristol and Leicester covered those prevention guidance recommendations concerning measures to detect alcohol misuse among adults and young people (area 2), and brief interventions to manage alcohol misuse among adults and young people (both within and outside primary care) (area 3) (Recommendations 5-12). The reason for testing recommendations under area 1 separately from areas 2 and 3 was due to the different focus the guidance covers and the need to stratify the sample accordingly. As shown in Figure 1, the focus of area 1 upon price, advertising and law enforcement required input from professionals in sectors such as licensing and retail in addition to those also listed (e.g. local authorities, the alcohol industry), whereas areas 2 and 3 required consideration from professionals in clinical health services and social welfare. Based upon the research teams' previous fieldwork experience it was also felt that testing recommendations in this way ensured that delegates are not overwhelmed by the workload required and had sufficient time to fully consider and provide feedback on the relevance, utility and implementation of the recommendations. Furthermore, despite geographic allocation, all professionals were provided with the opportunity to choose which meeting to attend.

In order to gain a detailed understanding of the political and social context in which the programme guidance is aimed at, experts from a variety of organisations and agencies were invited. A matrix of relevant professional roles was constructed and convenience sampling undertaken across health, criminal justice and social services; and independent, voluntary and community sectors. Due to the focus of the draft recommendations, emphasis was placed on policy makers, practitioners, and commissioners. Invitations were sent to professionals in suitable roles. Cross reference was made with registered NICE stakeholders to ensure adequate representation of relevant organisations. Letters were followed up by invitation emails and telephone calls where necessary.

Figure 1: Fieldwork meeting sample by guidance area and location



Each meeting lasted one working day. The first part of the meeting consisted of presentations, introducing the aims and objectives of the day, and information about the development of the draft recommendations. During the discussion periods, attendees were subdivided into groups, each working with a trained facilitator. A standard discussion guide was used by facilitators to inform the structure of discussion for each recommendation (see appendix 3). The specific prompt for discussion of each draft recommendation was:

> *Given that the evidence suggests that a particular kind of intervention/activity has worked in the following circumstances, and that this should form the basis of a recommendation, what would need to be done to make it work in your local situation?*

Example follow up prompts included: *If this would not work, why not – and what would?*

Overall, discussion focussed on three areas:

i. Relevance of the draft recommendations: What is the current practice of professionals and non professionals working in the area? Are the recommendations appropriate for these groups? Is there

evidence, from practice or other sources, that has not been considered in developing these recommendations?

ii. Usefulness: How might these recommendations build on or change current policy, practice and / or service provision? What are the implications of this? Are they accessible and clear? Are they appropriate to different client groups? Are they likely to be sustainable?

iii. Feasibility: What are the barriers to / opportunities for implementation? What further resources, training or support might be needed to implement them? To which other professional groups might they apply? How might the range of professional groups involved be reached?

Additional researchers attended meetings to provide technical advice on matters relating to the evidence review. NICE representatives (project team/implementation) were also in attendance to respond to queries on the guidance production process. The latter two groups acted as independent observers and did not contribute to the discussions unless requested for matters of clarification. To assist frank discussion, anonymity of the attendees was reinforced.

2.1.2 Online questionnaire

A short online questionnaire was developed using Bristol Online Survey (BOS; http://www.survey.bris.ac.uk) software (see Appendix 4). The questionnaire presented draft guidance and asked respondents to rate their level of agreement with components of the recommendations (e.g. relevance, usefulness, feasibility). Open questions allowed respondents to elaborate on specific issues. The results of the survey are presented in Appendix 5, although the findings are considered alongside the focus group discussions in the main results section.

Access to the online questionnaire was promoted through CPH contacts as part of the fieldwork sample recruitment outlined above (2.2.1). In addition, delegates who were registered to attend the fieldwork meetings, but did not attend on the day of events, were sent a reminder of the opportunity to complete the online questionnaire. During fieldwork meetings delegates were also reminded that they could provide comments on areas of the guidance that were not covered by the meeting they attended by using the online questionnaire.

2.2 Sample

The target sample size for area 1 fieldwork meetings was larger than the area 2 and 3 meetings (> 40 delegates compared to > 30 delegates) to ensure a sample balance for each of the three areas the recommendations covered. A total of 99 professionals participated in the fieldwork meetings from all target sectors outlined in Figure 1 above. A total of 14 participants completed the online questionnaire. Details of fieldwork meeting attendees are provided in Appendix 1 including details of the agency or organisation they represented.

2.3 Analysis

2.3.1 Field meetings

The proceedings of at least one group in each of the meetings were digitally recorded and fully transcribed. Researchers documented (through note taking) emerging themes in groups that were not fully transcribed. Qualitative data were coded from transcripts using thematic categorisation within and between groups (Glaser and Strauss, 1967; Kimchi et al., 1991). The computer software system NVivo (v8, QSR International) was used to assist all qualitative analysis.

Although work of this nature is subject to subjective interpretation by the researcher, the use of independent coding aimed to reduce sources of bias (Grbich, 2007). Each recommendation was considered separately although general themes across recommendations were also identified as they emerged. Representative quotations, attributed to professional role, were given for each theme summary. The report was circulated among the attendees of the meetings (and interviewees) for feedback and comments to check for accuracy and to ensure that anonymity in quotes was upheld.

In brief, one researcher firstly read the transcripts and coded the general themes within the responses. Validity was enhanced by the expertise and knowledge of the research team in this field, and therefore items unrelated to the topic of investigation were excluded. A second researcher repeated the above processes, checking and challenging the first coder's steps/outputs with the aim of enhancing the validity of the categorisation process and minimising any of the initial researcher's biases. Finally, each set of categories were re-read by the initial researcher in relation to all of the responses received in order to confirm that the categories reflected the thematic content of the responses. Only when consensus was reached among the researchers regarding the results of this qualitative analysis were the first draft of the fieldwork report produced.

2.3.2 Online questionnaire

Quantitative data from the online questionnaire were extracted from the Bristol Online Survey and analysed using the statistical software package SPSS (v17). Descriptive statistics were presented and data compared across geographical region and strata, such as professional role. Qualitative data obtained through open ended questions were analysed using thematic analysis as outlined above (2.3.1).

2.4. Transparency of process

A series of measures were taken to ensure that the research process was clear to all participants and that the findings presented an accurate representation of their views. Prior to the commencement of

fieldwork, delegates were provided with a copy of the draft recommendations and details of the research process, including question and feedback opportunities. As stated previously (section 2.1.1) each meeting began with a presentation which outlined the day's proceedings and provided information about the development of the draft recommendations. Delegates were provided with opportunities to ask questions before the breakout sessions commenced. Facilitators aimed to ensure that a range of views were encouraged. The online questionnaire sought to gain overall consensus of views towards the recommendations in order to compliment interview data. The online questionnaire also gained perspectives from those who were unable to attend the fieldwork meetings.

3. Results

Results from the field meetings and web survey are presented by recommendation, and each section is addressed sequentially. Results are organised to ensure a clear narrative rather than presentation of discrete sections concerning relevance, usefulness, and feasibility. Each recommendation follows the same format and illustrative quotes, which are representative of the discussion, are presented after relevant bullet points. Wherever possible the progression of each section follows the ordering of bullet points in the draft recommendations.

3.1 General Comments

At the beginning of each workshop, participants were given the opportunity to make general comments on the guidance or to ask questions on topics which they believed the draft guidance did not adequately consider. These, and more general points that arose during discussion of specific recommendations, are summarised below.

- The whole document was seen as important. Although delegates recognised that NICE only had the authority to make recommendations to NHS professionals, it was believed that good communication with professionals in other sectors and also the public was needed. Firstly, this would clearly explain the aims of initiatives such as minimum pricing, which has been subject to confusing public discussion, and secondly, would prepare members of the public for increased scrutiny of their alcohol related behaviours upon presentation to a wide variety of services. A clear elaboration of the aims of population approaches to health promotion (i.e. programmes aim to decrease the overall burden of alcohol related harm by decreasing harm in all members of the population through initiatives such as restrictions of marketing) compared to individualised interventions was also required. Secondly, it was believed that professionals in non-health sectors should have equal responsibility in identifying alcohol misuse as health workers. Although the concept of 'NHS professionals' used throughout the guidance was likely to be well understood, 'non-NHS professionals' was believed to be vague, and a wider elaboration of which roles this included should be provided. Without specification, it would be too easy for some professionals to 'opt-out' of delivering the recommendations if they believed that it did not refer to them. This would acknowledge that public health is the responsibility of all sectors of society, not just the NHS.

- Discussion of policy and licensing based recommendations was broader in perspective than those affecting practice. Discussion of the latter tended to focus on the alcohol funding situation in the UK, ordering of the recommendations, the characteristics of the suggested interventions and the language used. Policy discussions not only included consideration of the draft recommendations but also the alcohol use culture that exists in the UK and other societal factors that drove use. This meant that comments on practice recommendations were quite specific and delegates provided suggestions for particular improvements, whilst those on policy issues reflected more popular discourse and actions were discussed alongside these extraneous factors.
- Recommendations 1-4 were seen as very timely with respect to recent advocacy work from the British Medical Association and Alcohol Concern arguing for restrictions in alcohol marketing. This should be seen against the 2008 Advertising Standards Authority alcohol survey which indicated that 99% of alcohol advertisements complied with its standards.
- As with the introduction of most new guidance, participants wondered how the practice recommendations (4-12) were going to be funded. Although it has received greater attention in recent years, particularly with the increased responsibility of the National Treatment Agency, alcohol budgets were relatively small compared to that received for illegal drugs. Participants working with young people also remarked that they would not tend to commission separate drug and alcohol services, as clients would tend to present with concerns related to polysubstance use rather than independent drug or alcohol use disorders.
- Some delegates were surprised at the general nature of the recommendations as they had been expecting specific recommendations in a similar manner to NICE's clinical and technical guidance. Whilst some welcomed the relative flexibility in practice this would allow, others thought that it was important that alcohol professionals worked to the same standards and delivered comparable services. This would require a clear statement of recommend activities, screening techniques and referrals by sector/role. It was suggested that the NICE implementation team develop a guidance matrix which would identify sectors (e.g. NHS and non-NHS professionals), roles within sectors (e.g. probation officer, nurse alcohol specialist), and actions that each professional should take to achieve the aims of each recommendation.
- Commissioners of alcohol services generally thought that the guidance provided validation of recent work across the field to deliver comprehensive and integrated alcohol services. A small number of delegates thought that the guidance would stifle innovation if the services they were allowed to commission were limited to those indicated in the draft recommendations.
- There was unanimous agreement that the term *motivational counselling* used throughout the draft guidance was unhelpful. This was not a term that participants were familiar with, even those working as behaviour change specialists and counsellors. If NICE retained this term in the final guidance there was the concern that commissioners would not know how to respond. Professionals would not be trained in this technique and services would not effectively offer it. The glossary definition was thought vague as it could be applied to a number of different models of work. When questioned further, participants were unable to reach agreement on

what they thought the term meant. Part of the discussion was whether the term reflected general intervention competencies or if it referred to a specific way of working. Delegates questioned why this term had been introduced when it was not in common usage, and speculated whether it should instead refer to motivational interviewing (MI). If motivational counselling was deliberately chosen in preference to MI, the reasoning should be clearly explained and the resource implications presented.

- Those delegates supporting particular recommendations believed that statements of evidence had powerful effects on the reader. Each recommendation should be preceded by a short summary indicating the strength and quality of the evidence. This was only currently provided for recommendations 1 to 3.
- Delegates wished to see more explicit reference made to third sector and voluntary/community organisations in the guidance as it was thought that these types of service might think themselves excluded from the delivery of the recommendations.
- Delegates agreed that it was often difficult to engage with members of minority and excluded communities. However this difficulty was not seen as an excuse for not conducting work to a high standard. Working with some faith groups was thought to be particularly challenging where use of alcohol was prohibited and negotiation with gatekeepers was important. There was sometimes thought to be collusion between community leaders, the alcohol drinker and/or services where harmful behaviour was either not identified, ignored, or promises of action were provided but not fulfilled because of perceived cultural barriers. Other discussions focused on the idea that 'intervention' and health promotion were Western models, and that in some other cultures and communities the idea of outside agencies assisting families with health problems was unusual. Because of differences in cultural understanding and lack of background in prevention principles, some 'high risk' groups might also actively reject the underlying assumptions of intervention efforts or may take more time to understand and accept them. Further debate concerned ethical issues in changing 'traditional' practices and techniques to accommodate conventional forms of health and wellness interventions such as those recommended by NICE. It was thought that second and third generation migrants would have a greater level of acculturisation and would not only be more likely to be alcohol users (on a par with majority ethnic and cultural groups) but would be more likely to utilise services if necessary.

Recommendation 1 – Pricing

Who should take action?

The Chief Medical Officer should have lead responsibility for coordinating the broad approach across government, supported by the Department of Health.

The following departments and national agencies should be involved:

• Advertising Standards Authority
• Department for Business, Innovation and Skills
• Department for Children, Schools and Families
• Department for Culture, Media and Sport
• Department for Environment, Food and Rural Affairs
• Department of Communities and Local Government
• Department of Health
• Home Office
• Ministry of Justice
• National Treatment Agency
• Ofcom
• Office of Fair Trading
• Treasury.

Organisations that should be consulted include:

• alcohol producers
• off- and on-sale retailers
• national non-governmental organisations, for example, Alcohol Concern and the Royal Medical Colleges

What action should be taken?

Consider the following measures:

• Introducing a minimum price per unit.

• Linking alcohol duty to inflation and earnings.

Language of recommendation

- The language of the recommendation was criticised. Although participants acknowledged that NICE could not dictate treasury policy, most (but not all) argued that the imperative form of wording should be used (e.g. 'Minimum pricing should be introduced') rather than the current permissive form (i.e. 'Consider…). Those expressing favour with this approach argued that the recommendation should also be accompanied by a specific unit price (e.g. 40p a unit).

"This is either important enough to be looked at and for politicians to do something about it, or it isn't."

Public acceptance

- In contrast, an opposing view was that specific prices might lead to rapid rejection by law makers and the public. By gradually introducing the concept of minimum pricing, through subtle language and inclusion in alcohol debates, public acceptability might increase over time.

"In the early '90s, '93 … the price of alcohol at that time was dropping, and it dropped and your chemical ciders came on the market...And believe me, prices have been static. In fact, in some cases they have reduced. And we find ourselves now, I think, with a situation where price increases would be too great a step. So what's the other ways we can do it? And I think a minimum unit price is a step in the right direction. It doesn't redress it immediately but it's a step in the right direction."

- A comparison was drawn between alcohol and tobacco; whilst both are legally available (although purchase is restricted) the latter is subject to a high level of taxation that was widely accepted by the public. It was noted that the population was encouraged to drink sensibly, and the alcohol industry was a major provider of jobs and supported the economy. No such messages are evident for tobacco, as all levels of consumption were considered dangerous. The result of this was whilst there was clear health related messages regarding smoking, and cessation support for all types of smokers is provided, conflicting evidence was often presented for alcohol (specific examples cited included evidence that alcohol in moderation might be cardioprotective, whilst increased the risk of oral cancer). The public were therefore more resistant to proposals which might change access and affordability of alcohol.

"But it's also making the economy an awful lot of money as well and employing millions of people; people who have picked hops, people who distribute, people who manufacture glass or casting, people who sell it in shops, a whole host of small local brewers, big companies, bottlers.... it doesn't need to stay in the UK, it's a big company and it could well go to another part of Europe. We need a balance…alcohol harms and alcohol gains. It's not all doom and gloom but there are problems. But again, it's a very high tax regime and a lot of that money comes from the industry to go to central government, which has to allocate resources."

"The slight difference between smoking and drinking is, almost there's a people shouldn't be smoking, where we want people to drink the majority of times but to drink sensibly and socially. But I think what there is, is with drinking the message is very confused; it's a very mixed message. So when you hear about pricing, people all panic because they think they're going to pay tons and tons of duty. And I suppose for me, the health message with smoking is tons clearer than that with drinking. The health message with drinking is not a clear one or not made as clearly as it should be."

Political pressures

- Participants were mindful of recent political and public discussions regarding minimum alcohol unit pricing. The Prime Minister had appeared to publicly reject the idea, and there was opposition from Members of the Scottish Parliament (MSPs) in Scotland. Numerous national media commentators had also written criticising the proposals. Delegates were awaiting the outcomes of the current Scottish process with anticipation.

Professional support for minimum pricing

- Participants working in public health and allied services tended to support the introduction of minimum unit pricing, regardless of the public opposition this might provoke. Parallels to other initiatives were introduced. Relevant examples cited were the ban on public smoking in 2007, and blood alcohol limits for drivers which were first introduced in the late 1960s. Both were initially unpopular but have now been accepted and behavioural adjusted accordingly.

"I spoke to a girl the other day and she was a [heavy drinker]*. I said to her, what's the one thing that would cut you down, that would help you? She said take my money off me, being able to afford it. And she was in the stage where she would drink what she had financially and, therefore, the more expensive the better."*

"It's worth pointing out, one of the pieces of work that we've carried out is a systems dynamics model to look at the economic value based on bed stays in the hospital, based on different investment that we would put in, and the impact that would have. By far the most effective intervention was minimum pricing. I'll give you an indication. Tier 3 treatment would have a value of one, alcohol liaison nurse would have a value of two, and minimum pricing had a value of four, with a reasonably quick return."

Current alcohol pricing

- Anecdotally it was suggested, that acknowledging differences between some regions, the mean price of an alcohol unit was far less than 50p. Work from the North West of England was described[1] which suggested, based on a survey of retailers, unit price ranged from 17p for 'value' ciders to 70p for alcopops. This finding contrasted with some delegates' views that alcopops should be specifically targetted with legislation, although all types of participant frequently referred to cheap, high strength ciders as their main drink of concern.

Feasibility

- Other delegates believed that with respect to current uncertainties around the legality of 'price fixing', the law (UK and EU) would only allow a range of price options, which would have to be agreed locally, and within existing licensing legislation.
- Examples were given of local authorities that had introduced minimum drink prices to target 'irresponsible' promotions and alcohol related disorder. Blackpool have had a voluntary code of practice since 2006. The code was developed by the Town Centre Pubwatch scheme with the support of the responsible authorities. The code prohibits licensed premises (On sales) from selling alcohol for less than £1.50 a drink (except half pints of beer) between Thursday and Sunday. This initiative, alongside the use of polycarbonate drinking vessels (as a replacement for glassware) has reduced violent crime in the town centre and reduced glassing admissions to A&E. The council, police and PCT are now seeking to enforce a

[1] Bellis MA, Phillips-Howard PA, Hughes K, Hughes S, Cook PA, Morleo M, Hannon K, Smallthwaite L, Jones L (2009) Teenage drinking, alcohol availability and pricing: a cross-sectional study of risk and protective factors for alcohol-related harms in school children *BMC Public Health* 2009, **9:**380 doi:10.1186/1471-2458-9-380

minimum pricing policy for all alcohol sales across the town. Oldham Council's Trading Standards Department recently recommended that problematic premises introduced a minimum 75p/unit price; premises not adopting this faced more severe licensing restrictions such as police supervision and limits on the number of drinks a consumer could buy at one time. This was intended to have two outcomes. Firstly, an increase in operational costs would be seen as more burdensome than the introduction of minimum pricing. Licensees would be forced to pass on the increased expense to consumers, thus indirectly driving up unit costs. Secondly, if licensees did not pass on the additional costs to consumers, the restrictions on purchasing would slow down the speed of alcohol consumption.

"*We've got to the point now where the council are putting forward a motion to work towards minimum pricing within Blackpool and its neighbouring authorities if possible, as far as we can using current licensing legislation. And the reason we've got that far is by me going around… going to various CDRP* [Crime and Disorder Reduction Partnership] *executives, the health and scrutiny committees, and actually explaining the impact that'll have on the average person who's drinking a bottle of chardonnay every three nights, rather than the people who are drinking the Tesco's own brands white cider*."

Implementation

- Optional pricing policies might fail if all types of retailers did not sign up to it. There was concern that although minimum pricing might be welcomed by pubs and bars (which already tend to charge in excess of suggested minimum unit prices), supermarkets and off licenses might resist the initiative if it adversely impacted upon their overall marketing strategies. For example, one of the main challenges to the Oldham scheme referred to above was that the council had no control over pricing strategies of supermarkets as they were not subject to the same licensing conditions as other retailers. No supermarket representatives attended the meetings and so the veracity of this claim could not be tested.

"I'm a publican. I live in a pub; my family have had pubs for the last 22 years. And actually, it would be very beneficial for the pub trade.... [the pub trade] *can't compete* [with supermarkets] *and because of the level of prices on the high street out of the off licence service and supermarket service, the pub trade has been doubly hit really; first with the smoking ban and then with the low prices..."*

- A small number of delegates believed that if an optional minimum pricing scheme was introduced, those that did not comply should be 'named and shamed' by local authorities.

Effectiveness of minimum pricing

- Minimum pricing was believed to be one of the few strategies that could tackle 'pre-loading' in drinkers, whereby large amounts of alcohol are consumed before a night out in order to save money on bar prices. This was believed to be a problem that was not restricted to young and under-age drinkers. Extending this discussion, delegates argued that alcohol health and social burdens were not restricted to the young and problematic drinkers; self-identified 'sensible drinkers' are still at risk of alcohol related harm, although many do not recognise

this. Minimum pricing might be one means of persuading them that all sectors of the population are potentially at risk and might benefit from pricing initiatives.

"*We need some tangible explanations for the public; e.g. spend £12 more a year* [on personal alcohol] *but save X amount on health. We need examples*."

- Some delegates admitted that as parents they had sometimes purchased alcohol for their children or gave them the extra drinks obtained through price promotions in order to control the types of alcohol they were consuming. They believed that as consumers, and despite their health/social service background, they were just as sensitive to pricing promotions as members of the general public. These participants suggested that minimum unit pricing would mean it would be less likely that they would purchase alcohol for their children. However, they were also worried that their children, in keeping with other young people, would still pursue alcohol intoxication, and would obtain it from other less well controlled sources, such as though underage purchasing, friends' parents and proxy purchasing by adults.

"There's alcohol, like you were saying before, chardonnays, wines and stuff like that, most [young] *people don't buy those. They buy strong, White Lightning cider. Its dirt cheap and it does what you want it to do. And under those things, what you can get, you can get probably 20/30 units worth of alcohol for three quid. So that completely screws things because what you have is very strong, very potent, very powerful lager being sold phenomenally cheaper...well cheaper than buying coke* [coca cola] *in some instances...so what you have is people going for very specific types of alcohol because if you want to get intoxicated very quickly, you'll buy the stuff that does the job."*

- Other delegates, including researchers, representatives of the alcohol industry, and professionals outside of public health thought that the implications of minimum pricing were more complex than suggested in the guidance. As the final NICE guidance was due to be published in March 2010, a few weeks before an anticipated general election, it was feared that minimum pricing could become a party political issue, and both of the main parties would reject it to avoid alienating voters. It was considered that the ban on public tobacco smoking might not have been carried if it had been announced in a general election year. A small number of practitioners working with young people argued that, in their professional opinion the low cost and easy availability of illicit drugs would mean that pricing alcohol outside of the affordability of under 18s would result in substitution with other substances. Although these workers did not separate the risks and harms of alcohol and illegal drugs in young people, the clandestine manufacture of the latter meant that these substances posed potential harms over and above that of alcohol. A related concern was that a decrease in the affordability of alcohol might lead to an increase in thefts from stores. This point of view was countered by the observation that many health promoting (e.g. sports) or health neutral (e.g. cinema) activities were currently too expensive for many young people and that these should be made more affordable. The potential health, social, and criminal justice savings would also offset those resulting from a small rise in the incidence of petty crime.

"*Well the dependent drinker will just start to steal it or steal other goods in order to pay for their alcohol, that is of little consequence to the police or to society, compared with domestic violence, violent crime and other violent behaviour such as criminal damage."*

"Participant 1: I think the government's frightened and the opposition are frightened about this because it's not a vote winner saying...because people don't understand the issues and people will think well if my alcohol's going up, I don't have any other pleasures in my life, certainly not going to vote for this lot. And I think that's where the issue is. I think there's an understanding at government that this needs to be done to safeguard public health but I think...

Participant 2: But not until after the general election."

Justification of minimum pricing

- A more general discussion was held on the nature of scientific evidence and that decision-making should also consider public opinion, cultural factors and the ethics of population based behavioural change.
- Delegates believed that there was little public understanding of the aims of minimum pricing and the true financial costs to consumers. Most of the public debate had focussed on the financial burden that would be placed on 'responsible drinkers' as a result of legislation introduced in response to the behaviour of the minority of problematic drinkers.
- Public communications should be clear about the objectives of population based initiatives (including ethical arguments about individual contributions to the health of a population), the true costs and benefits of minimum price legislation on the consumer (for example, most drinks in bars and pubs would not change in price), and the likely health benefits that could be obtained (for example freeing up funds to pay for other treatments). The positive effects of this recommendation on crime and anti-social behaviour, an issue perhaps of greater salience to the public than alcohol related morbidity, should be included in such discussions.
- The concurrent debate on drug related harms was often referred to as an example of the complexities of evidence based policy; objective evidence might demonstrate the usefulness of a particular strategy, but this also had to carry public and political support.

"*We want to play on health and pull on people's heart strings. For example, there is only sio much money for breast cancer treatment, or should the money be spent on helping people get drunk on nights out? In the economic downturn people would rather see cuts in services than tax increases, so cut out the services for drunk people. It's a very difficult situation, but people just don't want to pay extra."*

Professional understanding of minimum pricing strategies

- Interestingly, despite prompts, there was less discussion on the second part of this recommendation, that alcohol duty might be linked to inflation and earnings. CPH facilitators speculated whether this might be due to discussions in the field meetings reflecting the wider popular discussion that had almost exclusively focussed on unit pricing. It emerged that many delegates did not have a clear understanding of this type of approach, what legislation would be required, and how it might impact drinkers.

- Participants had little experience of how inflation and earning related pricing might proceed, although it was recognised (in accordance with the University of Sheffield modelling which informed the draft guidance) that it was likely to have less impact on purchasing patterns than minimum unit pricing. The example of Australia of was provided whereby the excise duty on alcohol was related to the consumer price index. Although consumers often did not notice an increase in price, opponents had criticised this approach as an unpopular 'stealth' tax, which would be used in party political debates. Taxation was seen as disproportionately affecting poorer members of the population, and thus might lead to reinforcing inequalities.
- It was proposed that minimum pricing should be introduced first to ensure reduced availability of very cheap alcohol, with the link to inflation/earnings introduced later to maintain the unit price.

"So the socio-economic impact is going to be much greater. That's my concern about it really is that … rather than promoting health it's going to be used as a tax on the poor."

Recommendation 2 – Availability

What action should be taken?

- Licensing legislation could be revised to ensure:

  - it takes account of evidence on the link between the availability of alcohol (number of alcohol outlets in a given area and times when it is on sale) and alcohol-related harm (for example, crime and disorder and in relation to health)
  - licensing departments take the above links into account when considering a license application
  - it includes protection of the public's health as part of licensing objectives
  - it gives licensing departments an enforcement role
  - immediate sanctions can be imposed on any premises in breach of their license, following review proceedings.

- Legislation on personal import allowances could be reviewed and consideration given to reducing them.

Structure of recommendation

- Delegates with a health background requested that public health be the first point mentioned in the proposed revised legislation.

Current licensing procedures

- Currently, English licensing legislation has four objectives: a) the prevention of crime and disorder; b) public safety; c) the prevention of public nuisance; and d) the protection of children from harm. Delegates welcomed the inclusion of public health into the objectives but commented that licensing boards should already be considering the other sub items in the recommendation when granting licenses or reviewing licenses of problematic premises, and already had the powers to impose sanctions or order closures. However, it was common to hear that these were not often applied, or that it was too difficult to close premises in breach of their licenses due to lack of evidence or the slow progress through the courts. Some delegates were also worried about consequences of a potential increase in premises closures that this recommendation might provoke.

"I think it would be very difficult. The feasibility thing is one of the factors we need to look at. If you've got an existing range of businesses in an area, how would you begin to say you've got to close down? If you're really well run, even if everyone is a well run operator, if you've got some poor performers, then obviously you've got your sanctions already, so you'd say to them right we're going to consider your position. So there are some fantastic powers of the Licensing Act. If it's an off-licence or big supermarket, you can say right, alcohol only to be sold from aisles one to three. Or if you're a pub,

right we want you to close at 10.30, or if you're going to run this promotion, we want you to have an SIA registered door supervisor on, or whatever. But there are powers there, but to say you've got to go because there are too many, I don't think that's feasible. That would just be a recipe for court action under current legislation."

What is an alcohol outlet?

- Delegates requested clarification on exactly what was meant by an 'outlet' and whether legislation would be applied to them equally. Opening hours and the 'type' of drinker would differ between outlets. For example, in the late 1990s and the earlier part of this decade, promotion of the night time economy (NTE) was seen as a means to regenerate many town centres. This led, in some places, to an over-representation of premises selling alcohol and premises promoting drinking rather than socialisation. It was believed that whilst this practice had largely stopped (mainly due to commercial saturation), town planners were only beginning to promote the NTE as a family friendly environment with the introduction of cafes, restaurants, and family pubs. Legislation was seen as one way to support this shift in focus.

"Certainly in […], there's a big turnaround on ownership of licensed premises, because they will purchase it or take out a lease, realise it's not making as much money as they'd expected because of the sheer amount of competition."

"The prices have gone down to attract, because you have to attract people if...if you're in competition with 10 or 15 other pubs and clubs, then if you're offering two for ones or five shots for a fiver or something, then obviously. So you're right, you do have saturation and it must be difficult making money in that respect."

A broad definition of public health should be used

- The definition of public health used in this recommendation should be as broad as possible. City centre managers and alcohol co-ordinators were keen to see design led approaches to alcohol harm reduction and suggested that licensing departments could also account for the environment and facilities around premises when considering applications (e.g. defusing 'flashpoints' such as taxi-ranks and fast food outlets; bar designs which discourage 'vertical drinking' and crowding at the bar). Licensing officers reported that currently most objections against the granting of licenses raised at committees came from the police. Promotion of public health would require a greater commitment by PCTs, children's services, and alcohol leads in local authorities (e.g. DAATs) than is currently seen. The procedure for granting licenses could also be simultaneously reviewed, as although interested parties are able to give evidence at hearings, only council members are allowed to issue judgements.

"*Our licensing manager turned around to me the other week and said that he thinks in 1- year time that licensing will be part of public health. That's how far he thinks that...somebody works in that field, that they do work that closely together.*"

- A simple application of a public health licensing objective would be that applicants would have to prove that their premises would not adversely impact upon the public health. Although this might be difficult for some applicants to prove, particularly if the intention was to establish a premise in or near a problematic area, licensing officers still believed that providing the evidence should lie with the applicant.

Monitoring the effects of licensing

- Participants had a clear understanding of what datasets would be required in order to monitor public health impacts of licensing. The majority of these were already available, including alcohol related crime and violence; intentional and unintentional injuries (such as the Trauma and Injury Intelligence Group (TIIG) monitoring system in the North West[2]); Hospital Episode Statistics; Accident and Emergency data (although this was often difficult to obtain); Alcohol Treatment data (e.g. ATMS), and ambulance statistics. One concern, however, was that this synthesis would have to be dynamic and data would need to be prepared and synthesised on a regular basis (e.g. monthly – quarterly) to respond to changes in the local situation (for example, successes of previous licensing initiatives) and it was thought that licensing officers would not have the time or the necessarily skills to achieve this. It is also important to note that there is great regional variability in the quality of data collection procedures, and data sharing protocols can sometimes take several years to establish. Expected reduction in possible public expenditure also had to be factored in. Local academic departments or health observatories could be contracted to produce this data, and in many cases would only have to make small additions to existing synthesis reports commissioned by local organisations.

"*Regarding saturation policies for off licences, I believe we're still the only ones in the country who've got one for an off licence, in four of our wards. In one particular ward, we have an off licence for every 240 people, and that includes newborn children. Not sure how any of them make a profit. But that was built on public health data, which we then used that to say right in this area, we'll now look for crime data from this. Because that's all you can do in current legislation. If in future we're able to do that based on public health data, that would be far more beneficial.*"

"*This has been taken forward generally though and most departments now have been given a license to share commissioning data with the police through the local harm reduction partnerships. And we've got police in our A&E department now on a Friday, Saturday and Sunday nights, gathering this information. And basically it was a particular hotspot where we get a lot of assault and crime from, and they'll target that and the police will act upon that... I don't know whether their links with the licensing authority but that's something that's been developed.*"

Appealing licensing decisions

- Delegates required clarification on what the review and appeals process would look like if legislation was amended, as the current description was not detailed enough. Licensing officers reported that although they had existing powers, one of the most difficult tasks they faced in responding to problematic premises in breach of their licence was collecting sufficient evidence. Several examples were given of protracted reviews that were terminated when

[2] http://www.tiig.info/

police obtained Closure Orders for licensed premises in response to severe public disorder offences; incidents which could have been avoided if a timely conclusion had been reached by licensing officers in the courts.

"*There's a range of sanctions. The police already have the power to go in and do what's called an immediate closure, if they fear there's a risk of serious crime disorder. Then there are other sanctions, a range of sanctions. Extra conditions can be put on for less serious offences. So that wouldn't happen immediately; that would be where you go to a review panel and the police would recommend to the licensing team that the pub or the shop be required to do a certain number of other things, restrictive things. And it may be extra door supervisors, it may be tougher signage or people in the alcohol aisles and not just at the checkouts, whatever it is. And some of those will be agreed voluntarily and some of them will be made a mandatory part of your conditions. So there is this range of sanctions. It's a question of, are they being used effectively?"*

- A few delegates reported that existing appeals processes were sometimes open to abuse. It was claimed that when a premises faced removal of their alcohol license it was common for an appeal to be lodged. During this phase the licensing decision was suspended and so the licensee was able to operate during the appeals period, which might take several months. Despite later investigation by the authors, no further evidence could be found to support these claims, although delegates were of the opinion that such events were commonplace.

"*And, of course, depending on the timing, the premises has the ability to make an appeal. Now what normally happens, they'll make that appeal in order to delay that to a better time for them. So if it's around Christmas time, they'll appeal, hoping that they'll get it in February. Instead, often that can backfire to about Easter and they really lose out.*"

Public health in licensed premises

- An interesting expansion of this recommendation would be the requirement of licensees to promote public health in their premises. This could take several forms (although the feasibility of each would require additional investigation), for example, an obligation to contribute to local health promotion initiatives, or the expectation that managers of licensed premises would participate in server education 'train the trainers' programmes.

"*You can educate in bars, via posters, if the licensees are happy to put the posters up. We have polycarbonates, which have got our own.... it's got our own logo on it and it has unit information on there. So it says two units with the percentage below it, three units with the percentage below it, and we've done the same for wine glasses. And people do discuss it…So you can educate but you don't want to preach.*"

"*Because of the meeting in […] I attended, they were encouraging certain clubs and, in fact, attaching its conditions of their license, that they didn't have glass bottles going out over the bar. So everything had to be decanted, it was going into plastic glasses. Then, of course, you got the objection that it's the modern young trendies that drink from a bottle, so they were having plastic bottles actually introduced. And again, they were linking that to the amount of trauma injuries that we're seeing."*

Feasibility of recommendation

- Delegates questioned whether the second part of the recommendation concerning import allowances was feasible. Current EU law allows unlimited importation of alcohol if the

individual transported the goods themselves; the goods are for personal use or as a gift (if the person given the goods offers payment in any way (including reimbursement of expenses or payment in kind), then it is not a gift and the goods may be seized); and if the goods are duty and tax paid in the EU country where they were acquired. Delegates believed that this was unlikely to change as a result of NICE guidance.

- It was believed that as a result of the recent poor performance of the British pound against the Euro, and the discounting offered by supermarkets, fewer individuals were making special trips abroad to purchase alcohol for personal use. It was believed that lone traders were still importing alcohol though, particular for the purpose of private sales. It was suggested that one unforeseen impact of minimum alcohol unit pricing would be that cheap alcohol would be obtained from such unlicensed retailers. It was further suggested that these illegal imports were worthy of continued investigation as avoidance of alcohol duty was only one of several crimes committed by perpetrators.

"*When you do your trade standards visit, what you do find out is that if you find out they're breaching one piece of legislation, then...as we have done, you take Inland Revenue in, you take Customs & Excise, you do your under 18 checks...we had immigration in. You find they're breaching every one of those areas. They have illegal staff selling to young people products which are brought in without paying taxes on. And then customs & excise will look up their books and realise they're not paying the correct amount of VAT*."

"*I think the issue in Customs & Excise is exactly that point, the illegal traffic sometimes of falsely manufactured whisky but it's tobacco and obviously drugs, other drugs as well. But it's that stuff coming into the UK and being sold in the white van or illegally, or given to the corner shops. And the government looks at it because it's tax revenues. And we all look at it because of the clear health implications. What's the point of, say, the responsible shops, putting up signage, training their staff to prevent underage sales? What's the point of them doing that if these kids are getting in the estate or around the back of some garages in the white van?*"

"*A consequence of increasing the price, there could be an increase in the illegal import and distribution of alcohol, but that's unlikely to be affected by or relevant to people's personal import analysis. And what's required potentially is action to target the illegal imports and distribution sale.*"

Recommendation 3 – Marketing

What action should be taken?

To reduce the effect of alcohol advertising on children and young people consider:

• ensuring all alcohol marketing, particularly marketing that makes use of newer media (for example, web-based channels) is covered by a regulatory system which includes the monitoring of practice
• banning alcohol advertising from all media outlets where more than 5% of the audience is under the age of 18 years
• restricting alcohol marketing and advertising to the facts about the product
• in the longer term, banning all forms of alcohol advertising and marketing through television, radio, cinema and via sports sponsorship (as is the case with tobacco advertising).

General considerations

- As with other policy recommendations, but particularly for this one, delegates believed that the implications of the draft guidance required more detailed discussion than was allowed in the time-restricted field meetings. This was because the recommendation not only addressed policy and operational decisions, but also potentially aimed to influence the national culture of alcohol drinking, how individuals viewed alcohol in their lives, and the (perceived) function it served.
- Delegates questioned why *print* appeared to be excluded from the list of media that alcohol advertising should be banned from.
- The evidence summary introducing this recommendation undermined its potential impact. In contrast to other recommended strategies it was clear that there was only limited research in support of its effectiveness. Delegates suggested that this would not only dissuade professionals from pursuing its objectives, but that it also undermined the credibility of the whole set of recommendations. Delegates expected NICE to issue recommendations on the basis of strong evidence, but in this area at least it was revealed to be “inconclusive” (pg 20, draft guidance document).

Current advertising regulations

- A representative from the Portman Group outlined current regulatory systems on alcohol marketing. The Advertising Standards Authority (ASA) regulates broadcast and print advertisements whilst the Portman Group seeks to complement ASA activities by regulating

other advertising forms such as sports, packaging and websites. Both codes of conduct have strict rules, including that advertising should not appeal to under 18s or suggest that drinking leads to sexual success. Both have independent complaints and appeals panels and these are convened by independent members.

- However, these two processes rely on self regulation and besides recommending that advertisements should be changed or withdrawn; neither have the power to issue statutory penalties such as fines. Although the alcohol industry stated that these procedures were robust, public health professionals were concerned that self-regulation meant that industry could manipulate the rules and would suffer little censure if adjudicated against.

"*Yes they [i.e. alcohol industry] comply with the rules but the rules are too lax. The rules need tightening."*

Feasibility of recommendation

- Although health professionals favoured this recommendation more than delegates from other sectors, they recognised that it would take a long time to come into effect, if at all.
- The example of tobacco advertising was cited several times as how this recommendation might be enacted, and many delegates could remember when tobacco manufacturers sponsored cricket competitions and pointed to recent changes in EU legislation which banned tobacco sponsorship in Formula 1.
- If this initiative failed or was likely to be introduced after several years delay, delegates thought that NICE should, in the interim, include recommendations on the inclusion of health messages on alcohol advertisements. A range of suggestions were proposed (e.g. direction to health websites, graphic imagery), but there was an understanding that different messages would vary in their effectiveness and NICE would have to examine the relative effectiveness of each before it could issue recommendations.
- A code of practice on alcohol advertising through web based and other new media was welcomed by delegates, but and on a practical note should not be grouped with other forms media in the recommendations. This is because internet representations pose more challenges than traditional media. Internet users are able to access websites from around the world, and regardless of legislation in their country of residence, are generally able to access any sites that they choose. Furthermore, although some larger, advertising funded, websites claimed to have software in place which targetted adverts based on the users' profile (including date of birth), this was believed to be flawed. For example, users could easily fake their date of birth at registration and access adult targeted content such as alcohol adverts. Delegates also provided anecdotes whereby their young children had received alcohol adverts, despite accurately stating their age on the website registration form. Commercial software which parents could install to prevent access to sites mentioning key words such as alcohol, drugs, or sex, were mentioned (indeed some organisations based at educational institutions already had these filters installed), but these were criticised as they prevented

young people (and sometimes staff) accessing useful health promotion information, and were also easily bypassed by technologically competent children.

"*I'm not sure whether you could ban advertising on things such as like the Internet, because the companies that might be sending the content might be from different countries, mightn't they?*"

"*But it would prevent You Tube and the like because You Tube is able to identify which country you're in and only permits you to see certain content based in that country.*"

"I think this is actually a children's safeguarding issue, rather than a marketing issue. Because if you think about what children services departments all across the country are doing, is that they're thinking about safety and how to give children and young people the skills to protect themselves online, or using new technologies. And this is part of that agenda, isn't it? It's something about.... there's two sides of it. One of it is restricting what can be marketed to children. But the other side is also getting children at a young age to understand how to tell the difference between something that's just an advertisement and something that's actually useful to them, when they're using new technologies"

"I think the other thing with alcohol marketing on the web is, quite often you'll access some information on the web and not expect to see an alcohol advert, and it'll be there. So I am addicted to the sports page of the Guardian website, and quite often an advert for Guinness will popup."

- Delegates believed that banning alcohol advertisements from media outlets where more than 5% of the audience was under the age of 18 was equivalent to a total ban and was not currently feasible. This was partly because with increased access to internet broadcasting and hard drive TV recorders, it would be impossible to accurately profile audience figures. Young people themselves actively sought out and viewed programmes intended for adult audiences. Furthermore, the Broadcasters Audience Research Board (BARB) does not currently provide specific data breakdowns for under 18s, and as a commercial organisation, provides viewing figures at a cost. Regular monitoring of viewing figures would not only be expensive but also require changes in the way in which BARB collects and reports its data. A pre-9PM watershed ban on alcohol advertising was suggested as a more feasible alternative.

"*But they also pick up on the fact since tobacco advertising was banned, there's been a decrease in tobacco. So it's difficult to prove the impact of something until you take it away. Maybe what we need to do is stop advertising for two years and see what impact that has.*"

"Just because it doesn't have a couple of kids in it doesn't mean that young people won't aspire, if they're buying the kind of, I want to be a grown up and that's the kind of grown up I want to be"

- Participants questioned why a 5% under 18 audience cut-off was specified as this did not seem to be explicitly supported by the evidence statements included in the draft guidance. This was believed to be an arbitrarily chosen figure and as such could not be justified over the Portman Group's guidance figure of 25% audience share.

Mobile phones

- Several delegates noted that mobile phone marketing was not specifically mentioned, and thought it should be made clearer that this was part of 'newer media'. This form of marketing sometimes took the form of direct to handset advertising, or Bluetooth messages beamed to handsets as the user passed licensed premises.

Product placement

- The draft recommendations would not cover product placement in TV programmes. The Department for Culture, Media, and Sport (DCMS) has recently (November 2009) issued a consultation paper on whether this should be allowed[3]. Although meeting delegates did not have full details of the consultation it was requested that the report authors alerted the PDG to this. A brief reading of the consultation shows that alcohol is specifically mentioned several times, including consideration of whether alcohol should be excluded from the plans in order to avoid exposure of children to alcohol products[4]; a discouragement of placements which encouraged 'immoderate' consumption (not defined) of alcohol; and a proposed levy on alcohol placements (and other high risk products) to fund monitoring research to inform decisions about whether placement results in harmful outcomes.

Online social media

- Industry representatives argued that 'irresponsible' representations of their brands on social media sites, where users could upload their own content, were beyond their control. Official brand representations would be subject to the same types of regulation as other forms of media, and it would not be in the interests of the industry to promote an image that was detrimental to health.
- It was argued though that the alcohol industry indirectly benefitted from user generated content that depicted excessive alcohol use in particular groups. For example, a Facebook fanpage dedicated to a particular brand of alcohol would not be sanctioned by the manufacturers, but they would also have no control over its content, which might display or even encourage excessive consumption and problematic behaviour as desirable.

Facts about alcohol

- Limiting advertising to the 'facts' about alcohol was believed to be problematic. Taken to its extreme this would mean that different products would be advertised on the basis of price and strength, which was counter to the aims of the recommendations, and was something which the industry did not want to see as its advertising strategy depended on presenting different brands of alcohol to different types of drinker.
- Further discussion focussed on what the 'facts' on alcohol actually were and how to strike the balance between positive and negative effects. A realistic portrayal of alcohol would be that within sensible drinking guidelines alcohol is unlikely to cause harm and could be protective to

[3] http://www.culture.gov.uk/reference_library/consultations/6421.aspx
[4] *The wording being* should there be restrictions on placing certain types of products (e.g. HFSS foods or alcohol) in programmes with a disproportionately high child audience? (pg 18 of consultation paper)

health, and causes relaxation and mild euphoria. However, these would not be the facts that health promoters would wish to present.

- Similarly, facts relating to the costs of alcohol to the state, the dangers of early initiation, and the proportion of hazardous drinkers in the country would be unlikely to resonate with drinkers and industry would not wish to issue such advertisements.
- Messages built on health promotion, the unit content of drinks, enjoying sensible and social drinking with a particular brand, and sources of further help were considered to be appropriate compromises.

"The facts about alcohol are, in my view, predominantly negative. And companies are not going to want to market on that premise."

The wider alcohol culture

- A broader discussion of the representation of alcohol in media was undertaken. Imagery and branding was not only reinforced through direct advertising, but also depictions within programmes.
- Ofcom has responsibility for the content of programmes but delegates could not recall any incidents of censuring on the basis of representations of alcohol.
- Soaps, for example, were discussed as superficially representing alcohol in a genuinely positive way, with a focus on licensed premises as an inviting and supportive community hub. This was countered by views which suggested that soap operas rarely depicted the consequences of regular alcohol use in a realistic manner and focussed on extreme negative outcomes such as drink driving and alcoholism. Alcohol was depicted as essential for all types of celebrations and rites of passage, and the depiction of day time drinking as a background to professional activities and working lunches was seen by delegates as unhelpful. Intoxication after drinking was only occasionally depicted. One youth orientated soap in particular, Hollyoaks, was identified for criticism as although it occasionally presented isolated 'alcohol issues' storylines, these were rarely integrated into ongoing storylines and alcohol use was either neutrally or positively presented in regular narratives.
- Magazines were also subjected to similar criticisms by delegates. 'Lads Mags' were thought to reinforce problematic behaviours by promoting particular forms of male identity through (excessive) alcohol consumption.

"And maybe within TV.... the actual production of TV programmes, the use of alcohol within settings promoting relaxation, promoting the things it actually sells itself on as being something to.... when you're happy something to do, when you need to chill out and relax something you need to."

- Many delegates argued that the healthy lifestyles of professional athletes (especially footballers) would be undermined by excessive alcohol use, and that it was therefore counter-productive for the alcohol industry to target sports for sponsorship.
- This discussion was widened and it was thought that particular types of alcohol use were presented as part of leading athletes' lifestyles away from the sporting arena (e.g.

champagne). This conformed to the idea of the athlete as a modern celebrity, whereby independent fame would accompany sporting prowess. It was commented that it was common to see particular sportsmen and women in lifestyle magazines, often drinking champagne or other expensive forms of alcohol. One interesting line of discussion suggested that by sponsoring sports teams, alcohol manufacturers were not trying to suggest their brand produced sporting prowess, health and fitness[5], but that it added to the enjoyment of spectating; particularly as more individuals watch sports on TV at home and in licensed premises than actually take part.

"*We're all of us very…. well young people are very brand conscious about things. And what this is, is when we're looking at the negative messages, for most footballers they're fit, healthy athletes and we've got Carling or whatever sprawled across his chest. It's a part of.... again, it's that aspirational, this is.... and it's not in your face; it's that little bit of subliminal message around it*."

[5] Although within recommended guidelines alcohol consumption is not incongruous with a healthy lifestyle.

Recommendation 4 – Licensing

Who is the target population?

Alcohol licensee holders and designated supervisors of licensed premises.

Who should take action?

Local authorities, trading standards officers, the police and magistrates.

What action should they take?

• 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.
• Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, non-compliance with other alcohol license condition and illegal imports of alcohol.
• Work in partnership with the appropriate authorities to identify premises that regularly sell alcohol to people who are under age or intoxicated.
• Undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales and to identify premises where sales are made to people who are intoxicated.
• Ensure sanctions are fully applied to businesses that break the law on under-age sales and sales to those who are intoxicated. This includes fixed penalty notices and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

Existing intelligence

- Delegates reported that most local alcohol strategy groups (which should include licensing authorities) would already have a good indication of local alcohol-related problems through alcohol needs assessments, although some localities would need to update these.
- Some delegates asked for support and guidelines on how to conduct a high quality needs assessment. The London Drug and Alcohol Network and Alcohol concern have produced a toolkit to help local strategists identify indicators of alcohol-related harm[6]. The Department of Health funded Alcohol Needs Assessment Research Project (ANARP) was the first alcohol needs assessment in England conducted on a national scale. The tools developed through this project allow local commissioners to compare the prevalence of harmful, hazardous and

[6] Available from http://www.localalcoholstrategies.org.uk/keyarealist.php

dependent drinking in the area to national and regional averages, and to other areas that are similar in terms of environmental factors.

Controlling outlet density

- With respect to limiting the number of licensed premises in an area using cumulative impact policies, delegates referred to the discussion of Recommendation 2. Licensing officers reported that councils used these powers to assess new applications and amendments to licenses rather than for withdrawal of existing licenses. This was because many town centres had high density drinking areas, for example a central square bordered by bars. Although there might be a high level of alcohol related disorder and harm in the locality it would not be possible to identify a single premises as being the greatest contributor and there was an assumption of shared responsibility. Whilst there might be anecdotal evidence that one particular premises was, for example, serving intoxicated customers or not monitoring the welfare of customers, there would be little quantitative evidence available to back this up as the patron may have visited several venues beforehand or 'pre-loaded' at home.
- Furthermore, the majority of drinking may have occurred in other 'early entry bars' which did not have late licenses. Whereas antisocial behaviour may not have occurred outside this type of premises, it would have contributed to the overall level of victim/perpetrator intoxication. Delegates thought that this recommendation would not be sufficient on its own to reduce existing alcohol related harm.
- Delegates referred back to the example of Oldham's strict licensing conditions as a better means of controlling irresponsible retailers.

"That thing about preloading, it's too literally, no pun intended, it's a really loaded question isn't it? Because anybody who presents as drunk in a pub environment, in a club environment, in an off-licence environment, and they've drunk an awful lot before with the intent of not needing so much to drink when you get into that pub, the damage isn't being done in the pub, it's been done back there."

"*They might have just as easily been to 10 different pubs and drunk that much alcohol. The publican that's selling them that one or two too many doesn't know that."*

Alcohol Disorder Zones

- Delegates referred to Alcohol Disorder Zones as an alternative strategy to tackle alcohol related harm in an area. These zones allow Police and Local Authorities to use a Designated Public Place Order, to confiscate alcohol containers within a certain area. The zones would cover licensed premises in areas that experienced alcohol related disorder. Before such a zone was designated, licensed premises would be warned to take their own steps to reduce alcohol disorder otherwise a designation would be imminent. They would also be required to contribute towards the policing and other local costs of dealing with the disorder in this area.

Test Purchasing

- Test purchasing and 'mystery shopper' schemes were thought by delegates to be valuable but due to funding restrictions were often only commissioned by Trading Standards once or twice a year.
- It was acknowledged that test purchasing was not an effective standalone initiative and premises would not be compelled to increase the robustness of their ID checks if only small fines were received each year.
- One delegate could only recall one successful case of a licensed premise being closed for persistently selling to intoxicated and/or underage customers in their region. This was attributed to the difficulty in obtaining robust evidence for prosecution.
- Suggestions for penalties for selling to underage customers included harsher fines and 24 hour closure orders on peak commercial days.
- There was debate about whether existing rules clarifying permissible activities in such schemes should be changed. Unlike many under 18s trying to buy alcohol underage, test purchasers were unable to change their appearance, lie about their age, or present fake ID. Often Trading Standards would announce the dates of test purchasing events, which was thought to be unhelpful. These restrictions are in place to avoid accusations of entrapment, although unlike the USA, this is not a valid defence under UK law. Other EU countries circumvent these restrictions on test purchasing and allow purchasers to both alter their appearance and lie about their age; it is the responsibility of the licensee to ensure that age restrictions on purchasing are not being broken. The UK restrictions were criticised for not reflecting the reality of underage purchases, although no consensus was reached on whether a similar set of rules as manifest in some EU Member States should be adopted here.

"*I don't think they should put too many restrictions about no make-up and things. Because teenagers wear make-up ordinarily, so if one walked into an off-licence with no make-up on, that would be suspicious.*"

"I think if you're going to test, you properly need to test under real conditions, don't you?"

- One important point raised was that age restriction policies do not affect alcohol purchases by parents for their children.

What is alcohol intoxication?

- A broader discussion concerned the definition of alcohol 'intoxication'. This tended to have different definitions depending upon the professional background of the respondent and the circumstances of consumption. For example, intoxication with regards to drink driving limits was achieved at around two drinks, but it would be very unlikely that any server would stop selling at this point.
- It was clear that no consensus could be reached and some delegates requested that the word *intoxication* be removed from the guidance and be replaced with a phrase relating to acute

alcohol effects and behaviours that were likely to result in harmful outcomes. This would of course in part also be socioculturally defined but would allow servers to make a better informed decision on whether it was acceptable to allow the customer to purchase alcohol. For example, although overt signs of alcohol consumption such as gait difficulties and aggressive behaviour could be recognised, it was important that excessive consumption by 'non problematic' drinkers was also monitored. The behaviour of the latter group might not be antisocial or criminal, but may have long term health consequences.

"I think if somebody's behaving properly and they're not causing themselves or anybody else harm, then they're policing themselves there, aren't they? Even if they may have had over the legal limit to drive or whatever, if they're not going to get behind the wheel, then obviously they're drinking within their own limits."

"I think the other thing, this thing about people being intoxicated, it's just how do you judge that? What level of intoxication is enforceable and how do you judge that? Do you breathalyse people? And I just think it's unworkable. I just think almost every off-licence and pub serves people who are intoxicated because they're making money as they do."

Alcohol server training schemes

- Delegates highlighted the successes of alcohol server training in the USA and Australasia. Amongst the development of skills concerning licensing regulations, these schemes are designed to support servers in recognising the signs of intoxication and to be confident in refusing to serve customers. For example, New Zealand has adopted a 4 stage intoxication check model which includes signs such as customers being too drunk to pass money for drinks over the counter.
- Benefits for staff taking part in server training would include increased earning capability and promotion to positions with more responsibilities. Managers would be less susceptible to prosecution and/or having conditions placed on their licence if they had a trained workforce.
- The schemes are mandatory in many states in the USA and there is a profitable (private) training market attached. Delegates encouraged the introduction of voluntary schemes in the UK with the long term aim of making server training mandatory for permanent and more senior members of staff. Whilst it was recognised that turnover of staff is high in some types of premises (e.g. student bars), it was thought that many temporary and part time servers would stay within the alcohol/hospitality industry and retain the skills learned.
- Similar server training skills were also important for off-licence staff, as it was believed that some employees could be intimidated into serving aggressive and intoxicated customers, particularly those working in smaller local 'corner shops'.
- Delegates recognised that many of the major supermarkets already had robust age check schemes in place (often introduced after a series of successful prosecutions), and some would not serve alcohol to those customers who appeared under 25 years unless identification could be provided. One scheme mentioned was the Think21 campaign. Although an inconvenience for some customers, these approaches were praised by many delegates.

“But most bars nowadays where there are three deep at the bar will have doormen. And doormen are always on the lookout not just on the door but they're usually inside as well, on the lookout. Because it's very easy to identify people who've had too much to drink. They can't walk straight, they can't talk properly. They're usually falling all over the place. Very often, they're looking for trouble, and those are the sort of people that any....even managers and publicans and staff want to keep out of their pubs because they don’t want to upset the rest of the clientele who are spending money and making people.... improving the environment, if you like, in terms of the atmosphere. We just have a policy, all of our staff, no matter how junior they are, even if it's working on a Saturday, can just say no I'm not serving you.”

“you're just asking people to ensure that their staff in pubs and staff in off-licences have a certain basic level of training, just as any local authority officer or any PCT officer would be expected to have a basic level of training around, I don't know, health and safety. Even if you weren't a specialist, you'd be expected to have a basic knowledge. So you could just say, there's a basic level of training that all staff have to have, which will give them common sense skills to make judgements.”

“I think the problem that I'm guessing for young, under age people, it's much harder to buy a bottle of whisky from Sainsbury's than it is to buy White Lightning from an off-licence. So you might be able to get big companies to buy into it, but I think it would be very hard to get small off-licences and how are you going to police it?”

Recommendation 5 – resources for screening and brief interventions

Who is the target population?

Professionals who have contact with those aged 16 and over.

Who should take action?

• Commissioners of NHS healthcare services and from multi-agency joint commissioning groups.
• Managers of NHS-commissioned services.

What action should they take?

• Commissioners should ensure a local joint alcohol needs assessment is carried out in accordance with 'World class commissioning' and 'Signs for Improvement'.
• Commissioners should ensure commissioning plans include the provision of brief-interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers).
• Commissioners should make provision for the likely increase in the number of people requiring referral to tier three and four alcohol services as a result of screening. These services should be properly resourced to support the stepped care approach recommended in 'Models of care for alcohol misusers'.
• Service managers must ensure staff are trained to provide alcohol screening and structured brief advice. If there is a local demand, staff should also be trained to deliver motivational counselling.
• Service managers must ensure staff can easily access validated screening questionnaires suitable for local use.
• Service managers must ensure staff have enough time and resources to carry out screening and preventive work effectively. Staff should have access to recognised, evidence-based packs, such as the 'Drink-less pack' or the 'How much is too much?' pack. These should include:
- a short guide on how to use the intervention, questionnaires, visual presentations (comparing the person's drinking levels with the average), self-help leaflets and possibly a poster for display in waiting rooms.

A comprehensive response to alcohol use

- Workshop facilitators sometimes had to explain the full range of NICE alcohol guidance that would be available by the end of 2010 as delegates questioned the omission of particular

groups and models of working in the current document. Delegates stressed the importance of the range of NICE alcohol guidance being seen as a suite of responses rather than standalone responses; this would cover risks to pregnant women, early identification and prevention, and support offered to problematic and dependent drinkers. It will be important for NICE implementation teams to describe and differentiate the wide range of alcohol guidance available.

Hazardous and harmful alcohol use

- There was debate over whether the terms *hazardous* and *harmful* were useful. There was the suggestion that the Department of Health now preferred the terms 'lower risk' (for scores 9-15 on the AUDIT) and higher risk (scores 16-19; dependency would be indicated by scores > 20). Standardisation in risk classification and terminology needs to be established before the guidance is published.
- Although referring to unit consumption and AUDIT score in adults (in accordance with WHO guidelines), participants believed that for younger drinkers, professional judgement and characteristics of the case should determine how the style of drinking was classed. For example, one pattern of drinking might be discouraged as potentially harmful in one young person, but a similar pattern would be considered hazardous because of additional vulnerabilities or circumstances faced. Furthermore, the Chief Medical Officer recommends that all alcohol in under 15s should be considered harmful and so AUDIT classifications would not be relevant.

"Why is it hazardous and harmful drinkers and not increasing risk and high risk? Which is what.... it feels like it's out-of-date to where the NHS is now."

"But again, that's potentially quite problematic when you're looking at the under 18 age group because to classify hazardous drinker in terms of what constitutes hazardous, what constitutes harmful is actually really out of sync with this most recent guidelines regarding what's a safe amount for young people."

Public acceptance of screening

- Effective implementation of recommendations 5-12 would mean a large increase in the number of screenings and the locations in which these would take place. Members of the public would be aware of an increased focus on their alcohol related behaviours and questions on its impact. In many cases these questions would come from previously unexpected sources such as dentists, pharmacists, the fire service, and non-health care staff. Delegates were unsure whether the population was ready for this perceived intrusion and wondered whether it would be seen as more Government interference in their lives (i.e. the so called 'nanny state'). Greater acceptance would only arise alongside a change in cultural attitudes towards alcohol use, which was beyond the influence of public services.

World Class Commissioning

- World Class Commissioning meant that commissioners should already be working towards, and achieving the objectives of this recommendation. However, the reality appeared to be different with few high quality alcohol services being delivered and in some places a lack of differentiation between drug and alcohol services. This was partly blamed on years of perceived under-investment compared to drug services, and/or lack of leadership in some PCTs which was undermining DAAT activities, but also some unhappiness with the role of the National Treatment Agency which was believed to have under resourced alcohol services and imposed unrealistic client monitoring requirements.

"I don't know whether it's unique to […]. I suspect it's not, but I think that one of the things underlying this in a way is that there is a differential between the extent to which commissioning of alcohol services as a PCT function has the same degree of development or sophistication that we have for illicit drug commissioning. But we have very well established joint commissioning mechanisms for illicit drug services. I would argue that they're not there in terms of alcohol services and there's a true developmental need, and probably a policy push really to actually encourage, or even cajole PCTs to come up to speed on that."

"I don't think it's [i.e. alcohol commissioning] as polished as the drug commissioning process, and there's a way to go. And I think stuff like this is useful in terms of giving leverage to start to have that dialogue, to have those conversations."

"A lot of the services were set up originally, the young people's services were set up under the.... using the NTA drugs money. So a lot of the young people's services are still very focused on substance misuse, whereas in fact it may well be alcohol and drugs and the whole risk taking thing, where they don't perceive alcohol as being the issue."

Usefulness of recommendation

- Participants criticised this recommendation for targeting such a broad age group. Although high quality alcohol services must be available across the lifespan, this did not reflect the differences and realities of local commissioning.
- Young people are well supported up to the age of 18, but there is little transitional work that takes place between the ages of 18-24 with the result that services are re-encountering clients with more serious alcohol problems. Delegates stressed the need for joint commissioning approaches to consider integrated pathways between services *and* across ages.
- It was believed that Criminal Justice Services in particular would benefit from multi-agency joint commissioning as currently they did not operate according to NHS pathways. All services would benefit from joint commissioning as there was the perception that currently many clients were forced to present at several services and were being repeatedly assessed on alcohol use behaviours.
- Some delegates preferred to see NICE supporting abstinence based approaches in responding to more problematic patterns of alcohol use. Whilst there was recognition that NICE was not explicitly excluding this type of outcome, considering current debates in the

professional press it was important that encouragement of abstention was included, particularly for younger drinkers.

Positive and negative outcomes of increased screening

- More widespread screening would have both positive and negative outcomes. Harmful alcohol drinkers were considered unable or unwilling to recognise that they might need further support and so screening would allow more opportunities to identify drinkers before harmful effects emerged and motivate them to ask for intervention.
- Increased screening would lead to increased referrals and a waiting list 'bottle neck' as without further investment more specialised help would not be available. Examples were given of practitioners having to turn down qualifying cases as individual caseloads were too high. This would have the added disadvantage of raising the expectations of clients and might make them less likely attend in future.
- Other participants thought that the burden might not be so great as attending further support was voluntary and in their experience, without self-awareness and acceptance of alcohol related problems, clients were unlikely to show up at the referred-to agency. However, some courts had placed conditions on bail for substance using offenders so that they had to attend follow up appointments if a need had been identified, and locally, reductions in fixed penalty notices had been negotiated for those offenders also keeping appointments.

"And I think it is going to have a massive impact when you start screening, on resources. In […], we've started to ask GPs to carry out alcohol screening. And you can see already that it's having an impact on the Tier 3 service. And now there's a waiting list, which then means that the Tier 2 are then holding and then doing that kind of Tier 3 work. It is having a massive impact already, and it's only just started."

Training requirements

- The increased training requirements resulting from an expansion of screening programmes was unlikely to be covered in existing budgets. As an example it was estimated that GPs received between £7 and £10 for each 10 minute alcohol consultation. Commissioners reported that the amount of money received for alcohol services was already low with the result that training was often the first activity to be cancelled in budgeting exercises.
- Existing training for screening and brief intervention tended to be relatively informal with little assessment of its quality or outcomes achieved. This resulted in a large number of professionals involved in screening, but little understanding of how competencies might vary.
- Online training was suggested as an alternative to costly daytime training which took practitioners away from services. One cited example was the online screening and brief intervention training provided through the Alcohol Learning Centre[7]. This resource is

[7] http://www.alcohollearningcentre.org.uk

supported by the RCN, RCP, and RCGP and through funding provided by the Department of Health, is free of charge.

- Training should not only include advice on how to use screening tools and to make appropriate referrals but also to ensure that staff attitudes towards clients were supportive, and that they took alcohol seriously as a public health issue (as opposed to an exclusive criminal justice or education problem). Some staff would also need further support to increase their confidence when asking (intrusive) questions about alcohol use.

Feasibility of recommendation

- Delegates understood what was meant by the phrase "*Service managers must ensure staff have enough time and resources…"* but believed that this was unrealistic in an environment of heavy workloads and competitive funding. A better use of time and resources was to identify and target those professionals who would be most likely to benefit from training and just support those individuals; an example was given of PCT administrative staff who received screening and brief intervention training but who never had face to face encounters with members of the public.

Examples of the recommendation in practice

- Local examples were provided of well established screening and referral schemes that were perceived to be effective and in keeping with these recommendations. Addaction in Leicester currently uses AUDIT as part of their substance use screening pilots in local prisons. An AUDIT score up to 7 would lead to education if requested; 8-19 would result in a brief intervention being offered (this was currently being reviewed so that scores of 8-14 would result in the offer of a simple brief intervention, whilst 15-19 would result in the offer of an extended session); and a score of 20+ would result in the offer of more specialised treatment.
- Participants reported that a wide variety of screening tools were available for use in different locations and with different populations. Most were familiar with the cited evidenced-based packs and adoption tended to be based on what supplies PCTs or DAATs had received. Adoption of recommended screening tools and evidence based self-help packs was not perceived to pose difficulties.

"We have a tool that's been developed by our team that's an interactive tool for young people, called Engage, and it does look at a young person's drug or alcohol use. And it is based along the lines of the common assessment framework."

"…*And it looks like other issues like sexual health, physical and mental health and the community, offending. So they'll do like a wide screen of it and that'll give them what we call a first line assessment. So from that, they'll be able to pick out if there's alcohol issues, then they'd make the relevant referral onwards*."

"I think on the whole, we tend to use the FAST screening tool. And in my area, I think that's the one that we recommend are included in most information packs that I've sent out to all sorts of people, through social services, health, whatever. So it would be the one from those choices."

Support for families of drinkers

- Family workers requested that NICE consider circumstances whereby a family member requested intervention on behalf of a relative, or who requested family support because of drinking problems. It would be important to consider whether staff should also receive training on how to identify risky patterns of alcohol drinking based on proximal report.

Recommendation 6 – supporting children and young people aged 10 to 15 years

Who is the target population?

• Children aged 10 to 15 years who are thought to be drinking a hazardous or harmful amount of alcohol.

Who should take action?

• NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Routinely assess the ability of these children and young people to consent to alcohol-related interventions and treatment.
• Use the Common Assessment Framework (CAF) to establish if they are at risk of harm from their drinking and if other psychological or social factors need to be considered.
• Consider referral to child and adolescent mental health services, social care or to young people's drug and alcohol services for treatment, as appropriate.

Qualification of drinking impacts

- As discussed in Recommendation 1, defining hazardous and harmful drinking in young people was perceived as problematic. Regardless, it was important to quickly determine whether alcohol use was in fact an important factor in the presentation and to qualify its impact, rather than rely on perceptions of drinking as suggested by the wording of the recommendation (i.e. "…who are thought to be drinking…").
- The wording of the recommendation was also thought to suggest that determination of harm would be related to frequency of drinking and unit consumption (Glossary definitions). This was less relevant to young people than adults as 'safe' unit limits had not been determined for those aged under 18. Often the biographical, social, and familial environment surrounding the drinking and situational factors would determine whether drinking should be considered hazardous or harmful.

"It's up for personal discretion, isn't it? If we're talking about members of the police perhaps making referrals or community organisations working with young people, they're making a decision, aren't they, on what's hazardous and what's harmful about a young person's level of use and there doesn't seem to be any guidance for them because we don't really have guidance for parents."

"You could almost put a full stop after drinking...'who are thought to be drinking'"

"I think you're also asking those professionals to give contradictory messages. Again, if you compare what the CMO advice is, because by implication there's.... if they're thought to be drinking at hazardous or harmful amount of alcohol implies an acceptance of some use of alcohol. And yet, if they were following the earlier guidance, the CMO guidance, they would be working to discourage young people under the age of 15 from drinking at all"

What is social care?

- Delegates requested clarification on what roles were included in 'social care', as the current wording did not allow them to decide whether this included professionals such as teachers, after school workers, Connexions counsellors, police officers and probation workers.

"You need education in there, don't you? Because very few children come into contact with children's social care. So education should be there"

Links to Hidden Harm

- It was argued that more explicit reference should be made in this recommendation to Hidden Harm and family based work. It was believed important that the behaviours of children in families with problematic substance use should receive particular attention. Similarly, an alcohol related incident in a young person might indicate problems in the family that were previously unknown to authorities.

"But I'll just say one other thing. In areas like this, I don't think we should forget the context, the child belongs to a family. And that really needs to be brought in here somewhere. We can't just take children out of that and treat them as though they're individual adults. It really does need to be seen as part of family. So I think there is guidance coming out or recently published, about that. Certainly, hidden harm training has been established in Nottingham for all services dealing with children and young people. That is a key factor"

Early intervention and links to previous NICE guidance

- Specialist workers reported that they rarely saw young people at the lower end of the age range specified in the recommendation. If they did they were not the first professional to see the young person. Usually schools or teachers had contacted services on behalf of the young person and their families, or if they suspected that alcohol misuse was taking place. Alternatively, if schools had greater concerns that the alcohol issue was related to neglect, then they might contact child services directly. It was usual for schools to invite alcohol services into the classroom after a minor incident to provide advice and a resource for further support; however this largely relied on self identification and presentation by the young person. Delegates referred to earlier NICE guidance on alcohol prevention in school settings

(PH7 School-based interventions on alcohol), which provided guidance to educationalists on identification and referral. NICE should be aware of, and contribute to, the current DCSF consultation on its updated drugs and alcohol guidance for schools. An example was given of a school based referral scheme in the North of England. Alcohol incidents or young people's concerns about their own or others' health were forwarded to a specialist substance use service that would send a worker to the school to offer brief intervention and support (up to 5 sessions). The programme ran for two years and mostly worked with young alcohol drinkers. It was reported that funding for the service eventually stopped because it was commissioned by a specialist Tier 3 service provider but the NTA had ruled that this provider could not also run Tier 2 services. This claim could not be independently verified.

"Who should take action? Well the first people who are going to pick this up probably well before any NHS or social services person gets anywhere near them, the first people who are going to pick this up are the teachers."

Young people's presentation to services

- Young people presenting at A&E after an alcohol incident would sometimes provide false names and addresses to avoid parental or police discipline. Although they would agree to take up a referral for further advice, they subsequently would not attend. As these young people were considered particularly vulnerable (i.e. they were presenting with harmful consequences of alcohol use) it was agreed that more effective means of monitoring young people's presentations and referral pathways was required in acute care settings.
- Young people workers indicated that they assessed ability to consent on the basis of Gillick competencies and Fraser guidelines. This was, however, also subject to a case by case assessment and would not be undertaken whilst the young person was intoxicated. There was also the belief that some workers might refer to these types of principles without having a deep understanding of their implications or having assessed whether the young person had achieved sufficient understanding and intelligence to enable them to understand fully what was proposed. It was suggested that referral to intervention was often based on obtaining the young person's assent to what was proposed rather than consent, that is they agreed it was the right course of action rather than considering the intervention options and making a decision accordingly. This distinction was important as it was believed that many young people would not have the necessary insight into the potential harmful consequences of their behaviour.
- Delegates suggested that there was often some hesitancy in non-specialist staff in using the common assessment framework (CAF). This was partly because being identified as a non-specialist but competent user of CAF meant that the staff member was subsequently burdened by requests to complete assessments for other young people. Others believed that the CAF did not provide the level of alcohol detail that was needed by more specialist substance use workers.

"That's what I was thinking. So are they using the CAF to identify that? That won't work because the alcohol component or the CAF is not sufficient enough in order to be able to correctly identify what level of intervention"

"I think where it's been clearly identified we need to address a young person's drinking or a child drinking, then I think it's appropriate to think about the CAF. But on the general population level, I think it's impossible"

"You don't need a CAF to establish whether a young person's at risk from their drinking.... at harm from their drinking. There are a whole range of others, like assessment criteria screening processes that you can go through. I understand why it's mentioned the CAF, because we're selling the CAF. CAF is big, but there's a danger of missing the point by just focusing on that."

Links with CAMHS

- Some delegates believed that there was great variability in the quality of Child and Adolescent Mental Health Services (CAMHS) between regions, and many inappropriate referrals. It was subsequently believed that some CAMHS services discouraged referral if substances were involved as they did not have the skills to respond effectively. Similarly, young people who had received a dual diagnosis of substance use disorder and mental illness did not always receive an acceptable level of care. It was requested that the standard and equivalence of CAMHS services, the types of referrals received, and their ability to deal with an increased case load should be investigated before NICE recommended referral of young alcohol users.

"*And I think the issue of CAMHS is.... they improved dramatically but there is still a huge demand for their services. And there is this sort of tendency to refer into CAMHS. And they get a lot of inappropriate referrals. So I'm just wondering if CAMHS is the first item on the list, is the most appropriate one*."

Recommendation 7 – screening young people aged 16 and 17 years

Who is the target population?

Young people aged 16 and 17 years who are thought to be drinking a hazardous or harmful amount of alcohol.

Who should take action?

NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Complete a validated alcohol screening questionnaire with this group. Alternatively, if they are judged to be competent enough, ask them to fill one in themselves. In most cases, AUDIT (alcohol-use disorders identification test) should be used. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ, FAST). Screening tools should be appropriate to the setting. For instance, in an accident and emergency (A&E) department, FAST or PAT would be most appropriate.

• Where routine screening is not feasible, focus on groups that may be at an increased risk of alcohol-related harm. This includes those:

– who have had an accident or a minor injury
– who request contraceptive advice
– involved in crime or other anti-social behaviour
– who truant on a regular basis
– at risk of self-harm
– who are looked after
– involved with child protection agencies.

• When broaching the subject of alcohol and screening, ensure discussions are sensitive to the young person's age and their ability to understand what is involved, their emotional maturity, culture and faith. The discussions should also take into account their particular needs (health and social) and be appropriate to the setting (for example, a different approach may be needed in a GP surgery compared to an A&E department).

• Routinely assess the ability of young people to consent to alcohol-related interventions and treatment.

- Alcohol specialists in particular believed it was more likely that dependent drinkers would be identified in this age group compared with younger clients, but questioned whether these should be classed as harmful drinkers or whether an additionally category was required to reflect the more problematic nature of use.

Common Assessment Framework

- Participants questioned the omission of the use of the CAF in this recommendation as this was suitable for all young people up to the age of 18.

"And again, there's no mention of the CAF, which…. who's going to initiate, if those young people aren't in the services, you're not going to get a CAF are you because you've got to be involved in a service."

Role of non-specialist workers

- Delegates agreed that as long as they had received suitable training it was appropriate for a range of non-alcohol specialists to screen young people for problematic alcohol use. Additional roles that were believed to be important for screening included community wardens, park keepers, youth group and religious leaders, and further/alternative education providers.

The use of screening tools

- Some delegates questioned whether the specification of particular screening tools in the recommendation meant that the use of locally developed screening tools, which also included information on referral pathways and brief advice, would be discouraged. Other professional groups might not believe that the recommended screening tools were appropriate to their practice settings. An example was given where local teachers were uncomfortable screening pupils with the AUDIT as such measures would imply that pupils were drinking alcohol underage. Instead the tool was integrated into an alcohol prevention programme, which also provided information on care pathways. Other participants thought that PSHE would be an ideal framework for delivery of similar types of approach.
- In contrast, commissioners believed that it was important that use of tools was consistent, for example FAST should be used for initial screening, and then the AUDIT upon referral to higher tiers of service. There was general agreement that professionals would need training on how to interpret AUDIT scores and how they should adjust cut off scores for different populations and circumstances.

"And then they need alcohol awareness training as well. For me, you're asking somebody to carry out an AUDIT, they need to understand about alcohol. So you'd have to have alcohol awareness training included in the AUDIT."

"*I think, where it says screening tools should be appropriate to the setting, I think a lot of services will be able to argue that it isn't appropriate. I think that is a bit of a loophole where a lot of.... I'm just thinking like the youth service will say that's not appropriate to...."*

"*I'd be wary about the screening tools as well. I just think that if you did look at AUDIT, for a 17 year old to really.... how many times have you done what you weren't expected to do? All the answers, do that anyway, probably every day. And how many have felt remorse? Are they really emotionally mature enough to look at remorse? Or is it just that I looked a bit of a prat because I drank too much? And also, when I'm thinking back, especially 18 year olds.... 17, 18, 19 year olds, they'll go clubbing three, four times a week and it's a natural part of growing up."*

- Although older young people spend a large part of their day at school or further education colleges, most conduct their drinking outside of educational hours and on the weekends. Delegates therefore believed that teachers and lecturers were likely to identify the signs of alcohol misuse in this age group compared with younger children. Screening undertaken at pupil referral units (for 16 year olds) was thought to be more effective than general screening in mainstream education as students would be more likely to exhibit risk factors that increased the propensity of harmful alcohol use.
- A & E departments were thought to be useful places to screen and assess older young people because their attendance would often be a result of alcohol use. However, busy medical staff would rarely have the time to conduct a thorough assessment and relied on the use of quickly completed screening tools like FAST. An example was given of a service where community nurses were co-located in A&E to provide support where young people were admitted after drug and/or alcohol use. Once a young person had been referred to the nurse, initial screening and a brief intervention would be conducted and, if the young person was identified as being in need of further support, the nurse would offer a follow up consultation. The young person would be provided with the opportunity to choose a suitable venue and most would reportedly ask to be seen in their educational establishment. During visits to schools the nurse would often be asked by school staff to see other pupils as well. In these cases, teaching staff had concerns about a pupil and asked them to see the nurse; or a pupil had confided in a member of staff and had been encouraged to see the nurse whilst she was in school.

"The AUDIT is a gold standard. If you've got the time to do AUDIT, it has the higher sensitivity and specificity. But the word pragmatic comes in, i.e. what is used in routine clinical practice. I think the AUDIT remains the gold standard."

- Several participants independently suggested that the words "where routine screening is not feasible..." (bullet point 2) be removed as this might give some practitioners an excuse for not conducting more widespread screening in populations that were perceived to be, either mistakenly or correctly, at lower risk from alcohol related harm.

Justification for screening

- It was considered important that young people were provided with valid reasons why screening was taking place, and that it should not be undertaken surreptitiously or with the aim of finding evidence to punish a young person. It was the experience of many practitioners that a large proportion of young people would resent the intrusion into their lives and it would be difficult to engage them in screening and referral.

"… young people aren't very good consumers of primary care. A lot of the young.... when I was a practitioner, which was until very recently, a lot of young people that I was working with say 17 years, didn't even know who their GP was and certainly couldn't remember the last

time they'd used them. So a focus on primary care, great if they use it, if there's engagement."

- When questioned, all agreed that asking for contraceptive advice was a positive indicator that the young person was interested in taking responsibility for their health. Discussion of alcohol on these occasions should be treated cautiously. Although seeking advice might mean the young person would be receptive to further support, they might resent the assumption that they were irresponsible in their alcohol use. It was pointed out though that the reasons for presentation for contraceptive advice needed to be determined as the request may have been due to an alcohol related sexual episode.

Other priority groups for screening

- Further suggestions for at risk groups included: young people using illicit substances; teenage parents; those with mental health problems; young people in families with substance use disorders; 16-17 year olds who drink at home with parents; young people at risk of mental illness. One group requested clarification of the meaning of someone being 'at risk' of self harm, namely whether this referred to young people who had self harmed in the past or who were likely to self harm in the future. Furthermore, self harm did not necessarily refer solely to cutting, but could also mean eating disorders and harmful sexual practices (e.g. exploitative relationships, sex work or trading sex for goods).

Recommendation 8 – motivational counselling with young people aged 16 and 17 years

Who is the target population?

Young people aged 16 and 17 years who have been identified via screening as drinking a hazardous or harmful amount of alcohol.

Who should take action?

NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Ask the young person's permission to arrange for them to have motivational counselling.

• Appropriately trained staff should offer motivational counselling.

• Provide information on the local specialist addiction services that can deal with young people to those who have scored 20+ in the AUDIT screening questionnaire, those who do not respond well to discussion and those who want further help. Refer them to these services if this is what they want.

• Give those who are actively seeking treatment for an alcohol problem a physical and mental assessment and offer, or refer them for, appropriate treatment and care.

What is motivational counselling?

- As described under general comments (section 3.1) at the beginning of this section, the majority of discussion concerned the term 'motivational counselling' and its implications.

The CAF

- Again, delegates believed that the use of CAF should be included in this recommendation, particularly as a means to record the types of intervention received and the outcomes agreed between client and practitioner (Section 4 of the CAF form).

Alternative approaches

- Some practitioners were concerned that as the order of recommendations currently stood it would mean that young people might be subject to several referrals and be required to present at different services. It was suggested that NICE consider whether in some more problematic cases an integrated care pathway approach should be taken where young clients would be allocated a particular practitioner earlier in their treatment journey who would guide them through the various assessments and interventions.

"And that's where things come in about who's doing the screening. Because if it's a Tier 1 person doing it, they probably are going to refer on. But if they're already presenting some Tier 3, Tier 4 service and they have the screening, they're going to stay within that service."

Feasibility of implementation

- Due to a lack of services and national provision, few examples of specialist young people alcohol services were provided. Where established, most were based on adult models of intervention.
- Motivational work with young people would often take place in informal settings, such as cafes or on the street, and the first few sessions would be used to encourage and engage the young person. Asking a direct question such as 'Do you want motivational counselling?' (as suggested in the first bullet point of this recommendation's actions) was believed unlikely to be accepted by young people. Practitioners more frequently use gradual persuasion to engage young people, or they use ideas and techniques that are not directly determined by the language of intervention.
- Some groups of young people might not have much choice in the type of intervention they received if it was court mandated.
- Delegates commented that it appeared to them that through this recommendation NICE were supporting adult models structures and questioned whether young people would be receptive to these types of intervention.
- Practitioners mostly delivered brief interventions, workshops and group work, and so the introduction of personalised one-to-one brief counselling approaches would not only require training but also a shift in the organisational culture and the adoption and ownership of new intervention paradigms.

"I think you're going to exclude so many. It says ask the young person's permission and it says refer them to services if they want to. Motivational counselling can be quite intimidating, I think, for someone of that age."

Training and commissioning of motivational interventions

- Participants referred back to the discussion of Recommendation 5 and considered the training implications of this recommendation. As previously suggested, most were uncertain about what changes were needed in existing training structures due to their lack of understanding of the motivational counselling technique. Neither *World Class Commissioning* nor *Signs for Improvement* mention this term although the latter refers to motivational interviewing and motivational skills development.
- Putting this confusion aside, a few commissioning options were discussed. It was notable that the outcomes of training were only very rarely monitored although this was something that commissioners were eager to do. Of interest were the learning outcomes achieved by trainees as well as evidence that training was being used in professional practice. Commissioners were interested in assessing the impact of workforce training on outcomes determined in evaluations of strategic plans or smaller scale health promotion programmes.
- It was also apparent that the commissioning of training programmes was conducted *ad hoc* and often based on the availability of trainers rather than the validation or accreditation of

their techniques. Most participants seemed unaware of NICE guidance on commissioning of behaviour change programmes (PH6 Behaviour Change), with its focus on developing competencies rather than specific techniques. After prompting, delegates wondered whether this earlier guidance contrasted with the apparent recommendation of specific techniques in this set of guidance.

Further clarification is required

- More information was requested on the physical and mental assessments included in the recommendation. Participants thought that this might dissuade some young people from accessing further help if it was a requirement of referral for non-alcohol related matters. There would also be differences in the requirements and outcomes, for example, of self report and clinician's assessments. Non-clinicians wondered whether they would have to request the support of specialist staff or GPs for all clients, or whether a brief semi-structured interview would suffice. Again, some of this information might have been recorded in the CAF and so it was important that there was no duplication of screening.

"I was going to say, is that not something that might necessarily actually be part of when they get to the agency they're being referred to, that actually position who.... the person who's doing the first three of those might not be in a position to do a physical and mental assessment, because it implies that you're a clinical worker. Well both clinical and a psychiatrist specialty as well."

"And who's qualified to provide physical and mental assessment. Because in my line of work, I don't think we'd be looking probably to say okay you need to go and see your GP. So we assume they have a GP and then how do I know they've been to see their GP?"

Recommendation 9 – screening adults

Who is the target population?

Adults.

Who should take action?

NHS and health and social care professionals who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink.

What action should they take?

• NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during patient registrations, when screening for other conditions, when managing chronic disease, promoting sexual health or treating minor injuries caused at work.
• Where routine screening is not feasible or acceptable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. These groups include people:

- with physical conditions (such as hypertension, liver disease or other gastrointestinal disorders)
- with mental health problems (such as anxiety, depression or other mood disorders)
- at risk of self-harm
- who regularly experience accidents or minor traumas.

• Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and on people that have alcohol-related problems. This will include those:

- at risk of self-harm
- involved in crime or other anti-social behaviour
- who practice unsafe sex
- whose children are involved with child protection agencies.

• When broaching the subject of alcohol and screening, ensure discussions are sensitive to people's culture and faith and tailored to their needs.
• Complete a validated alcohol screening questionnaire with the adults being screened. Alternatively, if they are competent enough, ask them to fill one in themselves. Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type), or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ, or FAST). Screening tools should be appropriate to the setting. For instance, in an A&E department, FAST or PAT would be most appropriate.
• Professionals should use their judgment as to whether to revise the AUDIT scores downwards when screening:
- women (women scoring above 7 in the AUDIT questionnaire should be offered brief advice)
- younger people (under the age of 18)
- people aged 65 and over
- black and minority ethnic groups

If in doubt, consult relevant specialists. Work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns.

• When it is not appropriate to use an English language-based screening questionnaire, consult relevant specialists (for example, when dealing with people whose first language is not English or when people have a learning disability).

• Do not use biochemical measures as a matter of routine to see if someone is drinking a hazardous or harmful amount of alcohol. These measures may be used to assess the severity of an established alcohol-related problem or to complement screening questionnaires within A&E.

Feasibility of recommendation

- The same types of comments made when discussing screening of young people regarding training, budgets, joint agency working and waiting lists were thought to be relevant here. Delegates generally welcomed the requirement of NHS staff to routinely conduct alcohol screening as part of their practice. This was thought to be an ambitious action and there were some doubts to its feasibility; funding restrictions would probably mean that a 'watered down' version would be delivered at a practice level and only selected groups of NHS staff would perform screening to the extent that NICE intended. It might be more feasible to recommend temporally determined screening such as once every six months for regular service users, or on every occasion for less frequently presenting clients.
- It was believed that it might be advantageous to set targets on the amount of screening that should be conducted each year. The NTA unit cost calculator for substance user services was recommended as a good means of calculating the likely financial impact of increase screening and referral as it allowed the modelling of different treatment scenarios[8].

Screening at GP surgeries

- Routine screening at GP registration was thought to be a good idea, although there was the concern that rather than this been undertaken by practice nurses (who may not be based in the surgery) or busy GPs it might be assigned as part of the duties of non-specialist staff such as receptionists, and use insensitive and non validated tools such as self report and GP derived questionnaires.
- Delegates believed that if appropriate contracts were in place then GPs usually provided a good standard of screening, although there were comments that PCTs sometimes found these expensive. Some delegates wanted GP contracts to be dependent upon evidence of the delivery of follow up advice or referrals made rather than the screening itself, although others thought that this would unfairly disadvantage GPs in healthy neighbourhoods.
- On a related topic it was believed by a small number of delegates that GPs were sometimes hesitant to record minor alcohol related ailments as they would be compelled to disclose these if an insurance company requested a summary of patient records in order to process an application[9].

"One of our GP surgeries actually has the admin workers asking the questions. They're the ones that have been trained to screen."

"They'll [GPs] *fill their form in to say they've been paid but we don't seem to have any comeback as PCT commissioners. We just have to go by the fact that they've said they've done X numbers of screens this month. I've got no way of knowing whether they've.... what the results were of that, whether they'd done a brief advice as a result of it, or if they've referred on. And I think that's the bit that's missing from some of this around that."*

[8] http://www.nta.nhs.uk/areas/unit_costs/web_based_tool.aspx
[9] See http://www.bma.org.uk/ethics/health_records/GPR.jsp

"Score below a certain point, give brief advice; score above a certain point, refer into Tier 2 service or to your primary care alcohol worker, or whatever the system is. But it's whether they do it or not."

"Perhaps it requires a qualification, for instance… [w]hen a patient registers, it's quite legitimate to bring up a number of factors relevant to health, such as obesity, smoking and alcohol. And that is a routine which is done to a degree now on patient registration, but many of us feel should be done actually more rigorously. Secondly, there are alcohol related conditions which will appear to a general practitioner, for instance lack of sleep, indigestion, where there should be, if you like, focused related screening. You can bring up alcohol because alcohol can be a cause of indigestion, alcohol can be a cause of less sleep. So there's two different scenarios. And in the latter scenario, you are trying.... if a patient is drinking too much, you're trying to get to patients to contemplate change because it is being brought up in relation to a problem that they have gone to the general practitioner to seek help for."

Contribution of non-NHS professionals

- Greater clarity was requested on example roles that would be included in the list of non-NHS staff. Suggested roles included the fire service, educators, police force, and those working in the criminal justice sector. In a similar manner to the young person recommendations it was believed that unless their role or sector was directly specified, some professionals would be quick to opt-out of acting if they believed that the recommendations did not concern them. Although not qualified to deliver interventions it was believed that criminal justice workers would be a key professional group delivering screening and referral recommendations as more programmes were being introduced that attached treatment and intervention to court orders.

"I'm looking at the children services obviously as I work with them. They don't do routine screening. They haven't got the resources or the training to do that"

"If we're being really pedantic, being a lifelong NHS professional, you could argue that, that exempts non-professionals, healthcare assistants, whatever, if you're going to say they're not in the profession from screening people. I think it means NHS staff really."

"I think there should be an expectation that the non-NHS professionals try and do it routinely. But it's almost like an assumption there that there won't even be a target for them … Whereas, with the NHS, they're looking at routine but if routine isn't feasible, then start looking at high risk and give examples of that. So why is it the non-NHS professionals can move away from routine stuff?"

Other priority groups

- It was requested that problematic drug users, smokers, mentally ill clients, perpetrators and victims of (domestic) violence, the long term unemployed, and the obese should be included in the list of priority groups recommended for screening by NHS and non-NHS staff.

Use of the AUDIT

- It was apparent that AUDIT was already being used to screen and refer clients to particular services. General questions on alcohol were also included in many informal and opportunistic screening tools. AUDIT was being used by a wide variety of health related roles, including pharmacists, sexual health practitioners, community nurses, and district nurses. Criminal

justice professionals were encouraged to being screening with AUDIT, particularly in response to the potential roll out of alcohol arrest referral schemes.

"Nowadays, intervention work is in custody suites anyway, although, at the end of the day, the police are looking at the crime. So your average bobby on the street doesn't actually get involved with any of this. It's having them.... I think when you talked about triggers, if there was something in the custody suite for police officers to say this person.... something to trigger, so that they can direct them towards the alcohol intervention workers."

- Delegates were uncertain of the reasons why AUDIT scores should be revised downwards, what these scores should be, and why the specified groups were chosen. It was thought that providing this additional information would increase compliance. Further, participants were unsure why BME groups were included in this list; discussion concerned population differences in the metabolism of alcohol and the apparent lack of engagement with services. In this respect it was thought that lowered scores might lead to more referrals.

"Does it mean adjusting the scores downwards or adjusting the thresholds downwards? Are we saying that somebody.... you add it all up and a woman scores eight, and you knock a couple of for some reason? Or is it saying that if a woman scores seven, you treat it as though it was an eight?

No. It's changing the interpretation, isn't it?

It's changing the interpretation or it should be as in the threshold."

"I'm not quite sure what they mean by black and minority ethnic groups. Obviously I know what they mean by that, but if you've got somebody in the second and third generation, why would you be adjusting the scores? I don't understand why you would be doing that for some people. If English is not their first language, yes. It just seems a bit general."

"In terms of consistency, it's interesting as well because take recommendation 7, which is young people aged 16 and 17, it says, in most cases audit should be used. There's nothing about downgrading the score, but then in the one that we're just talking about, it says you should, so there's a consistency point there."

Diversity and screening

- Participants agreed that it was important that clients' language requirements were met. Examples were given of some services that used a self completed AUDIT that had been translated into non-English languages, but these services did not have access to interpreters to respond to the results of the screening. In all cases it was thought beneficial if a trained worker was available to explain and/or read out questions to clients who had poor literacy skills. This was thought to be particularly pertinent for problematic substance users or those who had learning difficulties.
- With regards to the wording of this action point, clarification was requested on "relevant specialists". Some participants were unsure whether this meant alcohol specialists, or specialists experienced with working with people from other cultures or particular client groups.

"Validated and like we were saying about the young people; are we asking the right questions of the different group? Maybe there are other questions we need to be asking. I don't know what those might be, but if we're taking people's culture and faith into account, is the tool that we've got the right tool for other faith groups?"

"And also, it's not just about the language, just like you were saying before, the absence of diagrams and things, it's for visual learners and the different learning styles that people have. So we need to incorporate that as well."

The use of biochemical measures in screening

- There was a general agreement that biochemical measures weren't useful in routine screening and in non-specialist settings. Firstly because it was believed that they sometimes produced unusual and unhelpful results (e.g. a heavy drinker returning normal gamma-glutamyl transferase results) secondly that they only provided a snapshot of drinking and failed to take into account wider contextual factors and problems, and thirdly that were problematic drinkers might use the data to justify continued drinking (e.g. hepatic damage had already occurred and therefore no benefit in reducing drinking).

"I think, coming from a practitioner viewpoint, sometimes there is the issue of around someone's talking to you, their pattern of drinking is harmful or their pattern of drinking is hazardous. However, their liver function tests, etc., etc., have all come back within the parameters of normal or acceptable. And I'd be rich with the amount of folks who said to me, my GP says my liver's fine, so what's your problem? I think that's where this can become an issue."

"I think one does need to, in this paragraph, differentiate between biochemical measures in general and in A&E blood alcohol concentration within the context of what we're talking about, which is early identification, which should actually be part of clinical practice... and if you take a blood alcohol concentration, you've got to have the resources to be able to help the patient, if it's possible."

Recommendation 10 – brief advice for adults

Who is the target population?

Adults who have been identified via screening as drinking a hazardous amount of alcohol (that is, those scoring 8 to 15 on the AUDIT questionnaire) and who are attending:

• primary healthcare services

• A&E departments

• other healthcare services (general hospital wards, outpatient departments, occupational health services, prenatal book-in clinics, sexual health clinics, needle and syringe exchange programmes, pharmacies and dental surgeries)

• offender management and other criminal justice system services, social services and other non-NHS public services.

Who should take action?

• Professionals who have received the necessary training and work in the services above.

What action should they take?

• Primary healthcare professionals should offer a brief session of structured advice about alcohol.

• Non-primary healthcare professionals should try to find time to offer structured brief advice. If they miss an opportunity to do this they should offer an appointment as soon as possible. This appointment may be for a structured brief session or, where appropriate, motivational counselling (see recommendation 11).

• Structured advice should be based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy) and should:

- cover the potential harm caused by this level of drinking and reasons for changing the behaviour, including the benefits for health and wellbeing.
- cover the barriers to change
- lead to a set of goals
- last from 5-15 minutes.

• Use a recognised, evidence-based resource, such as the 'Drink-less pack' or the 'How much is too much?' pack which provides self-help materials.

• 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). Where required, they should offer an additional session of structured brief advice.

Feasibility of the recommendation

- This recommendation was perceived to be an ambitious proposal and whilst thought useful by the majority of participants, would require long term investment in training, and the development of new working relationships. Delegates reported that current finances would not cover the expanded range of training that would be required to incorporate both health and non-health specialists.

"There's a huge, huge training implication here and there's a huge assumption that some of these services that you're identifying might actually want to do it and take it on. We've had some issues with.... where we thought youth workers would be willing to do things around pregnancy testing and condom distribution. But actually, they're saying no, it's not my job, it's not my job."

"Well I think from the point of view that we haven't, at the moment, got all of our primary healthcare professionals trained in order to do this, to then say we've got to train and develop a whole range of non-primary healthcare professionals to do this, do you know what I'm saying? In terms of actually then making that happen, monitoring it, quality standards, governance, I just.... it just frightens the life out of me"

- Participants were concerned that the recommendation did not encourage professionals to make referrals if they believed that clients required more support than additionally identified. Furthermore, some expressed their concern that the recommendations might lead some non-specialists to believe that the use of a brief intervention was sufficient to deal with more problematic alcohol related behaviours, when specialist referral would be more appropriate.

"*My worry...if it's a brief intervention and a chat, well that stops someone perhaps going to a more professional service if they just go one session there*."

- Delegates discussed the feasibility of delivery of brief advice by the professionals listed in the target population. One line of discussion concerned the how professionals would know that they were working with a hazardous drinker unless there was comprehensive data sharing. For example, how would this information be shared with pharmacists and dentists, or was there the expectation that these roles would also have screened the client? It was questioned whether this was feasible in the busy commercial healthcare environment and whether the public would accept alcohol screening in non-primary healthcare settings.
- Furthermore, it was not considered feasible for many of the professional groups to follow up on their client's progress as they might not see them regularly (e.g. a dentist might only see a client once or twice a year, a pharmacist would be unlikely to encounter the same customer in a busy city centre pharmacist where retail/dispensing assistance would be the first point of contact). From the client's perspective it might also seem unusual that what they would ordinarily consider a primary care health related matter, i.e. risky alcohol use, was being responded to by a range of practitioners, and on repeated appointments.

"There's something very basic about this. I'm a pharmacist or a dentist. How do I know that the adult that I've got in front of me has been identified through screening as drinking a hazardous amount of alcohol?"

"I was chatting to a chap from [name of pharmacy] *about this on a training course. And he just said when it works it's great, but he finds it's very difficult because just the environment, that people want to nip in and get it quickly, and they feel quite abrupted by someone saying can I ask you a few questions about alcohol, especially if obviously the medication's nothing to do with alcohol. And then he said it's either that or you get people who are wanting to chat about it regularly. It's a bit out of depth"*

"The thing is, in the evidence statement as well, it's saying that the brief interventions were found to be effective in the reduction of alcohol use, when there were two to seven sessions within a duration of initial and brief sessions of 15 to 50 minutes, or 10 to 15 minutes in one session. So in actual fact, the examples that we're talking about, pharmacies, dentists, whatever, is it realistic that they're going to have several sessions that could last from 15 to 50 minutes? Because we're not.... if we look at what the evidence is saying and then we're trying to say well brief intervention is two minutes at the counter with the pharmacist, well then the evidence is saying that wouldn't be effective. So what they've really recommended here, I would say, doesn't match.... doesn't really match their evidence"

- Participants argued that the phrase "…*should try to find time*…" in action point 2 should be removed as it was likely that unless directly instructed otherwise, many professionals would use their busy schedules as a reason not to conduct structured brief advice sessions.

Providing brief advice

- It was believed that there was a fundamental difference between the purpose of FRAMES based structured advice, and structured brief advice. The latter category was believed to be simpler in form, instructive, and sometimes confrontational. FRAMES based advice was considered to be important in building up relationships with clients and required dedicated practitioner training. Participants questioned whether readers of the guidance would understand the difference between the two and sought clarification on why it was not considered appropriate for non-primary healthcare professionals to deliver FRAMES based advice.
- There was a difference in opinion in how long delegates thought that the brief advice session should last and how many sessions should be offered. Although it was possible to deliver a FRAMES based intervention in the specified 5-15 minutes, some thought that NICE intended the brief advice session to follow completion of AUDIT with the client, in which case the length of time required might double. Clarification was also needed on the most cost effective number of sessions to offer clients. Similarly an indication of the length of time required to complete the recommended evidence based packs was requested as commissioners would need to budget for this additional time. If NICE intended that 'self-help' packs were to be taken away by the client and therefore would not directly form part of the delivered intervention, then this should be clearly indicated.

"*I worry about how much time people are going to give...if it's all of the people we mentioned previously. Some motivational counselling, it can take quite a few sessions. And we deliver up to six, and I don't know whether that's the right number or not. They last about 50 minutes. For some people that won't be enough, some people it will be plenty. But lots of different agencies do it. And I don't know how they're going to be scored on outcome and funding, etc., because they will need funding for it. So there's no mention of how long it needs. Is it one session, two?"*

- Participants generally agreed with the suggested content of the intervention, but to make it more relevant to non-healthcare practitioners other types of harms should be explicitly mentioned, such as alcohol associated criminal activity. This would make the action more relevant to those working in the criminal justice field.

Outcomes of brief advice

- The outcomes of brief advice, to reduce alcohol consumption to a 'low-risk' level, was supported in principal but delegates thought that this might lead to a lack of consistency in the number of sessions offered to clients and how success was determined. Although an AUDIT score of 8 provided a consistent cut off, this might not be accompanied by a reduction in risky alcohol related behaviours (e.g. sexual risk taking, drink driving, alcohol related violence etc.) and so the two types of outcome should be considered together. Participants generally agreed that due to a lack of public understanding of the meaning and quantification of alcohol units, client determined goals should not refer to these.

"We've had.... where we were chatting and saying oh so-and-so's score.... got the same score for two people, and they were really hugely different in their behaviour. The way the AUDIT is and a lot of the screening is, if you'd happened to have been at a wedding that week or drunk excessively, whichever, you could have just had a one-off or not a real.... you have this set of behaviours that would give you massive scores. So I think the fact that they think they need it or they want to talk to us is more important to me than the score."

"Yeah. Oh right, so you've just told me you've got three kids. Hmm. And you scored 10 on your AUDIT. And does he then say oh right I'll ring social services or whatever? You're going to have a duty officer going spare, because all the guidelines say that just because someone is drinking or misusing substances does not necessarily mean that, that parent is unfit... it starts to become very complicated"

"You can't expect a GP to ask the same person back six times. You just can't. You can't expect an A&E worker.... an A&E person to do the same. You need to have a specialist. There's no way around it."

"And you're looking at an hour and an half, 20 to 30 minutes per session, and then again, they're still asking to evaluate the success of those sessions with the audit. So somebody's got to screen again at the end and evidence that..."

Recommendation 11 – motivational counselling for adults

Who is the target population?
Adults who have:

- scored 16 to 19 on the AUDIT questionnaire
- not responded to brief structured advice
- chosen to undergo motivational counselling
- need motivational counselling for other reasons.

Who should take action?
Professionals who are in contact with adults and have received training in motivational counselling.

What action should they take?

• Offer motivational counseling to people who:

- are ambivalent about the need to reduce the amount of alcohol they drink
- have failed to benefit from structured brief advice
- in the professional's judgment, need more than structured brief advice
- for any reason, wish to discuss their drinking further with a trained professional.

• Sessions should last from 20 to 30 minutes and should aim to help people reduce the amount they drink (ideally, so that they score less than 8 on the AUDIT and consume less than the recommended level of alcohol).

• Follow up and assess people who have received motivational counselling. Where necessary, offer up to three additional sessions or referral to a specialist alcohol or addiction treatment service (see recommendation 12).

- Delegates preferred to discuss this recommendation alongside recommendation 10; hence considerations raised in the previous section should also be referred to. This was because the two types of action were seen as closely aligned and that motivational interventions would, in most cases, be delivered in the same service as brief advice. There was recognition,

however, that far fewer of the non-specialists detailed in recommendation 10 would be involved in delivering these activities as they would not have the necessary skills and training.

Targeting professionals

- When asked to specify which groups they thought would be most likely to deliver motivational counselling, participants responded that in accordance with Models of Care it would be Tier 2 alcohol workers. Trained probation and arrest referral workers were also thought to be important deliverers.

Content of the recommendation

- A small number of participants expressed concern with the use of the term 'structured' in this, and previous recommendations. This term was believed to limit the range and type of work that could be undertaken and may have the effect of dissuading the non-specialist from intervening. Although the activities should remain the same it was believed important to give the impression that the recommendations were not proscriptive and that professional experience was also important.

The type of intervention offered

- It was suggested that FRAMES based principals should also be included in this recommendation as the activities it supported were also useful in more problematic drinkers.
- Although some clients may request motivational counselling, the practitioner needs to make a professional decision if they believe that the individual may not benefit from it or if other types of intervention would be more suitable.
- Similarly, the decision to make an onward referral to more specialist treatment or ancillary services should not be made on the basis of AUDIT score alone and should be considered in the context of individual cases. For example, someone with a history of alcohol use disorders who had relapsed would benefit from referral regardless of AUDIT score. There were some doubts as to whether non-specialists would be able to make such decisions.

"You see, I think there are slight problems in pigeonholing people into specific boxes, because somebody could be scoring 17 and actually have very complex needs, and alcohol clients do have complex needs. And I think what this is doing is actually... it's a staged process that you do this first, then you do this, and then you do this. And I think there perhaps need to be an understanding that maybe for some clients, you can't follow that linear pathway that you need to think, you give them the brief advice and you give them the extended, but whilst those two things are happening, in the meantime you've made a referral to specialist services, as opposed to doing one, tick that box, two, tick that box, oh now I need three. Because somebody's that experienced would know that maybe somebody scoring 18 or 19 on the audit is going to need all in terms of services."

- Participants wondered whether in all cases sessions should last from 20-30 minutes for a maximum of three sessions, as depending upon the needs and nature of the client, more time was sometimes needed. This was an important point of clarification as future funding for this type of intervention might be based on a maximum 30 minute session.

- There was some concern that there was no recommendation of alternative forms of support in this recommendation; for example, family based intervention, 12 step programmes, self help or social support. Delegates wanted clarification on whether the absence of other types of intervention meant that NICE were recommending against their use.

Recommendation 12 – referral

Who is the target population?

Those aged 10 years and over who attend NHS or non-NHS services and may be alcohol-dependent.

Who should take action?

NHS and non-NHS professionals who have contact with anyone over the age of 10.

What action should they take?

Consider making a referral for specialist treatment if they:

• have scored 20 or more on the AUDIT screening questionnaire
• show signs of moderate or severe alcohol dependence
• failed to benefit from structured brief advice and motivational counselling and wish to receive further help for an alcohol problem
• show signs of alcohol-related damage (for example, liver damage or mental health problems).

Usefulness of the recommendation

- Most participants were of the view that including such a broad age range of targets (aged 10+) was unhelpful. Young people scoring 20 or more on AUDIT (which for consistency with earlier recommendations would have to be revised) would indicate serious child protection issues, perhaps requiring the involvement of police and social services. Recommending referral to specialist alcohol treatment was simplistic and did not reflect the realities of professional responses if such cases were identified. It was proposed that this recommendation should be divided according to age group as not only would different service provision be required but different legal issues would also need to be considered.

"Sorry, I'm shocked that you're going to do an AUDIT on a 10 year old."

"I think this 10 and over is very problematic. They're very different.... there should be.... there's different age boundaries here. Because I would be very concerned if somebody at 11.... it was considered appropriate just to do a bit of structured brief advice at the first instant and left maybe a bit of motivational counselling and then see if that works or not. I would want more of a response really"

"I think it throws up safeguarding issues. There's a whole range of stuff that if you just.... a 10 year old is not a 16 year old is not a 25 year old. And I think this 10 is too broad an age category. I think they should go back their 16 pluses and their 16-18. "

"What made me smile, you've got a 10 year old who's maybe alcohol dependent and the first action is... I don't see social care in it. And if I had a 10 year old who's dependent, I'd make a referral to social care. That is... and yet it's the first time they're not mentioned specifically. They have been in the other ones [i.e. reference to social care in other recommendations]. *I'd be extremely worried if I had a 10 year old who was alcohol dependent."*

"I'm basing this not on current experience but previous experience, I think there was a reluctance to involve social services; the fear of actually losing the young person, having them disengage. But as a manager, my perspective was very much it's important that social services are aware of this. And a lot of social services departments are pretty good and they will do a level of work with a key worker."

Feasibility of the recommendation

- Delegates noted that this recommendation was based on the assumption that professionals would have suitable services to refer clients aged under 18 years of age to. Although early intervention and prevention was important, specialist provision for young people is rare and practitioners would have to consider whether it was in their client's best interest to begin attending adult alcohol services.
- If clients had "failed to benefit from structured brief advice and motivational counselling" it was questioned whether they would subsequently benefit from further more specialised help as this would suggest that they were not yet ready to change their behaviour.
- Practitioners reported that if faced with a client who showed signs of alcohol related damage they would almost always refer to specialist treatment if it was not already being received. The focus on medical consequences of use was also criticised as a true public health response to problematic alcohol use would encompass a wider definition of alcohol related harm.

"Can I suggest a change? Point four. Show signs of alcohol related damage. It's very medicalised, liver damage or mental health. For me, it's alcohol related harm, because it may well be social harm. There may be impacts in terms of domestic abuse for child protection. And it may well be if somebody's AUDIT score is below 20..."

- To place this recommendation in the context of the overall treatment pathway, it was requested that references to NICE clinical guidance on alcohol dependence was included

*"We're in the reality of PCT land and local authorities and we are going to be operating on shrinking budgets, not expanding ones. And although alcohol is coming up the agenda as a priority, it's sitting there, fighting all kinds of other priorities that PCTs and local authorities need to deliver against. And that's the reality of where we're going with it. and I'm sitting here thinking there's no way that we can do some of this, with the best will in the world, because I know that we haven't got the sort of money, investment that will enable us to do this. A lot of public health budgets that came down through Choosing Health and Spearhead areas got lots of money and were able to do it. I've only had money since last April to do anything at all with alcohol. We've had no prevention agenda, nothing. I think our total budget for alcohol spend prior to last April, for health promotion was £340 on the prevention agenda around alcoho*l."

4. Conclusions & Recommendations

A brief summary of major topics emerging from discussion of each particular recommendation is provided below. The online survey (Appendix 5) allowed invitees who were not able to attend the field meetings the opportunity to contribute their views to the fieldwork. These findings were incorporated into the general consideration of recommendations at the end of this section.

General considerations

There was a clear differentiation between the general acceptability and perceived effectiveness of the policy and practice recommendations. This seemed largely determined by delegates' professional background. The majority of public health, licensing, and social welfare practitioners supported measures to increase the price and availability of alcohol, regardless of political and public opposition. Although of course there was variation in the views expressed, opponents of these recommendations argued that they would be unpopular, were based upon relatively weak evidence, and would place an undue burden on both retailers and consumers. Of course, all delegates wished to clamp down on irresponsible alcohol promotions (supermarkets were thought to be important targets of action), and supported health initiatives that assisted problematic drinkers, but it was apparent that population based approaches received less support than individualised action. The reasons for this did not emerge during the fieldwork discussions and are likely to be complex. However, there are some areas worth considering. As government policy seeks to promote sensible and social drinking, population based approaches would disadvantage those drinkers who strive to consume within recommended limits. Counter to this, population based interventions (such as those detailed in the draft recommendations) assume that a favourable health target is the overall reduction of alcohol related harm in the population, which would be shared by all its members. Furthermore, it is likely that there is a large population of harmful drinkers in the UK that are not aware of potential problems and have not traditionally been the target of intervention. These would therefore be unlikely to respond to individualised opportunities to consider their alcohol related behaviours. Population based approaches would mean that some of these barriers would be overcome. Health professionals described how they thought that most of the public discussion of initiatives such as minimum pricing had focussed upon costs to the individual rather than the benefits to the whole population. Reframing this discussion may make these types of approaches more acceptable to the public.

Delegates described how historically the UK has had an unhealthy alcohol culture, and although comparisons were made to Mediterranean countries there appeared to be a growing understanding that youth alcohol cultures in particular were becoming more homogenised across the EU. This meant that at least for young people, it was inappropriate to make comparisons to supposed sensible drinking whereby small amounts of alcohol would be introduced to children as part of a meal. Problematic patterns of alcohol drinking in young people were thought to be a common feature of youth culture in the EU. The global nature of contemporary entertainment and online advertising meant that policy makers in the UK now have to consider international influences of young people,

many of which are beyond the control of government. These types of discussion were not just limited to young people. Delegates believed that most adults had a 'hypocritical' attitude towards alcohol use behaviours. Discussion focussed, for example, upon the (draft) CMO guidance on recommended drinking limits in young people. Whilst there was thought to be acceptance that action was required to reduce alcohol related harm in young people (particularly around antisocial behaviour), advice from government was thought to unnecessarily interfere in parenting practice. Delegates thought this unfortunate as it was believed that a large proportion of drinking behaviour and culture was transmitted through the family. Frequently, comparisons were made between the different attitudes towards smoking and alcohol. There clear health related messages regarding smoking, and cessation support for all types of smokers is provided. Despite initial resistance the population has now largely accepted anti-smoking legislation as beneficial to health. Although there are clear differences between the epidemiology and negative outcomes of the two substances, it was believed that population based approaches to alcohol would only be effectively implemented if they were delivered in the same, non negotiable manner as anti-smoking strategies. Form the public announcements of some politicians, and the tone taken in newspaper editorials, many delegates believed that it could be concluded that there wasn't the will to implement many of the recommendations in the draft guidance.

Limitations of the methodology

It is important to recognise weaknesses in the field research, which although weren't substantial, are useful to consider. Some of the more pertinent limitations are mentioned here. The aims of the fieldwork phase were largely determined by the need to consult with professionals on the content, practice implications, and potential impact of the draft recommendations. Although the researchers analysed data independently of these aims, and identify themes accordingly, the final report was drafted to be of maximum utility to the NICE PDG, hence some areas of discussion, which were of interest to professionals, but not relevant to the overall aims of the fieldwork report, were omitted.

Secondly, because of changes in the overall NICE consultation timetable, fieldwork events had to be rescheduled at short notice. This meant that a large proportion of delegates from the alcohol industry and retailers weren't able to attend. Although the authors were mindful of this and ensured that all perspectives were heard during the discussions and included in this report, it meant that a weighting could not be applied to the level of agreement on particular points. For example, although a majority of delegates reported support for minimum pricing this may have been a result of the large representation of public health professionals at the event; a more equal balance of sectors may have lead to a more refined distinction. Furthermore, it was anticipated that industry representatives, although acknowledging that they would not have specific expertise, would contribute to the practice discussions, particular around alcohol screening in the population. Unfortunately, despite attendance at relevant events industry delegates believed that they had little to contribute and exercised their right to withdraw from the event. This meant that useful discussions about how alcohol industry might support professionals to deliver screening and brief intervention were omitted.

Finally, the qualitative methodology used to analyse data was relatively simplistic. Thematic categorisation was chosen because it generated data in a relatively rapid manner, and it enabled comparison and contrasting of data from the group discussions and individual interviews. However, this approach meant that it was not possible to validate emerging themes with fieldwork participants/interviewees or retest themes within the wider research team.

General comments on the guidance

- A treatment pathway matrix should be provided which would not only visualise the stages of care that the recommendations covered, but also outlines the roles and responsibilities of different professional groups in delivering the guidance.
- Good communication was needed between NICE and organisations in non healthcare settings in order to establish alcohol at the heart of partnership working.
- NICE should work closely with the National Treatment Agency (NTA) to ensure that commissioners' concerns about lack of investment in alcohol service relative to drug service were considered.
- The use of the term *motivational counselling* should be reconsidered or clearly differentiated from other motivational approaches.
- The presentation of the guidance will contribute to its impact and likely adoption. A standard approach should be used whereby each recommendation is preceded by a short statement of the evidence and a discussion of the likely outcomes of implementing the proposed actions.
- The contribution of third sector, community and voluntary groups in responding to alcohol related harm should be acknowledged and organisations working in these sectors should be mentioned throughout the guidance.

Recommendation 1 - Price

- The language of the recommendation was criticised. It was believed that if NICE was serious about Government implementing its recommendations then imperative forms of language should be used.
- The concept of minimum pricing would be likely to be unpopular with politicians and members of the public. It should be introduced gradually and the benefits explained. The true cost of minimum pricing to the industry and consumers should be clearly defined.
- The majority of public health professionals supported minimum pricing initiatives regardless of the opposition this might provoke. If introduced this should not be optional and a specific unit price should be provided.
- Delegates anticipated that the experiences and legal rulings on the proposed introduction of minimum pricing in Scotland would dictate policy in England.

- Some local authorities had introduced schemes which sought to control alcohol pricing through licensing conditions.
- There was a concern that decreasing the affordability of alcohol for some groups would have unintended effects such as increased illicit drug use and petty crime. This might be offset by the health service and criminal justice savings that a reduction in problematic alcohol use might bring.
- Participants had little understanding of how linking alcohol pricing to inflation and earnings might work, or how it currently worked in places such as Australia.

Recommendation 2 - Availability

- The inclusion of public health objectives in licensing was welcomed.
- Local authorities already had powers to close premises that were selling alcohol irresponsibly or in a manner that might harm public health, but these powers were infrequently and inconsistently applied.
- The procedure for granting licenses should be reviewed. Health and social care representatives should be included as decision makers.
- Partnerships should be established with regional public health observatories and University departments to streamline the reporting of data to inform licensing strategies.
- Delegates were unsure whether, with respect to EU law, alcohol import allowances could be changed.

Recommendation 3 - Marketing

- For consistency, print media should be included in the list of sources from which alcohol advertising should be banned.
- NICE should acknowledge that the evidence supporting this recommendation is relatively weak.
- A code of practice on the advertising of alcohol using new media such as mobile phones and the internet is required.
- Regulatory systems already exist that control the content of alcohol advertisements. These systems were thought to be successful by the alcohol industry. Some delegates wished to see these bodies granted more punitive powers (e.g. fining offenders).
- NICE may need to review its guidance if product placement in TV shows is introduced through the Department for Culture, Media and Sport.
- Banning alcohol advertisements from media outlets where more than 5% of the audience was aged under 18 was considered to be equivalent to a total ban.
- Young people learn about alcohol not just through advertisements but also how drinking, and its uses and consequences are portrayed within TV programmes and other media. NICE

should consider how programme creators can be persuaded to include healthier representations of alcohol use in storylines and other content.

- The alcohol industry seeks to distance itself from the irresponsible promotion of brands on user generated and social media websites. It has little control over the content that web users choose to upload to personal sites or unofficial 'fan pages'.
- NICE needs to be clearer on what the 'facts' on alcohol should be; whether this should include a balance of positive and negative aspects, or whether they should be limited to price and alcohol content.

Recommendation 4 - Licensing

- Alcohol needs assessments should have already provided a good indication of local alcohol related problems. Toolkits are available for those organisations wishing to update, or improve the quality of existing reports.
- Licensing officers already have, and use, a range of powers to control the number of licensed premises in an area or to review existing licenses. The use of cumulative impact policies meant that individual premises were not usually isolated and targetted for action. Furthermore, local authorities preferred to take more strategic action to deal with problematic alcohol use in particular geographical areas as trouble was unlikely to be restricted to a single venue and would result from a combination of structural and environmental factors.
- Test purchasing and 'mystery shopper' schemes were perceived to be valuable but did not receive sustained funding to be particularly effective. Furthermore, restrictions placed on test purchasers (e.g. unable to lie about age, carry fake ID or wear makeup) meant that they provided a poor simulation of 'real world' alcohol purchasing conditions.
- Licensing officers believed that existing laws were sufficient to control irresponsible retailing. However, these were inconsistently applied and often provided little punitive discouragement. It was suggested that harsher fines and 24 hour premises closures could be potential options for dealing with irresponsible retailers.
- The introduction of alcohol server schemes were supported. These would allow retailers to respond to signs of problematic drinking. Key features of such schemes should include training to allow recognition of intoxication, confidence building (to support refusal of service to intoxicated customers), awareness of the law, and basic health promotion skills.

Recommendation 5 – Resources for screening and brief intervention

- The range of NICE guidance that will be available by the end of 2010 (including clinical guidance) should be seen as a suite of responses to alcohol misuse. Professionals should not consider one piece of guidance in isolation from others.
- World Class Commissioning would provide the framework for delivery of most of the draft recommendations.

- Standardisation in descriptors of types of alcohol misuse was required as there was the suggestion that the Department of Health prefers to express alcohol use in terms of the level of risk posed.
- There may be public resistance to an increase level of scrutiny of the role of alcohol in their lives. The purpose of screening in non-traditional settings (e.g. dentists, pharmacists) should be clearly explained and justified.
- There was the belief that alcohol services had been under resourced for many years compared with drug treatment. There needs to be a clear differentiation between drug and alcohol services, with equivalent funding, if a comprehensive public health and social welfare response is to be delivered.
- Attention needs to be paid to changes in alcohol drinking when clients move from young people to adult services. Clients often disengage when they leave services at the age of 18 and may re-present several years later with increased problematic behaviour.
- All services expected to respond to alcohol misuse would benefit from clearly defined joint commissioning. Clients would benefit due to a more integrated treatment pathway.
- Abstinence based approaches should be supported by NICE if there is the evidence to back these up.
- An increase in referrals to tier 2 and 3 services as a result of more widespread screening would worsen the current 'bottle neck' and waiting lists for people needing more specialist help.
- Existing budgets were thought to be insufficient to cope with the increase in screening and referral recommended. NICE should investigate the use of free online training courses to support skills development.
- Training for professionals should not just be alcohol specific. General competencies were important as well as modules that explored and enriched trainees attitudes to alcohol and individuals with alcohol related problems.
- There are many local examples of screening and referral schemes based on use of the AUDIT and other validated tools.

Recommendation 6 – Supporting children and young people aged 10 to 15 years

- 'Safe' unit limits have not been established for young people. It is therefore important that the role of alcohol in the client's wider biography should be evaluated before considering further action or referral.
- Non-healthcare professionals would need encouragement and incentivisation (not necessarily financial) to deliver NICE guidance. The first step should be for NICE to identify which roles they expect to integrate the recommendations in their professional practice.
- More explicit reference needs to be made to Hidden Harm throughout the draft guidance, but in particular for this recommendation.

- Schools were usually the first place that young people's alcohol use became apparent. Earlier NICE guidance (PH7 School based interventions on alcohol) is important in this regard. NICE should be aware of, and contribute to the current DCSF consultation on its updated drugs and alcohol guidance for schools.
- The follow up and monitoring of young people presenting at A&E with alcohol related conditions needs to be improved.
- Even in non-intoxicated states young people may not be able to fully consent to receiving an intervention or referral. In some instances young people may not understand the implications of their behaviour and why support was required. In circumstances where practitioners had concerns over a young client's wellbeing, providing support was more important than establishing whether the young person had full understanding of what actions were proposed.
- The ability of local CAMHS to effectively respond to young people with alcohol related problems should be established before referral is made.

Recommendation 7 – Screening young people aged 16 and 17 years

- The Common Assessment Framework should continue to be used with this age group and so should be mentioned somewhere in the text.
- As long as they had received suitable training it was appropriate for a range of non-specialists to screen young people. At a minimum, training should cover non-confrontational ways of broaching the subject of alcohol, the use of appropriate tools, and interpretation of AUDIT scores in different populations and age groups.
- Screening should be included in alcohol education components of PSHE.
- Screening should not be used to gain evidence to punish young people.
- Co-location of alcohol specialists (e.g. alcohol nurse specialist) in A&E would be a better means of screening presentations than relying on busy emergency staff.
- Other groups believed to be at particular harm, warranting extra focus, included; young people using illicit substances; teenage parents; those with mental health problems; young people in families with substance use disorders; 16-17 year olds who drink at home with parents; young people at risk of mental illness. One group requested clarification of the meaning of someone being 'at risk' of self harm, namely whether this referred to young people who had self harmed in the past or who were likely to self harm in the future. Furthermore, self harm did not necessarily refer solely to cutting, but could also mean eating disorders and harmful sexual practices (e.g. exploitative relationships, sex work or trading sex for goods).
- Engaging minority faiths and cultures in health promotion can sometimes be challenging. NICE should be aware of factors such as collusion between problematic drinkers and gatekeepers in denying the existence of alcohol-related problems; the rejection of 'Westernised' models of intervention; and the ethical issues of changing traditional healthcare practices to accommodate more conventional types of intervention.

Recommendation 8 – Motivational counselling with young people aged 16 and 17 years

- In more problematic cases, rather than repeated screening and referral, an integrated care pathway approach should be taken, whereby a young person would work with only one or two practitioners who would guide them through all the different assessments and interventions required.
- There are few specialist young person's alcohol treatment services in the UK. The majority of those that accept young people are either adult services or have adopted adult models. This should be considered when recommending referral.
- Although working according to motivational principles NICE should recognise that much of practitioners work with young people was undertaken informally as this was the only way to engage clients.
- Court mandated interventions would not require the young person's permission.
- The outcomes of training are rarely evaluated, whether in relation to the development of trainees' skills or the effects of training on public health outcomes. NICE should encourage research into the effectiveness of motivational counselling training and seek to identify how training could become standardised and/or accredited.
- More information is required on the physical and mental assessment actions in this recommendation. Detail is needed on whether this should only be undertaken by a clinician, or whether self report or assessment through the CAF is sufficient.

Recommendation 9 – Screening adults

- Funding restrictions would mean that it would not be feasible to deliver this recommendation as required. It is likely that a 'watered-down' version would be put in place whereby only selected groups of NHS staff would conduct training. To support implementation, targets should be set on the amount of screening taking place each year, and (additional) payment to GPs and pharmacists could be made on the basis of the number of referrals made rather than just the number of screens.
- In a similar manner to recommendations for young people's practice it was believed that some non-healthcare roles would opt out of delivery of this recommendation if they were not specifically mentioned. Suggested roles included the fire service, educators, employment officers, and the police force and other criminal justice workers.
- Problematic drug users, smokers, those with mental illnesses, perpetrators and victims of (domestic) violence, the long term workless, and the obese were all thought to have important needs related to alcohol. Delegates believed that the draft guidance should also include specific reference to these groups.
- The reasons for revision of AUDIT scores for particular groups should be fully explained and advice given on what revised scores should be.

- It is insufficient for non-English versions of screening tools to be available. Specialist translators and interpreters should also be available to help interpret the results. Greater consideration also needs to be made on how services will work with those clients with learning disabilities and difficulties.
- There was general agreement that outside of A&E, biochemical measures weren't useful in routine practice. This was due to their expense and that they sometimes provided unhelpful, time limited results. For example a drinker who had indirectly experienced harm from their alcohol use (e.g. perpetrator/victim of violence) might show liver functioning within the normal range.

Recommendation 10 – Brief advice for adults

- Current finances would not be sufficient to provide training for both healthcare and non-healthcare specialists.
- The expected outcomes and limitations of brief intervention need to be clearly stated so that professionals would understand when referral was more appropriate.
- If properly trained, non-healthcare professionals should also be given the opportunity to conduct FRAMES based interventions.
- Comprehensive data sharing protocols would be needed to ensure that the range of professionals listed would know they were working with a hazardous drinker. Alternatively, if it was expected that non-specialists would also conduct screening then it should be acknowledged that in busy commercial/professional environment it might not be feasible to offer brief advice and follow up recipients for further sessions and feedback.
- Unless directly instructed to do so it was thought unlikely that many professionals would "…*try to find time*" to conduct advice sessions as requested in action point 2.
- It should be made clearer that alcohol related harms are not just limited to those related to health. This would encourage professionals from other sectors to integrate NICE recommendations into their practice.
- An AUDIT score of 8 should not be used as the only indicator or a reduction in alcohol related harm. Alcohol related behaviours (e.g. sexual risk taking, drink driving, alcohol related violence) should also be taken into account. As a result of public misunderstanding of meaning and quantification of alcohol units, client determined goals should not refer to them.

Recommendation 11 – Motivational counselling for adults

- Motivationally based interventions were often delivered in the same services and by the same professionals as brief advice. In many cases, clients would receive brief advice before a more structured intervention. However, far fewer of the non-specialists mentioned in Recommendation 10 would be involved in delivering these types of activities as they would not have the necessary skills and training. It would be mostly tier 2 alcohol workers, with the

addition of trained probation and arrest referral workers who would have responsibility for delivering this recommendation.

- Although a client might specifically request a motivationally based intervention, professional judgement should be used as to whether this is appropriate and/or an effective use of resources. Other types of intervention might be more suitable and the practitioner may believe that the client would not benefit from a motivational interview. Similarly, the decision to make on onward referral should not be made on the basis of AUDIT score alone.
- Differences in the needs and nature of the client would mean that 3 sessions lasting 20-30 minutes each may not be sufficient. It was important that funding decisions were not based solely on this model.
- NICE needs to clarify whether the absence of other types of intervention in the recommendations (e.g. family based programmes, 12 step programmes, self help) meant that they were recommending against their use.

Recommendation 12 - Referral

- There was the belief that use of the AUDIT was not appropriate for children as young as 10.
- Including such as broad age range in the target population is unhelpful. Young people scoring above 20 on the AUDIT may indicate serious child protection or neglect issues and therefore the police and social services might have to be involved.
- This recommendation assumes that practitioners would have suitable specialist alcohol services to refer young people (and adults) to. Variability in the level and quality of provision suggests that this is not always the case.
- Clients showing signs of alcohol related damage would almost always be referred to specialist treatment, regardless of AUDIT score.
- NICE should refer to its (forthcoming) clinical guidance on alcohol dependence in this recommendation so that readers have a better understanding of the overall screening and treatment pathway that was proposed

References

- Glaser BG & Strauss AL. (1967) The Discovery of Grounded Theory. New York, Aldine.
- Kimchi J, Polivka B, Stevenson JS (1991) Triangulation. Operational definitions. Nursing Research 40: 120–123.
- Grbich C (2007) Qualitative data analysis: an introduction. London, Sage Publications.

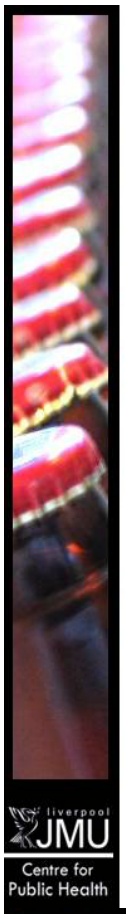
Appendix 1 Field meeting delegates. Please note that some participants did not wish to be identified here.

Sue Allchurch	The Linwood Group, Community Alcohol Services
Karen Alloway	Avon & Wiltshire Mental Health Partnership NHS Trust
Barry Ashbolt	Blackburn with Darwen DAAT, Community Safety Team
Stephen Bagnall	Gov Office North West, Community Safety Team
Gary Baskott	Liverpool City Council
Jez Bayes	Cornwall & Isles of Scilly DAAT
Bob Beckett	UK Advocates
Charlotte Blencowe	Camden PCT
Adrian Brown	St Mary's Hospital
David Brown	Sedman Unit
Mike Burden	Pharmacy Special Interest Group (SIG) of the UK Public Health Association (UKPHA)
Michelle Butterworth	Kent and Medway Health and Social Care Trust
Sarah Christian	CRI, Alcohol Brief Interventions Service
Richard Cooke	Birmingham University, School of Life & Health Sciences
Jerry Cragg	Merseyside Police
Carl Cundall	Sheffield DAAT. Relatives of Drug Abusers (RODA)
Debra Cunningham	Leicester DAAT
Stuart Dodd	Liverpool PCT
Jill Downey	Hillingdon PCT - Integrated Commissioning Team
Lois Dugmore	Leicestershire Partnership NHS Trust
Lydia Fleuty	Manchester PCT
Will Formby	Kirklees Council CHYPS
Saul Freeman	Phoenix Futures, Bromley Community Alcohol Service
Will Galloway-Grant	Addaction
Kayley Galway	Leicester Criminal Justice Drugs Team
Kristy Gentle	YPDAT, Nottingham City Council
Cath Gillver	SIFA Fireside
Mandy Goodenough	Nottingham City Council
Caroline Gordon	Westminster DAAT
Keith Gorman	Health@Work
Trevor Hague	Sheffield DAAT.
Ruth Hamilton	Wirral Alcohol Service
Leanne Hanley	Rutland DAAT
Kevin Hardy	St Helens Hospital, Diabetes Centre
Alison Heathcote	Leicestershire Partnership Trust
Louise Helliwell	Tameside DAAT - Branching OUT
Gina Helsby	Bury DAAT
Nigel Hewett	Clinical Lead Drug and Alcohol Services

Gavin Hogarth	Shropshire DAAT
Sue Holden	Leicester Council (DAAT)
Samantha Holdstock	The Social Partnership Halton Reach Out Project
Stephen Hood	University Hospital Aintree
Joanne Hough	Trafford Healthcare NHS Trust
Neill Hughes	Salford Royal NHS Foundation Trust Hospital
Mike Jones	Greater Manchester Public Health Network
Nikki Jones	Wirral PCT
Clare Kambamettu	Camden's Sensible Drinking Service
Gill Le Page	Leicestershire Community Projects Trust
Greg Lee	Lancashire NHS
Graham Lettington	Bexley Council
Anthony Lilley	Oldham DAAT
Vicky Lindsay	Aquarius Northamptonshire
Carla Lyndon	Aquarius - Birmingham
Laura Mabel	Haringey Youth Offending Service
Ann Maguire	Poole DAAT
Kim Major	NHS Blackburn with Darwen
Sam Marsh	Birmingham's Primary Care Alcohol and Lifestyle Service
Richard Matthews	British Beer and Pub Association Midland Counties
Adrian McNulty	National Probation Service West Midlands
Diane McNulty	NHS Dudley
Richard McVey	Aquarius - Birmingham
Jane Milne	Sheffield DAAT
Sally-Jane Monaghan	Trafford General Hospital
Steve Morton	NHS Blackpool
Robert Mulliss	South West Public Health Observatory
Pauline Munroe	Leicestershire Community Projects Trust
James Nicholls	Bath Spa University
Candy O'Connell	Blackburn with Darwen Borough Council
Susan O'Looney	Liverpool PCT
Terry Pearson	Northamptonshire DAAT
Jayne Peters	Bristol Drugs Project
David Poley	The Portman Group
Katie Porter	Bristol PCT
Clare Pritchard	Safeguarding Nurse for Children
Michael Przybysz	Lancashire County Council
Brad Rootes	Addaction Cornwall (Services for Drug & Alcohol Addiction)
Amanda Salmon	Aquarius - Birmingham
Sharon Sawyers	Bristol City Council
Rachel Seabrook	Institute of Alcohol Studies
Martin Siddorn	Safer Bristol
Lesley Sigton	Coventry DAAT
Enid Smith	IMPACT Alcohol Advisory Services

Karen Smith	Halton Reach Out Project
Geraldine Smyth	Bristol Directorate of Public Health, NHS Bristol
Sue Sprent	Addaction
Robert Standing	Haringey YOT
Anne Steele	Swanswell PCT
Sarah Stevens	NHS Cambridgeshire
Sarah Telford	Safer South Gloucestershire
Mark Thomas	Leicestershire County Council
Alan Tolley	Sandwell Metropolitan Borough Council
Robin Touquet	Imperial College London/St. Mary's Hospital
Aimee Walker	Addaction
Sonny Walker	Avon and Somerset Constabulary
Jude Ward	Torbay Primary Care Alcohol Team
Sarah Ward	Alcohol Concern
Ian Wardle	Lifeline Project
Oonagh Watson	Royal Liverpool University Hospital
Janet Woodruff	Merseyside Probation Trust

Appendix 2 *(overleaf)* Presentation given to field meeting delegates summarising the NICE guidance development process and outlining the objectives of the fieldwork meetings**.**



NHS
National Institute for
Health and Clinical Excellence

Fieldwork on Alcohol-Use Disorders in adults and young people (prevention)

Centre for Public Health
Liverpool John Moores University

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Content

- Purpose of today's event
- How the recommendations have been developed
- Public health need and practice
- The recommendations - explained
- The group work

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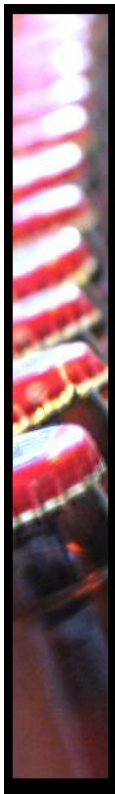
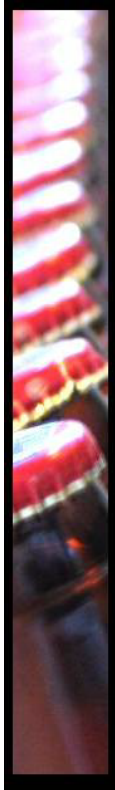


Purpose

- The aim of the workshop is to explore the relevance, usefulness and feasibility of the draft guidance and the conditions required for effective implementation and delivery of the specific recommendations



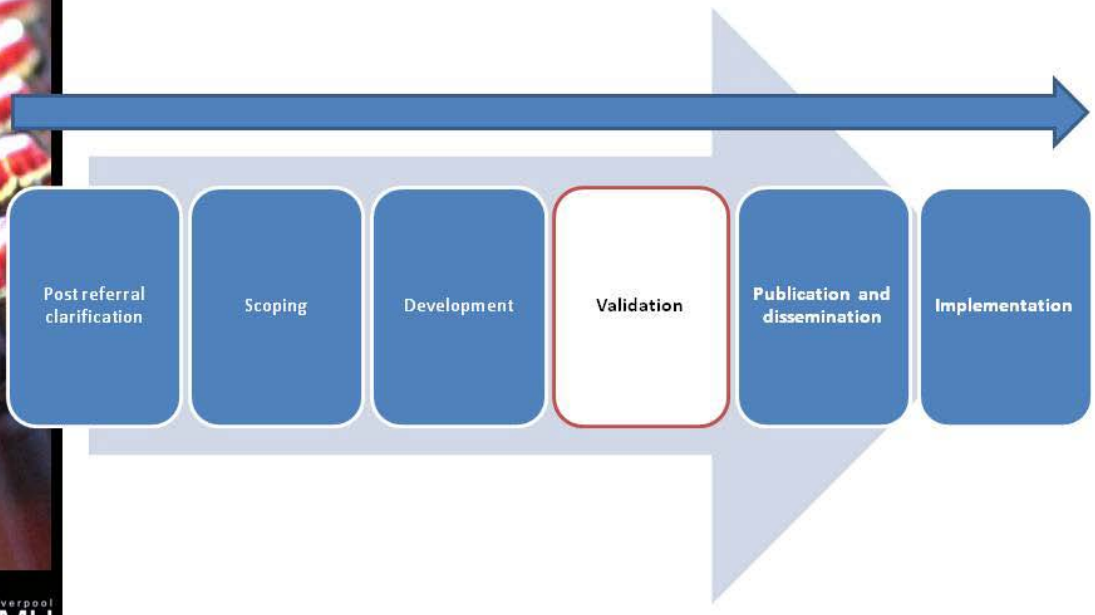
How the draft recommendations were derived

- The National Institute for Health and Clinical Excellence has been asked by the Department of Health (DH) to develop guidance on a public health programme aimed at the prevention and early identification of alcohol-use disorders in adults and adolescents.
- The School of Health and Related Research (ScHARR) at the University of Sheffield conducted a systematic review of the evidence
- This guidance will be developed alongside the NICE clinical guideline on the management of alcohol-use disorders in adults and adolescents.

How the draft recommendations were derived

- The Programme Development Group (PDG) is formed for the duration of the development of this guidance.
- It considers and interprets evidence, and makes recommendations for people working in the NHS, local government and in the wider public, private and voluntary sectors.

Guidance development process



Recent Policy, Guidance, and Publications

- Safe. Sensible. Social (HM Government, 2008)
- Youth Alcohol Action Plan (DCSF, 2008)
- Guidance on the Consumption of Alcohol by Children and Young People (Chief Medical Officer for England, 2009)
- Under the influence (British Medical Association, 2009)
- Selling alcohol responsibly: a consultation on the new code of practice for alcohol retailers (HO consultation, 2009)
- Alcoholic Drinks Advertisements Compliance Survey 2008 (Advertising Standards Authority, 2009)
- Choosing health: making healthy choices easier (Department of Health, 2004)
- Models of Care for Alcohol Misusers (DH/NTA 2006)
- PSA delivery agreement 14: increase the number of children and young people on the path to success; PSA delivery agreement 23: make communities safer; PSA delivery agreement 25: reduce the harm caused by alcohol and drugs (HM Treasury, 2007)

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Relevant NICE Guidance

Public health

- Interventions in schools to prevent and reduce alcohol use among children and young people (November 2007)
- Promoting children's social and emotional wellbeing in primary education (March 2008)
- **Alcohol use disorders in adults and young people: prevention and early identification** (March 2010)
- Guidance on school, college and community based personal, social and health education (TBC)

Clinical

- Alcohol use disorders in adults and young people: clinical management (March 2010)
- Pregnant women with complex social factors: a model for service provision (August 2010)
- Alcohol use disorders: management of alcohol dependence (December 2010)

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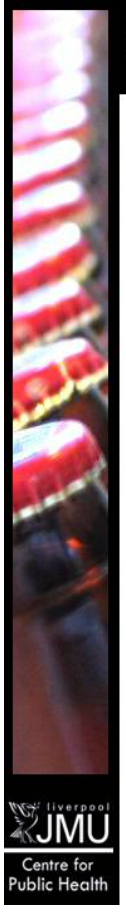
Public Health need and practice



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GUIDANCE IN ALCOHOL-USE DISORDERS (PREVENTION) IN ADULTS AND YOUNG PEOPLE. *Adults: key prevalence figures*

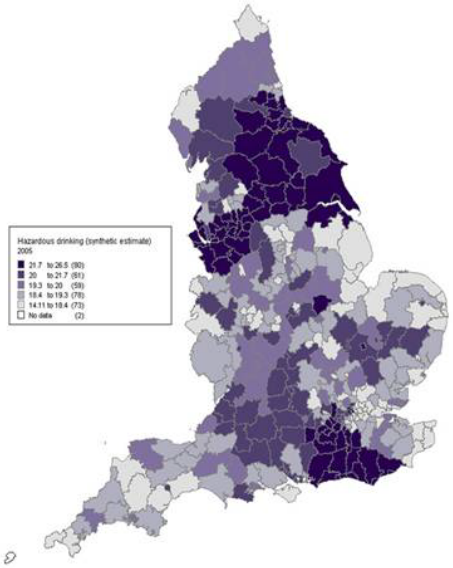
- Over 90% of adults drink alcohol (Prime Minister's Strategy Unit, 2004)

- An estimated 1.55 million people in England drink a harmful amount and a further 6.3 million drink a hazardous amount (North West Public Health Observatory 2007).

- Regional analysis of drinking patterns indicates that levels of hazardous and harmful drinking are consistently highest in the north of England (26–28% of men; 16–18% of women) (North West Public Health Observatory 2007).

Hazardous drinking

England = 20.1%



GUIDANCE IN ALCOHOL-USE DISORDERS (PREVENTION) IN ADULTS AND YOUNG PEOPLE. *Young people (>10 years) key prevalence figures:*

- Children in the UK (aged 11-17 years) drink around 17.2 million units of alcohol every week. Equivalent of 6.9 million pints of beer or 1.7 million bottles of wine (DCSF, CMO, 2009).
- By 16 years most children have drunk alcohol (Fuller, 2008).
- Children in the United Kingdom are more likely to drink alcohol than many other countries (Currie et al., 2008).
- UK 15-16 year olds drink more, endorse more positive consequences of alcohol use than any other EU country. Suffer more negative consequences with the exception of Bulgaria and Isle of Man (ESPAD, 2009).
- Early age of starting drinking is associated with higher trends of alcohol dependence in adulthood and a wider range of other adverse consequences (DCSF, CMO, 2009)

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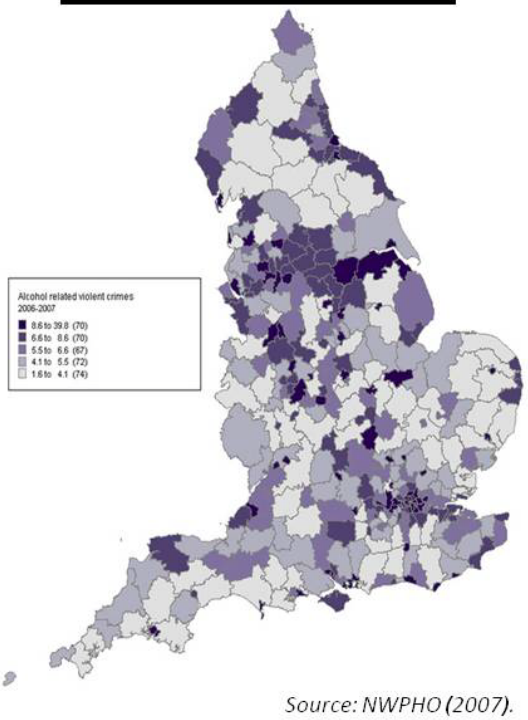
Impact

- Young people are three times as likely to have unprotected sex when drunk (Ingham, 2001).
- Alcohol abuse in adolescence, during a developmentally sensitive period, poses a particular danger to the emerging brain faculties of executive functioning and long
- There is a relationship between adolescent alcohol use and mental health problems term memory (Newbury-Birch et al. 2008)
- Associated with relationship breakdown, domestic violence and aggression, poor parenting, unsafe and regretted sex, (Prime Minister's Strategy Unit 2003).
- Nearly 10,000 children aged 11-17 are admitted to hospital each year in the UK as a result of their alcohol consumption (6,000 aged 11-15 and 4,000 aged 16-17).
- In 2006/07, it was linked with over 500,000 recorded crimes (North West Public Health Observatory, 2007)

Cost Per annum

- Estimated £20 billion (healthcare, crime and disorder, loss of productivity (Prime Minister's Strategy Unit 2004).

Alcohol related violent crime England = 7.2 per 1,000



Source: NWPHO (2007).

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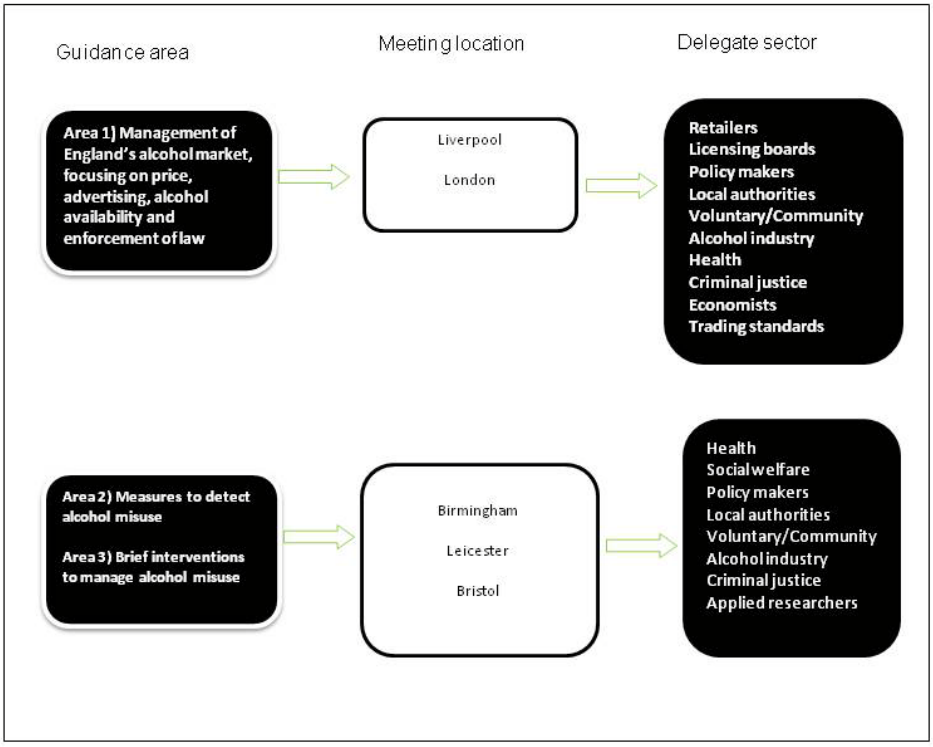
Fieldwork meetings



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The Draft Guidance

- **Please note the information discussed in these meetings do not constitute NICE's formal guidance on alcohol-use disorders prevention. The recommendations presented are provisional and may change after consultation with stakeholders and fieldwork**

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Policy recommendations

Who should take action?

- The Chief Medical Officer should have lead responsibility for coordinating the broad approach across government, supported by the Department of Health.

  The following departments and national agencies should be involved:

  - Advertising Standards Authority
  - Department for Business, Innovation and Skills
  - Department for Children, Schools and Families
  - Department for Culture, Media and Sport
  - Department for Environment, Food and Rural Affairs
  - Department of Communities and Local Government
  - Department of Health
  - Home Office
  - Ministry of Justice
  - National Treatment Agency
  - Ofcom
  - Office of Fair Trading
  - Treasury.

  Organisations that should be consulted include:

  - alcohol producers
  - off- and on-sale retailers
  - national non-governmental organisations, for example, Alcohol Concern and the Royal Medical Colleges

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Recommendation 1
Price

What action should be taken?

Consider the following measures:

- Introducing a minimum price per unit.
- Linking alcohol duty to inflation and earnings.

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Recommendation 2
Availability

What action should be taken?

- Licensing legislation could be revised to ensure:

  - it takes account of evidence on the link between the availability of alcohol (number of alcohol outlets in a given area and times when it is on sale) and alcohol-related harm (for example, crime and disorder and in relation to health)
  - licensing departments take the above links into account when considering a license application
  - it includes protection of the public's health as part of licensing objectives
  - it gives licensing departments an enforcement role
  - immediate sanctions can be imposed on any premises in breach of their license, following review proceedings.

- Legislation on personal import allowances could be reviewed and consideration given to reducing them.

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Recommendation 3
Marketing

What action should be taken?

To reduce the effect of alcohol advertising on children and young people consider:

- ensuring all alcohol marketing, particularly marketing that makes use of newer media (for example, web-based channels) is covered by a regulatory system which includes the monitoring of practice
- banning alcohol advertising from all media outlets where more than 5% of the audience is under the age of 18 years
- restricting alcohol marketing and advertising to the facts about the product
- in the longer term, banning all forms of alcohol advertising and marketing through television, radio, cinema and via sports sponsorship (as is the case with tobacco advertising).

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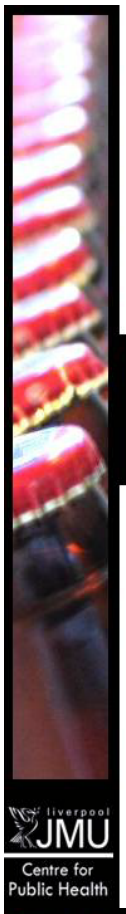


Practice recommendations

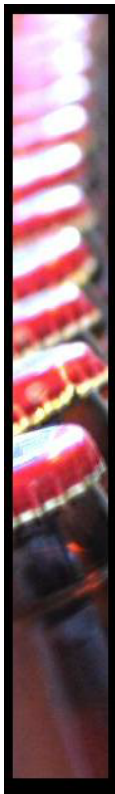
Recommendation 4
Licensing

Who is the target population?

- Alcohol licensee holders and designated supervisors of licensed premises.

Who should take action?

- Local authorities, trading standards officers, the police and magistrates.



Recommendation 4 *continued*

What action should they take?

- 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.
- Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, non-compliance with other alcohol license condition and illegal imports of alcohol.
- Work in partnership with the appropriate authorities to identify premises that regularly sell alcohol to people who are under age or intoxicated.
- Undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales and to identify premises where sales are made to people who are intoxicated.
- Ensure sanctions are fully applied to businesses that break the law on under-age sales and sales to those who are intoxicated. This includes fixed penalty notices and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

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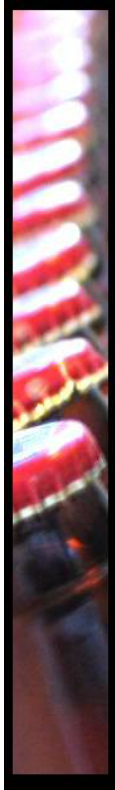

Recommendation 5

Resources for screening and brief interventions

Who is the target population?

- Professionals who have contact with those aged 16 and over.

Who should take action?

- Commissioners of NHS healthcare services and from multi-agency joint commissioning groups.
- Managers of NHS-commissioned services.

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Recommendation 5
Continued

What action should they take?

- Commissioners should ensure a local joint alcohol needs assessment is carried out in accordance with 'World class commissioning' and 'Signs for Improvement'.
- Commissioners should ensure commissioning plans include the provision of brief-interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers).
- Commissioners should make provision for the likely increase in the number of people requiring referral to tier three and four alcohol services as a result of screening. These services should be properly resourced to support the stepped care approach recommended in 'Models of care for alcohol misusers'.

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Recommendation 5
Continued

What action should they take?

- Service managers must ensure staff are trained to provide alcohol screening and structured brief advice. If there is a local demand, staff should also be trained to deliver motivational counselling.
- Service managers must ensure staff can easily access validated screening questionnaires suitable for local use.
- Service managers must ensure staff have enough time and resources to carry out screening and preventive work effectively. Staff should have access to recognised, evidence-based packs, such as the 'Drink-less pack' or the 'How much is too much?' pack. These should include:

  - a short guide on how to use the intervention, questionnaires, visual presentations (comparing the person's drinking levels with the average), self-help leaflets and possibly a poster for display in waiting rooms.

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Recommendation 6

Supporting children and young people aged 10 to 15 years

Who is the target population?

- Children aged 10 to 15 years who are thought to be drinking a hazardous or harmful amount of alcohol.

Who should take action?

- NHS and health and social care professionals who regularly come into contact with this group.

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Recommendation 6

Continued

What action should they take?

- Routinely assess the ability of these children and young people to consent to alcohol-related interventions and treatment.
- Use the Common Assessment Framework (CAF) to establish if they are at risk of harm from their drinking and if other psychological or social factors need to be considered.
- Consider referral to child and adolescent mental health services, social care or to young people's drug and alcohol services for treatment, as appropriate

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Recommendation 7

Screening young people aged 16 and 17 years

Who is the target population?

- Young people aged 16 and 17 years who are thought to be drinking a hazardous or harmful amount of alcohol.

Who should take action?

- NHS and health and social care professionals who regularly come into contact with this group.

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Recommendation 7

Continued

What action should they take?

- Complete a validated alcohol screening questionnaire with this group. Alternatively, if they are judged to be competent enough, ask them to fill one in themselves. In most cases, AUDIT (alcohol-use disorders identification test) should be used. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ, FAST). Screening tools should be appropriate to the setting. For instance, in an accident and emergency (A&E) department, FAST or PAT would be most appropriate.
- Where routine screening is not feasible, focus on groups that may be at an increased risk of alcohol-related harm. This includes those:

  – who have had an accident or a minor injury
  – who request contraceptive advice
  – involved in crime or other anti-social behaviour
  – who truant on a regular basis
  – at risk of self-harm
  – who are looked after
  – involved with child protection agencies.

- When broaching the subject of alcohol and screening, ensure discussions are sensitive to the young person's age and their ability to understand what is involved, their emotional maturity, culture and faith. The discussions should also take into account their particular needs (health and social) and be appropriate to the setting (for example, a different approach may be needed in a GP surgery compared to an A&E department).
- Routinely assess the ability of young people to consent to alcohol-related interventions and treatment.

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Recommendation 8

Motivational counselling with young people aged 16 and 17 years

Who is the target population?

- Young people aged 16 and 17 years who have been identified via screening as drinking a hazardous or harmful amount of alcohol.

Who should take action?

- NHS and health and social care professionals who regularly come into contact with this group.

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Recommendation 8

Continued

What action should they take?

- Ask the young person's permission to arrange for them to have motivational counselling.
- Appropriately trained staff should offer motivational counselling.
- Provide information on the local specialist addiction services that can deal with young people to those who have scored 20+ in the AUDIT screening questionnaire, those who do not respond well to discussion and those who want further help. Refer them to these services if this is what they want.
- Give those who are actively seeking treatment for an alcohol problem a physical and mental assessment and offer, or refer them for, appropriate treatment and care.

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Recommendation 9

Screening adults

Who is the target population?

- Adults.

Who should take action?

- NHS and health and social care professionals who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink

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Recommendation 9

Continued

What action should they take?

- NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during patient registrations, when screening for other conditions, when managing chronic disease, promoting sexual health or treating minor injuries caused at work.
- Where routine screening is not feasible or acceptable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. These groups include people:

  - with physical conditions (such as hypertension, liver disease or other gastrointestinal disorders)
  - with mental health problems (such as anxiety, depression or other mood disorders)
  - at risk of self-harm
  - who regularly experience accidents or minor traumas.
- Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and on people that have alcohol-related problems. This will include those:

  - at risk of self-harm
  - involved in crime or other anti-social behaviour
  - who practice unsafe sex
  - whose children are involved with child protection agencies.

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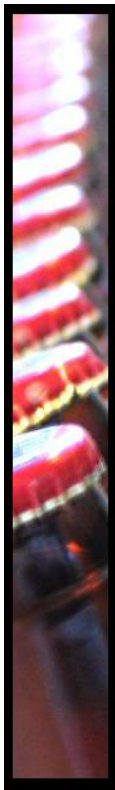

Recommendation 9
Continued

What action should they take?

- When broaching the subject of alcohol and screening, ensure discussions are sensitive to people's culture and faith and tailored to their needs.
- Complete a validated alcohol screening questionnaire with the adults being screened. Alternatively, if they are competent enough, ask them to fill one in themselves. Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type), or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ, or FAST). Screening tools should be appropriate to the setting. For instance, in an A&E department, FAST or PAT would be most appropriate.
- Professionals should use their judgment as to whether to revise the AUDIT scores downwards when screening:
  - women (women scoring above 7 in the AUDIT questionnaire should be offered brief advice)
  - younger people (under the age of 18)
  - people aged 65 and over
  - black and minority ethnic groups

  If in doubt, consult relevant specialists. Work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns.
- When it is not appropriate to use an English language-based screening questionnaire, consult relevant specialists (for example, when dealing with people whose first language is not English or when people have a learning disability).
- Do not use biochemical measures as a matter of routine to see if someone is drinking a hazardous or harmful amount of alcohol. These measures may be used to assess the severity of an established alcohol-related problem or to complement screening questionnaires within A&E.

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Recommendation 10
Brief advice for adults

Who is the target population?

- Adults who have been identified via screening as drinking a hazardous or harmful amount of alcohol (that is, those scoring 8 to 15 on the AUDIT questionnaire) and who are attending:

  • primary healthcare services
  • A&E departments
  • other healthcare services (general hospital wards, outpatient departments, occupational health services, prenatal book-in clinics, sexual health clinics, needle and syringe exchange programmes, pharmacies and dental surgeries)
  • offender management and other criminal justice system services, social services and other non-NHS public services.

Who should take action?

- Professionals who have received the necessary training and work in the services above.

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Recommendation 10
Continued

What action should they take?

- Primary healthcare professionals should offer a brief session of structured advice about alcohol.
- Non-primary healthcare professionals should try to find time to offer structured brief advice. If they miss an opportunity to do this they should offer an appointment as soon as possible. This appointment may be for a structured brief session or, where appropriate, motivational counselling (see recommendation 11).
- Structured advice should be based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy) and should:

  - cover the potential harm caused by this level of drinking and reasons for changing the behaviour, including the benefits for health and wellbeing.
  - cover the barriers to change
  - lead to a set of goals
  - last from 5-15 minutes.

- Use a recognised, evidence-based resource, such as the 'Drink-less pack' or the 'How much is too much?' pack which provides self-help materials.
- 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). Where required, they should offer an additional session of structured brief advice.

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Recommendation 11
motivational counselling for adults

Who is the target population?

- Adults who have:

  - scored 16 to 19 on the AUDIT questionnaire
  - not responded to brief structured advice
  - chosen to undergo motivational counselling
  - need motivational counselling for other reasons.

Who should take action?

- Professionals who are in contact with adults and have received training in motivational counselling.

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Recommendation 11
Continued

What action should they take?

- Offer motivational counselling to people who:

  - are ambivalent about the need to reduce the amount of alcohol they drink
  - have failed to benefit from structured brief advice
  - in the professional's judgement, need more than structured brief advice
  - for any reason, wish to discuss their drinking further with a trained professional.
- Sessions should last from 20 to 30 minutes and should aim to help people reduce the amount they drink (ideally, so that they score less than 8 on the AUDIT and consume less than the recommended level of alcohol).
- Follow up and assess people who have received motivational counselling. Where necessary, offer up to three additional sessions or referral to a specialist alcohol or addiction treatment service (see recommendation 12).

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Recommendation 12
Referral

Who is the target population?

- Those aged 10 years and over who attend NHS or non-NHS services and may be alcohol-dependent.

Who should take action?

- NHS and non-NHS professionals who have contact with anyone over the age of 10.

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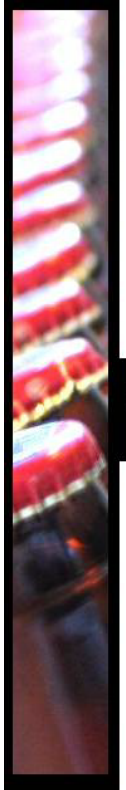


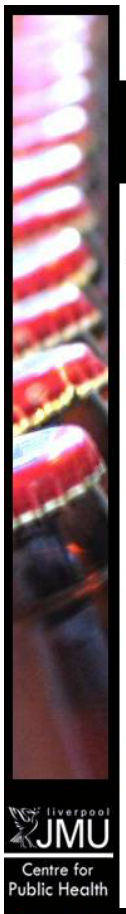
Recommendation 12
Continued

What action should they take?

- Consider making a referral for specialist treatment if they:

  • have scored 20 or more on the AUDIT screening questionnaire
  • show signs of moderate or severe alcohol dependence
  • failed to benefit from structured brief advice and motivational counselling and wish to receive further help for an alcohol problem
  • show signs of alcohol-related damage (for example, liver damage or mental health problems).

GROUP WORK

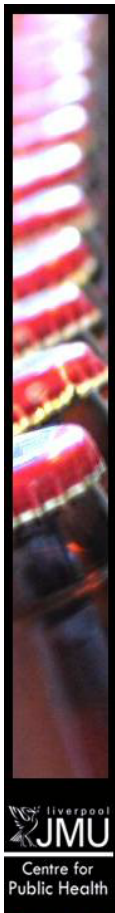


TASKS

- To explore the relevance, usefulness and feasibility of the draft guidance and the conditions required for effective implementation and delivery of the specific recommendations

Ground rules

- Encourage involvement - listen to all viewpoints
- Listen - allow everyone a chance for their voice to be heard
- Respect - no put downs
- Confidentiality
- Facilitators will have to move the discussion on to cover all topics

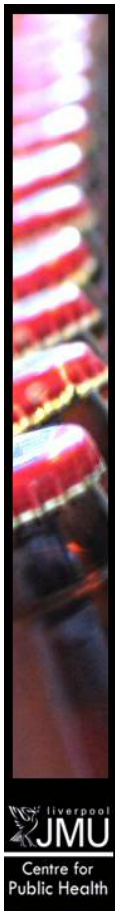


Who is here today?

- Centre for Public Health, Liverpool John Moores University
- Transcriber
- And YOU …… including health, social welfare, criminal justice, industry, retailers, researchers, policy makers, licensing boards, education, other public services…

What will happen next?

- CPH will prepare a report summarising and discussing the findings of the six fieldwork meetings and interviews
- PDG considers fieldwork report and stakeholder comments and delivers final recommendations
- Publication of guidance in March 10



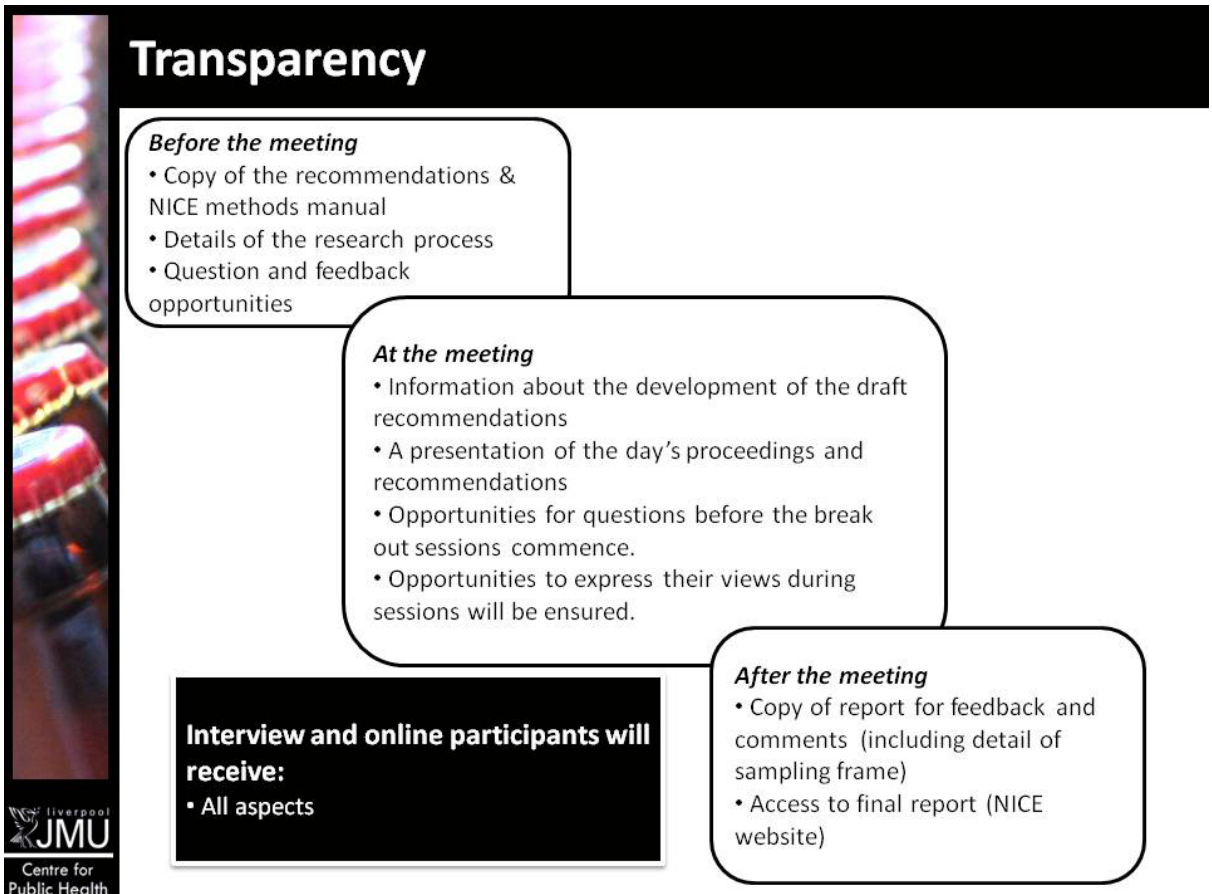
Next few weeks

- We will draft the fieldwork report
- You will have the opportunity to comment on the accuracy of data, and to ensure anonymity is preserved.
- Unless requested otherwise, you will be acknowledged in the fieldwork report
- Some of you may be asked to provide more detailed comments for clarification (optional)

Next few weeks

- We will try to ensure that you are kept informed of the publication of guidance

- Please consider registering as an official stakeholder for this and other NICE guidance (www.nice.org.uk)



Thank you

Contact :

Dr Harry Sumnall, Centre for Public Health, Liverpool John Moores University.
h.sumnall@ljmu.ac.uk

Appendix 3 Facilitators guide

Starting the group work sessions

1. Start with introductions e.g. name, organisation and position

2. Explain again the purpose of the group discussion

3. We are here to examine the practical application of the recommendations not examine the evidence.

   The aim of the workshop is to explore the relevance, usefulness and feasibility of the draft guidance and the conditions required for effective implementation and delivery of the specific recommendations

4. Participation important – preferably from all.

5. We'd like to hear from as many people as possible. So, occasionally we may ask an individual to finish their point so we can get around the group. Limited time is available. Must complete the task. So, we may have to curtail and move the discussion on.

6. Encourage the participants' to be specific – seek examples to illustrate points

7. Ground rules …

   - *Encourage involvement - listen to all viewpoints*
   - *Listen - allow everyone a chance for their voice to be heard*
   - *Respect - no put downs*
   - *Confidentiality*

8. Notes will be taken and the transcriber may spend time in the group. It may be important to attribute what you say to the type of organisation you work for. However, anonymity will be preserved in the draft report. You'll have the chance to read it before it is published.

9. Unless you tell us otherwise your participation in today's event will be acknowledged in the report.

Your cooperation with these matters will be appreciated

Recommendation 1 – Pricing

Who should take action?

The Chief Medical Officer should have lead responsibility for coordinating the broad approach across government, supported by the Department of Health.

The following departments and national agencies should be involved:

• Advertising Standards Authority
• Department for Business, Innovation and Skills
• Department for Children, Schools and Families
• Department for Culture, Media and Sport
• Department for Environment, Food and Rural Affairs
• Department of Communities and Local Government
• Department of Health
• Home Office
• Ministry of Justice
• National Treatment Agency

Key issues

- What are the costs and benefits to health, public safety, consumers, businesses, and competition?
- Who will need to sign up to this recommendation for it to work effectively?
- What will be the likely impact on business, jobs and enterprise?
- What will be the likely effect on alcohol purchasing patterns?
- What will be the likely effects on alcohol consumption?
- Should we/how do we support healthy drinking choices in (young) people who expect cheap alcohol?
- Will/How might retailers counter 'negative' effects of minimum pricing on alcohol sales?
- What do delegates think of the language of this recommendation? Is it authoritative enough?

- How should this be ‘marketed’ to consumers?
- Will consumers have a clear idea about how this will affect them financially v improvements in health?
- Will it make a difference to the health of more wealthy consumers?
- Will consumers understand why this recommendation is being made?
- Are there alternative pricing policies that could be considered?
- How do we counter parental purchasing of alcohol for young people?
- Will heavy and dependent drinkers defend their alcohol purchases to the detriment of other purchases?
- What is the likely impact on home drinking/pre-loading?
- Wording and comprehension of the recommendation
- How do you reach private members bars? E.g. sports clubs, social clubs, drinking clubs

Recommendation 2 – Availability

What action should be taken?

- Licensing legislation could be revised to ensure:

  - it takes account of evidence on the link between the availability of alcohol (number of alcohol outlets in a given area and times when it is on sale) and alcohol-related harm (for example, crime and disorder and in relation to health)
  - licensing departments take the above links into account when considering a license application
  - it includes protection of the public's health as part of licensing objectives

Key issues

- How does this recommendation sit with the expansion of the night time economy in the regeneration of many town centres?
- What would the public health elements look like? For example, would this include brief intervention training for bar staff/managers; Server training; Sensible drinking advice?
- Who would finance, enforce and monitor this recommendation? What changes in legislation would be required or do they fall under existing legislation?

Additional issues to discuss

- Supermarkets typically stock and display a large range of alcohol, how will this recommendation be enforced without disproportionately driving up their costs?
- Do delegates have local examples of where licenses have been refused on the basis of outlet density or evidence of ASB/harm?
- Examples of public health based licensing
- Provision of ‘free’ drinking water – unit cost to licensed premises
- How might design led initiatives be incorporated in environmental responses to outlet density?

Recommendation 3 – Marketing

What action should be taken?

To reduce the effect of alcohol advertising on children and young people consider:

• ensuring all alcohol marketing, particularly marketing that makes use of newer media (for example, web-based channels) is covered by a regulatory system which includes the monitoring of practice

• banning alcohol advertising from all media outlets where more than 5% of the audience is under the age of 18 years

• restricting alcohol marketing and advertising to the facts about the product

• in the longer term, banning all forms of alcohol advertising and marketing through television, radio, cinema and via sports sponsorship (as is the case with tobacco advertising).

Key issues

- What do delegates think of the current legislation regarding advertising of alcohol, and alcohol scenarios within programmes? Does it need to be strengthened?
- Mandatory vs voluntary regulation
- Do delegates think that there is a difference between direct advertising, sponsorship, and the (positive) representation of alcohol in TV shows?
- How do you regulate internet marketing considering its international content? Awareness of success of regulating smoking, drugs, and illicit pharmaceuticals
- Profiling TV shows is likely to be difficult. Many adult TV shows have large under 18 audiences. What are the issues around this?
- How does sport sponsorship by alcohol companies affect young people's behaviour?
- The list of banned advertising platforms doesn't include print (e.g. newspapers, magazines)? Why is this? Should it?

Additional issues to discuss

- Data is publically available for 16-21 year olds but not under 18s. Have to pay for this (expensive)
- Facts about alcohol at an individual level include its enjoyable to consume, the majority of people don’t suffer harm, the majority of people find it a useful socialiser, forms the basis of many communities (pubs) etc. how does this conflict with public health (population) messages?
- Should there be an alcohol advertising watershed?

Recommendations for practice

Recommendation 4 – Licensing

Who is the target population?

Alcohol licensee holders and designated supervisors of licensed premises.

Who should take action?

Local authorities, trading standards officers, the police and magistrates.

What action should they take?

• 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.
• Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, non-compliance with other alcohol license condition and illegal imports of alcohol.
• Work in partnership with the appropriate authorities to identify premises that regularly sell alcohol to people who are under age or intoxicated.
• Undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales and to identify premises where sales are made to people who are intoxicated.
• Ensure sanctions are fully applied to businesses that break the law on under-age sales and sales to those who are intoxicated. This includes fixed penalty notices and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

Key issues

• Is mapping and intelligence already being used to monitor the licensing act? Are other methodologies used? What about informal methodologies such as public concerns, observations of licensing officers?

• What data would need to be collected? Who will provide this and analyse it? Who are the key participants in this process?

• Evidence that sanctions are already 'fully applied', but in many cases these may be inadequate (e.g. £40 fine for serving intoxicated patrons).

• Where are conflicts likely to arise (e.g. licensing departments vs industry vs town planners vs chambers of commerce vs advocacy organisations)

• How should consultancy proceed? What if views of community are in opposition to public health priorities? What if communities feel intimidated or powerless?

• Have licensing authorities incorporated public health in their thinking in the past? Is it a priority for them?

• Test purchase rules would have to change. At the moment 'mystery shoppers' can't deliberately deceive shops (e.g. wear makeup, lie about age, use fake ID) as a young person might

• Where will resources come from? Existing provision? Home Office? NHS?

• How widely will these proposed powers be used, and why or why not?

• What should the burden of evidence be? What level and quality of evidence is required?

• What would an appeals process look like? (provide details if possible)

Additional issues to discuss

- How is ‘intoxication’ defined? > recommended daily limit? Subjective ‘drunkenness’? functional incapacity? How is consistency maintained between premises?
- What will happen to persistent street drinking offenders? Is there likely to be a cumulative penalty or some other approach (e.g. court summons for persistent drinking in restricted area)?
- Will there be popular public acceptance for fines?
- Will the effectiveness of schemes such as test purchases need to be evaluated? How and by whom?
- Are the proposals balanced or disproportionate?

Recommendation 5 – resources for screening and brief interventions

Who is the target population?

Professionals who have contact with those aged 16 and over.

Who should take action?

• Commissioners of NHS healthcare services and from multi-agency joint commissioning groups.
• Managers of NHS-commissioned services.

What action should they take?

• Commissioners should ensure a local joint alcohol needs assessment is carried out in accordance with 'World class commissioning' and 'Signs for Improvement'.
• Commissioners should ensure commissioning plans include the provision of brief-interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers).
• Commissioners should make provision for the likely increase in the number of people requiring referral to tier three and four alcohol services as a result of screening. These services should be properly resourced to support the stepped care approach recommended in 'Models of care for alcohol misusers'.
• Service managers must ensure staff are trained to provide alcohol screening and structured brief advice. If there is a local demand, staff should also be trained to deliver motivational counselling.
• Service managers must ensure staff can easily access validated screening questionnaires suitable for local use.
• Service managers must ensure staff have enough time and resources to carry out screening and preventive work effectively. Staff should have access to recognised, evidence-based packs, such as the 'Drink-less pack' or the 'How much is too much?' pack. These should include:
- a short guide on how to use the intervention, questionnaires, visual presentations (comparing the person's drinking levels with the average), self-help leaflets and possibly a poster for display in waiting rooms.

Key issues

- Is the target population appropriate? Will the 16-18 year old age group in particular pose problems as they will be typically working with young people services, and/or might be making the transition to adult services?
- Is the target population sufficient? Do other professional groups need to be included?
- Do World class commissioning' and 'Signs for Improvement' provide a sufficient framework for this recommendation?
- Examples of locally derived screening questionnaires. Difference between screening/diagnostic tools, e.g. AUDIT and tools which advise non-alcohol specialist of appropriate referrals.
- Should this recommendation be limited to NHS staff? Or include other sectors that are likely to come across individuals affected by alcohol? Do CJ staff have the skills to respond to alcohol use for example?
- What partnerships need to be established to successfully deliver this recommendation? Are those specified in Signs for Improvement sufficient?

Additional issues to discuss

- Views on Models of Care
- How do we get both the NHS and local authorities working together to address harmful alcohol use?
- What are the likely resource needs for increased tier 3 and 4 service need? Are there examples from other areas of healthcare where increased/improved screening has led to an increase in service demand? Has this always been mey?
- What is the likely increase in numbers of people needing specialist alcohol services? How can this be predicted?
- Are the public and patients ready for increased focus on their alcohol use? Will they respond to advice, will they see it as interference?
- Local examples of alcohol screening projects - what were the successes, burdens, and challenges experienced?

Recommendation 6 – supporting children and young people aged 10 to 15 years

Who is the target population?

• Children aged 10 to 15 years who are thought to be drinking a hazardous or harmful amount of alcohol.

Who should take action?

• NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Routinely assess the ability of these children and young people to consent to alcohol-related interventions and treatment.
• Use the Common Assessment Framework (CAF) to establish if they are at risk of harm from their drinking and if other psychological or social factors need to be considered.
• Consider referral to child and adolescent mental health services, social care or to young people's drug and alcohol services for treatment, as appropriate

Key issues

- Ways to identify young drinkers – schools, police, parents, youth groups etc. how should the subject be broached?
- Do professionals need to construct risk profiles for vulnerable groups? Should there be routine screening for these groups whenever they come into contact with services?
- What is a harmful amount to drink for 10-15 year olds? How does this correspond to CMO advice that under 15s should, ideally, not drink alcohol at all?
- Is intervention required for drinking that results in sustained/acute harms or both?
- How useful is CAF? Do professionals hold positive/negative views on its use? Why?
- How do you assess the ability of children to consent to interventions? Are existing principles sufficient (e.g. Gillick competency)? Does the recommendation suggest research is needed to establish best ways of assessing 'ability to consent', or is it down to professional judgement?
- What role should families play in addressing drinking in this age group?

Recommendation 7 – screening young people aged 16 and 17 years

Who is the target population?

Young people aged 16 and 17 years who are thought to be drinking a hazardous or harmful amount of alcohol.

Who should take action?

NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Complete a validated alcohol screening questionnaire with this group. Alternatively, if they are judged to be competent enough, ask them to fill one in themselves. In most cases, AUDIT (alcohol-use disorders identification test) should be used. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ, FAST). Screening tools should be appropriate to the setting. For instance, in an accident and emergency (A&E) department, FAST or PAT would be most appropriate.

• Where routine screening is not feasible, focus on groups that may be at an increased risk of alcohol-related harm. This includes those:

– who have had an accident or a minor injury
– who request contraceptive advice
– involved in crime or other anti-social behaviour
– who truant on a regular basis
– at risk of self-harm
– who are looked after
– involved with child protection agencies.

• When broaching the subject of alcohol and screening, ensure discussions are sensitive to the young person's age and their ability to understand what is involved, their emotional maturity, culture and faith. The discussions should also take into account their particular needs (health and social) and be appropriate to the setting (for example, a different approach may be needed in a GP surgery compared to an A&E department).

• Routinely assess the ability of young people to consent to alcohol-related interventions and treatment.

Key issues

- Long recommendation with lots of points. Does it need to be split into smaller chunks?
- Any other professional groups?
- Some overlap with Recommendation 6, some points likely to have been already discussed
- Does multiagency working with YP poses different challenges to adults? Is it easier, more difficult, different set of challenges and opportunities?
- Impact of repeated screening
- When is the ideal moment to intervene or screen?
- Do delegates believe shorter screening tools have real advantages over longer versions? What are these?
- Will there be many examples of local initiatives that have proceeded in accordance with these recommendations? Ask for local examples, what were the outcomes? Were there any unexpected difficulties faced and did the strategy have any unforeseen benefits?
- Will young people resent inquiries into other aspects of their life if they have presented to a service for a non-alcohol related issue?
- How should YP be best motivated to seek further help if the professional believes it is in their best interests? What does the professional do if they have serious concerns but the YP does not 'want' help
- Discussions needed on confidentiality and involvement of parents/carers. The need to involve guardians may inadvertently reveal attendance at other services.

Recommendation 8 – motivational counselling with young people aged 16 and 17 years

Who is the target population?

Young people aged 16 and 17 years who have been identified via screening as drinking a hazardous or harmful amount of alcohol.

Who should take action?

NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Ask the young person's permission to arrange for them to have motivational counselling.

• Appropriately trained staff should offer motivational counselling.

• Provide information on the local specialist addiction services that can deal with young people to those who have scored 20+ in the AUDIT screening questionnaire, those who do not respond well to discussion and those who want further help. Refer them to these services if this is what they want.

• Give those who are actively seeking treatment for an alcohol problem a physical and mental assessment and offer, or refer them for, appropriate treatment and care.

Key issues

- Again, discussion in previous recommendations relevant
- Does the point about asking permission need to be included? Isn't this a standard part of practice, or does it have to be emphasised?
- Who accredits training? What models of counselling should be used?
- Do delegates know, off the top of their head which services they would refer to in their regions?
- What kind are YP are active seekers of treatment and care? Are they in the minority?
- Improving engagement
- Are existing services working well with young drinkers? How should these be improved to support this recommendation.

Recommendation 9 – screening adults

Who is the target population?

Adults.

Who should take action?

NHS and health and social care professionals who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink.

What action should they take?

• NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during patient registrations, when screening for other conditions, when managing chronic disease, promoting sexual health or treating minor injuries caused at work.
• Where routine screening is not feasible or acceptable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. These groups include people:

- with physical conditions (such as hypertension, liver disease or other gastrointestinal disorders)
- with mental health problems (such as anxiety, depression or other mood disorders)
- at risk of self-harm
- who regularly experience accidents or minor traumas.

• Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and on people that have alcohol-related problems. This will include those:

- at risk of self-harm
- involved in crime or other anti-social behaviour
- who practice unsafe sex
- whose children are involved with child protection agencies.

• When broaching the subject of alcohol and screening, ensure discussions are sensitive to people's culture and faith and tailored to their needs.
• Complete a validated alcohol screening questionnaire with the adults being screened. Alternatively, if they are competent enough, ask them to fill one in themselves. Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type), or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ, or FAST). Screening tools should be appropriate to the setting. For instance, in an A&E department, FAST or PAT would be most appropriate.
• Professionals should use their judgment as to whether to revise the AUDIT scores downwards when screening:
- women (women scoring above 7 in the AUDIT questionnaire should be offered brief advice)
- younger people (under the age of 18)
- people aged 65 and over
- black and minority ethnic groups

If in doubt, consult relevant specialists. Work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns.

• When it is not appropriate to use an English language-based screening questionnaire, consult relevant specialists (for example, when dealing with people whose first language is not English or when people have a learning disability).

• Do not use biochemical measures as a matter of routine to see if someone is drinking a hazardous or harmful amount of alcohol. These measures may be used to assess the severity of an established alcohol-related problem or to complement screening questionnaires within A&E.

Key issues

- [Make sure discussion focuses on adults although comparisons with YP OK]
- Is there a role for CJ (e.g. police) and community workers (e.g. firefighters) in this proposal, or should it only focus on named roles?
- Additional payments may be required for some professional groups (e.g. GPs), whilst some might deliver it as part of their routine activities.
- What would a training framework look like
- What existing partnerships/organisations exist that can help train staff or deliver interventions?
- Any other key clinical populations of note?
- ID of populations practising unsafe sex might be difficult. How are these individuals identified? Through presentations at sexual health services? What about non-presenters?
- What is the best way to deliver and commission combined advice (e.g. alcohol & sexual behaviour, alcohol & obesity, alcohol & housing)?
- Are there any decision making tools which assist in the choice of screen?
- Do delegates agree that biochemical tools shouldn't be used to validate self reported drinking and screening?
- What are the best sources of recommendations of the content of BI and motivationally-enhanced counselling? What is the professional standard of training required before someone is considered competent enough to deliver these approaches?

Recommendation 10 – brief advice for adults

Who is the target population?

Adults who have been identified via screening as drinking a hazardous or harmful amount of alcohol (that is, those scoring 8 to 15 on the AUDIT questionnaire) and who are attending:

• primary healthcare services

• A&E departments

• other healthcare services (general hospital wards, outpatient departments, occupational health services, prenatal book-in clinics, sexual health clinics, needle and syringe exchange programmes, pharmacies and dental surgeries)

• offender management and other criminal justice system services, social services and other non-NHS public services.

Who should take action?

• Professionals who have received the necessary training and work in the services above.

What action should they take?

• Primary healthcare professionals should offer a brief session of structured advice about alcohol.

• Non-primary healthcare professionals should try to find time to offer structured brief advice. If they miss an opportunity to do this they should offer an appointment as soon as possible. This appointment may be for a structured brief session or, where appropriate, motivational counselling (see recommendation 11).

• Structured advice should be based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy) and should:

- cover the potential harm caused by this level of drinking and reasons for changing the behaviour, including the benefits for health and wellbeing.
- cover the barriers to change
- lead to a set of goals
- last from 5-15 minutes.

• Use a recognised, evidence-based resource, such as the 'Drink-less pack' or the 'How much is too much?' pack which provides self-help materials.

• 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). Where required, they should offer an additional session of structured brief advice.

Key issues

[This recommendation may have been covered in previous discussion]

- What are the specific issues in delivering brief advice in non traditional healthcare settings such as dentists, pharmacies and NSPs?
- Will new contracts have to be drawn, what are the likely cost implications?
- What are the quality standards in training required? Who will validate these?
- What kind of staff will deliver brief advice in non-healthcare settings? PCT teams? Non specialists?
- Is it feasible to follow up all individuals who have received brief advice, particularly in non health care settings? What are the confidentiality and data protection implications?
- What are the recommended "recognised intervention package"? Should NICE be endorsing particular packages, or is it left to professional judgement? Are there any ineffective packages that professionals should know about?

Recommendation 11 – motivational counselling for adults

Who is the target population?

Adults who have:

- scored 16 to 19 on the AUDIT questionnaire
- not responded to brief structured advice
- chosen to undergo motivational counselling
- need motivational counselling for other reasons.

Who should take action?

Professionals who are in contact with adults and have received training in motivational counselling.

What action should they take?

• Offer motivational counseling to people who:

- are ambivalent about the need to reduce the amount of alcohol they drink
- have failed to benefit from structured brief advice
- in the professional's judgement, need more than structured brief advice
- for any reason, wish to discuss their drinking further with a trained professional.

• Sessions should last from 20 to 30 minutes and should aim to help people reduce the amount they drink (ideally, so that they score less than 8 on the AUDIT and consume less than the recommended level of alcohol).

Key issues

[This recommendation may have been covered in previous discussion, previous discussion points also pertinent here]

- Some individuals may score at the low end of the AUDIT scale (~8). If they don't respond to brief advice because they don't consider their drinking to be harmful or disruptive, is a more formal intervention likely to be successful?
- Target audience includes individuals who "wish to discuss their drinking further with a trained professional" - should individuals considered at relatively low risk be offered this option if the professional does not think it is appropriate?
- Is the number of counselling sessions realistic and feasible, should it be more or less? Examples should be provided.
- Discussion on referral pathways, capacity, links to other agency that might support hazardous drinkers.
- Do enquiries need to be made about children of hazardous drinkers, in accordance with earlier recommendations?

Recommendation 12 – referral

Who is the target population?

Those aged 10 years and over who attend NHS or non-NHS services and may be alcohol-dependent.

Who should take action?

NHS and non-NHS professionals who have contact with anyone over the age of 10.

What action should they take?

Consider making a referral for specialist treatment if they:

• have scored 20 or more on the AUDIT screening questionnaire
• show signs of moderate or severe alcohol dependence
• failed to benefit from structured brief advice and motivational counselling and wish to receive further help for an alcohol problem
• show signs of alcohol-related damage (for example, liver damage or mental health problems).

Key issues

[This recommendation may have been covered in previous discussion, previous discussion points also pertinent here]

- Who should be making referrals? What is an appropriate referral to make?
- Is specialist alcohol treatment provision available across the country? Are there disparities?
- Is there sufficient specialist provision for subpopulations?
- For YP scoring > 20 on the AUDIT is there a need for additional investigation into the circumstances surrounding drinking, for example, should this be considered a neglect issue? Should child social care be informed?
- What is the best way to monitor referrals? Are they being picked up in local alcohol treatment intelligence? Do they need to be?
- What are the implications of identifying YP who score >20 on AUDIT? Should CJ and social welfare be informed?

Appendix 4 Questions included in online survey

Thank you for completing this survey and helping us with our research. The draft guidance consultation ends on 10th November 2009, with the final guidance expected to be issued in March 2010.
We would also encourage you to register as an official stakeholder in this guidance. This will provide you with the opportunity to submit comments that weren't covered in this survey. Please click here to visit the NICE website and scroll down until you reach the alcohol use disorders (under New programme of public health guidance - 15th wave).

Background information

Please provide the following information. This information is only being collected so that we have an understanding of who is completing the survey.

This information will not be shared with anyone outside of the project team and will not be used for any other purpose than this work.

About you and your organisation

1. Region
2. Name of your Organisation
3. Please choose the answer that best describes the type of organisation:
Alcohol Industry Drug/Alcohol Service Government Research/University Health Criminal Justice Social Care/Social Welfare Education
Other (please specify):

4. Scope of work:
Local Regional National International

5. Your name
6. Your role/job title
7. Optional - in case we need to contact you about your answers please provide a valid email address. We will only contact you if it is absolutely necessary

Recommendations for Policy

Who should take action?

The Chief Medical Officer should have lead responsibility for coordinating the broad approach across government, supported by the Department of Health.

The following departments and national agencies should be involved:

• Advertising Standards Authority
• Department for Business, Innovation and Skills
• Department for Children, Schools and Families
• Department for Culture, Media and Sport
• Department for Environment, Food and Rural Affairs
• Department of Communities and Local Government
• Department of Health
• Home Office
• Ministry of Justice
• National Treatment Agency
• Ofcom
• Office of Fair Trading
• Treasury.

Organisations that should be consulted include:

• alcohol producers
• off- and on-sale retailers
• national non-governmental organisations, for example, Alcohol Concern and the Royal Medical Colleges

Recommendation 1: Price

Making alcohol less affordable appears to be the most effective way of reducing alcohol-related harm. There is sufficient evidence (within the published literature and from the economic analysis) to justify reviewing policies on alcohol pricing.

What action could be taken?

Consider the following measures:

• Introducing a minimum price per unit.
• Linking alcohol duty to inflation and earnings.

8.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

9. [Optional] Is there anything else you would like to add? We're particularly interested in learning what you think about the following:

• What are the costs and benefits to health, public safety, consumers, businesses, and competition?
• Who will need to sign up to this recommendation (Treasury, alcohol producers, off- and on-sale retailers, NGOs, members of the public)?
• What will be the likely impact on business, jobs and enterprise?
• What will be the likely effect on alcohol purchasing patterns?
• What will be the likely effects on alcohol consumption?
• Should we/how do we support healthy drinking choices in young people who expect alcohol promotions?
• How might retailers counter 'negative' effects of minimum pricing on alcohol sales?
(Optional)

Recommendation 2: Availability

Making it less easy to buy alcohol, by reducing the number of outlets selling it in a given area and the days and hours when it can be sold, is another effective way of reducing alcohol related harm. As a way of achieving this in Scotland, protection of the public's health has been introduced as criteria into licensing regulations.

What action could be taken?

Licensing legislation could be revised to ensure:

- it takes account of evidence on the link between the availability of alcohol (number of alcohol outlets in a given area and times when it is on sale) and alcohol-related harm (for example, crime and disorder and in relation to health)
- licensing departments take the above links into account when considering a license application
- it includes protection of the public's health as part of licensing objectives
- it gives licensing departments an enforcement role
- immediate sanctions can be imposed on any premises in breach of their license, following review proceedings.

Legislation on personal import allowances could be reviewed and consideration given to reducing them.

10.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be					

relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

11. [Optional] Is there anything else you would like to add? We're particularly interested in learning what you think about the following:

- How does this recommendation sit with the expansion of the night time economy in the regeneration of many town centres?
- What would the public health elements look like? For example, would this include brief intervention training for bar staff/managers; Server training; Sensible drinking advice?
- Who would finance, enforce and monitor this recommendation? What changes in legislation would be required or do they fall under existing legislation?

(Optional)

Recommendation 3: Marketing

There is only limited evidence on how alcohol advertising affects consumption among adults. However, evidence shows that exposure to alcohol advertising is associated with the onset of drinking among children and young people - and increased consumption among those who already drink. It is difficult to protect children and young people from such advertising without introducing a complete ban. Evidence on whether or not it would be effective is inconclusive. However, a tobacco advertising ban has helped reduce the prevalence of smoking.

What action should be taken?

To reduce the effect of alcohol advertising on children and young people consider:

• ensuring all alcohol marketing, particularly marketing that makes use of newer media (for example, web-based channels) is covered by a regulatory system which includes the monitoring of practice
• banning alcohol advertising from all media outlets where more than 5% of the audience is under the age of 18 years
• restricting alcohol marketing and advertising to the facts about the product
• in the longer term, banning all forms of alcohol advertising and marketing through television, radio, cinema and via sports sponsorship (as is the case with tobacco advertising).

12.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

13. [Optional] Is there anything else you would like to add? We're particularly interested in learning what you think about the following:

- What is the current legislation regarding advertising of alcohol, and alcohol scenarios within programmes? Does it need to be strengthened?
- Mandatory vs voluntary regulation
- Do delegates think that there is a difference between direct advertising, sponsorship, and the (positive) representation of alcohol in TV shows?
- How do you regulate internet marketing considering its international content? Awareness of success of regulating smoking, drugs, and illicit pharmaceuticals
- Profiling TV shows is likely to be difficult. Many adult TV shows have large under 18 audiences. What are the issues around this?
- How does sport sponsorship by alcohol companies affect young people's behaviour?
- The list of banned advertising platforms doesn't include print (e.g newspapers, magazines)? Why is this? Should it?

(Optional)

Recommendation 4: Licensing

Who is the target population?

Alcohol licensee holders and designated supervisors of licensed premises.

Who should take action?

Local authorities, trading standards officers, the police and magistrates.

What action should they take?

• 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.

• Ensure sufficient resources are available to prevent under-age sales, sales to people who are intoxicated, non-compliance with other alcohol license condition and illegal imports of alcohol.

• Work in partnership with the appropriate authorities to identify premises that regularly sell alcohol to people who are under age or intoxicated.

• Undertake test purchases (using 'mystery' shoppers) to ensure compliance with the law on under-age sales and to identify premises where sales are made to people who are intoxicated.

• Ensure sanctions are fully applied to businesses that break the law on under-age sales and sales to those who are intoxicated. This includes fixed penalty notices and closure notices (the latter should be applied to establishments that persistently sell alcohol to children and young people).

14.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

15. [Optional] Is there anything else you would like to add? We're particularly interested in learning what you think about the following:

• Is mapping and intelligence already being used to monitor the licensing act? Are other methodologies used? What about informal methodologies such as public concerns, observations of licensing officers?
• What data would need to be collected? Who will provide this and analyse it? Who are the key participants in this process?
• Evidence that sanctions are already 'fully applied', but in many cases these may be inadequate (e.g. £40 fine for serving intoxicated patrons)
• Where are conflicts likely to arise (e.g. licensing departments vs industry vs town planners vs chambers of commerce vs advocacy organisations)
• How should consultancy proceed? What if views of community are in opposition to public health priorities? What if communities feel intimidated or powerless?
• Have licensing authorities incorporated public health in their thinking in the past? Is it a priority for them?
• Test purchase rules would have to change. At the moment 'mystery shoppers' can't deliberately deceive shops (e.g. wear make up, lie about age, use fake ID) as a young person might
• Where will resources come from? Existing provision? Home Office? NHS?
• How widely will these proposed powers be used, and why or why not?
• What should the burden of evidence be? What level and quality of evidence is required?
• What should the appeals process look like? (provide details if required)
(Optional)

Recommendation for Practice

Recommendation 5: Resources for screening and brief interventions

Who is the target population?

Professionals who have contact with those aged 16 and over.

Who should take action?

• Commissioners of NHS healthcare services and from multi-agency joint commissioning groups.

• Managers of NHS-commissioned services.

What action should they take?

• Commissioners should ensure a local joint alcohol needs assessment is carried out in accordance with 'World class commissioning' and 'Signs for Improvement'.

• Commissioners should ensure commissioning plans include the provision of brief-interventions for people at risk of an alcohol-related problem (hazardous drinkers) and those whose health is being damaged by alcohol (harmful drinkers).

• Commissioners should make provision for the likely increase in the number of people requiring referral to tier three and four alcohol services as a result of screening. These services should be properly resourced to support the stepped care approach recommended in 'Models of care for alcohol misusers'.

• Service managers must ensure staff are trained to provide alcohol screening and structured brief advice. If there is a local demand, staff should also be trained to deliver motivational counselling.

• Service managers must ensure staff can easily access validated screening questionnaires suitable for local use.

• Service managers must ensure staff have enough time and resources to carry out screening and preventive work effectively. Staff should have access to recognised, evidence-based packs, such as the 'Drink-less pack' or the 'How much is too much?' pack. These should include:

- a short guide on how to use the intervention, questionnaires, visual presentations (comparing the person's drinking levels with the average), self-help leaflets and possibly a poster for display in waiting rooms.

16.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

17. Is there anything else you would like to add? *(Optional)*

Recommendation 6: supporting children and young people aged 10 to 15 years

Who is the target population?

• Children aged 10 to 15 years who are thought to be drinking a hazardous or harmful amount of alcohol.

Who should take action?

• NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Routinely assess the ability of these children and young people to consent to alcohol-related interventions and treatment.

• Use the Common Assessment Framework (CAF) to establish if they are at risk of harm from their drinking and if other psychological or social factors need to be considered.

• Consider referral to child and adolescent mental health services, social care or to young people's drug and alcohol services for treatment, as appropriate.

18.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

19. Is there anything else you would like to add? *(Optional)*

Recommendation 7: screening young people aged 16 and 17 years

Who is the target population?

Young people aged 16 and 17 years who are thought to be drinking a hazardous or harmful amount of alcohol.

Who should take action?

NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Complete a validated alcohol screening questionnaire with this group. Alternatively, if they are judged to be competent enough, ask them to fill one in themselves. In most cases, AUDIT (alcohol-use disorders identification test) should be used. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ, FAST). Screening tools should be appropriate to the setting. For instance, in an accident and emergency (A&E) department, FAST or PAT would be most appropriate.

• Where routine screening is not feasible, focus on groups that may be at an increased risk of alcohol-related harm. This includes those:

– who have had an accident or a minor injury
– who request contraceptive advice
– involved in crime or other anti-social behaviour
– who truant on a regular basis
– at risk of self-harm
– who are looked after
– involved with child protection agencies.

• When broaching the subject of alcohol and screening, ensure discussions are sensitive to the young person's age and their ability to understand what is involved, their emotional maturity, culture and faith. The discussions should also take into account their particular needs (health and social) and be appropriate to the setting (for example, a different approach may be needed in a GP surgery compared to an A&E department).

• Routinely assess the ability of young people to consent to alcohol-related interventions and treatment.

20.

	Strongly Disagree	Disagree	Neither Agree nor Disagree	Agree	Strongly Agree
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

21. Is there anything else you would like to add? *(Optional)*

Recommendation 8: motivational counselling with young people aged 16 and 17 years

Who is the target population?

Young people aged 16 and 17 years who have been identified via screening as drinking a hazardous or harmful amount of alcohol.

Who should take action?

NHS and health and social care professionals who regularly come into contact with this group.

What action should they take?

• Ask the young person's permission to arrange for them to have motivational counselling.

• Appropriately trained staff should offer motivational counselling.

• Provide information on the local specialist addiction services that can deal with young people to those who have scored 20+ in the AUDIT screening questionnaire, those who do not respond well to discussion and those who want further help. Refer them to these services if this is what they want.

• Give those who are actively seeking treatment for an alcohol problem a physical and mental assessment and offer, or refer them for, appropriate treatment and care.

22.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

23. Is there anything else you would like to add? *(Optional)*

Recommendation 9 - screening adults

Who is the target population?

Adults.

Who should take action?

NHS and health and social care professionals who regularly come into contact with people who may be at risk of harm from the amount of alcohol they drink.

What action should they take?

• NHS professionals should routinely carry out alcohol screening as an integral part of practice. For instance, discussions should take place during patient registrations, when screening for other conditions, when managing chronic disease, promoting sexual health or treating minor injuries caused at work.

• Where routine screening is not feasible or acceptable, NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and those with an alcohol-related condition. These groups include people:

- with physical conditions (such as hypertension, liver disease or other gastrointestinal disorders)
- with mental health problems (such as anxiety, depression or other mood disorders)
- at risk of self-harm
- who regularly experience accidents or minor traumas.

• Non-NHS professionals should focus on groups that may be at an increased risk of harm from alcohol and on people that have alcohol-related problems. This will include those:

- at risk of self-harm
- involved in crime or other anti-social behaviour
- who practice unsafe sex
- whose children are involved with child protection agencies.

• When broaching the subject of alcohol and screening, ensure discussions are sensitive to people's culture and faith and tailored to their needs.

• Complete a validated alcohol screening questionnaire with the adults being screened. Alternatively, if they are competent enough, ask them to fill one in themselves. Use AUDIT to decide whether to offer them a brief intervention (and, if so, what type), or whether to make a referral. If time is limited, use an abbreviated version (such as AUDIT-C, AUDIT-PC, SASQ, or FAST). Screening tools should be appropriate to the setting. For instance, in an A&E department, FAST or PAT would be most appropriate.

• Professionals should use their judgement as to whether to revise the AUDIT scores downwards when screening:
- women (women scoring above 7 in the AUDIT questionnaire should be offered brief advice)
- younger people (under the age of 18)
- people aged 65 and over
- black and minority ethnic groups

If in doubt, consult relevant specialists. Work on the basis that offering an intervention is less likely to cause harm than failing to act where there are concerns.

• When it is not appropriate to use an English language-based screening questionnaire, consult relevant specialists (for example, when dealing with people whose first language is not English or when people have a learning disability).

• Do not use biochemical measures as a matter of routine to see if someone is drinking a hazardous or harmful amount of alcohol. These measures may be used to assess the severity of an established alcohol-related problem or to complement screening questionnaires within A&E.

24.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

25. Is there anything else you would like to add? *(Optional)*

Recommendation 10: brief advice for adults

Who is the target population?

Adults who have been identified via screening as drinking a hazardous or harmful amount of alcohol (that is, those scoring 8 to 15 on the AUDIT questionnaire) and who are attending:

• primary healthcare services
• A&E departments
• other healthcare services (general hospital wards, outpatient departments, occupational health services, prenatal book-in clinics, sexual health clinics, needle and syringe exchange programmes, pharmacies and dental surgeries)
• offender management and other criminal justice system services, social services and other non-NHS public services.

Who should take action?

• Professionals who have received the necessary training and work in the services above.

What action should they take?

• Primary healthcare professionals should offer a brief session of structured advice about alcohol.

• Non-primary healthcare professionals should try to find time to offer structured brief advice. If they miss an opportunity to do this they should offer an appointment as soon as possible. This appointment may be for a structured brief session or, where appropriate, motivational counselling (see recommendation 11).

• Structured advice should be based on FRAMES principles (feedback, responsibility, advice, menu, empathy, self-efficacy) and should:

- cover the potential harm caused by this level of drinking and reasons for changing the behaviour, including the benefits for health and wellbeing.
- cover the barriers to change
- lead to a set of goals
- last from 5-15 minutes.

• Use a recognised, evidence-based resource, such as the 'Drink-less pack' or the 'How much is too much?' pack which provides self-help materials.

• 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). Where required, they should offer an additional session of structured brief advice.

26.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

27. Is there anything else you would like to add? *(Optional)*

Recommendation 11: motivational counselling for adults

Who is the target population?

Adults who have:

- scored 16 to 19 on the AUDIT questionnaire
- not responded to brief structured advice
- chosen to undergo motivational counselling
- need motivational counselling for other reasons.

Who should take action?

Professionals who are in contact with adults and have received training in motivational counselling.

What action should they take?

• Offer motivational counseling to people who:

- are ambivalent about the need to reduce the amount of alcohol they drink
- have failed to benefit from structured brief advice
- in the professional's judgement, need more than structured brief advice
- for any reason, wish to discuss their drinking further with a trained professional.

• Sessions should last from 20 to 30 minutes and should aim to help people reduce the amount they drink (ideally, so that they score less than 8 on the AUDIT and consume less than the recommended level of alcohol).

• Follow up and assess people who have received motivational counselling. Where necessary, offer up to three additional sessions or referral to a specialist alcohol or addiction treatment service (see recommendation 12).

28.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					

c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

29. Is there anything else you would like to add? *(Optional)*

Recommendation 12 - referral

Who is the target population?

Those aged 10 years and over who attend NHS or non-NHS services and may be alcohol-dependent.

Who should take action?

NHS and non-NHS professionals who have contact with anyone over the age of 10.

What action should they take?

Consider making a referral for specialist treatment if they:

• have scored 20 or more on the AUDIT screening questionnaire
• show signs of moderate or severe alcohol dependence
• failed to benefit from structured brief advice and motivational counselling and wish to receive further help for an alcohol problem
• show signs of alcohol-related damage (for example, liver damage or mental health problems).

30.

	Strongly Disagree	**Disagree**	**Neither Agree nor Disagree**	**Agree**	**Strongly Agree**
a. This recommendation will help to prevent/reduce alcohol use disorders in the population.					
b. This recommendation will be relevant to my professional practice.					
c. This recommendation will be useful to my professional practice.					
d. This recommendation is feasible to introduce.					

31. Is there anything else you would like to add? *(Optional)*

End of Survey!
Thank you for completing this survey and helping us with our research. The draft guidance consultation ends on 10th November 2009, with the final guidance expected to be issued in March 2010.

We would also encourage you to register as an official stakeholder in this guidance. This will provide you with the opportunity to submit comments that weren't covered in this survey. Please click here to visit the NICE website and scroll down until you reach the alcohol use disorders (under New programme of public health guidance - 15th wave).

Appendix 5 Survey findings

3.2.1 Description of the sample

Fourteen individuals completed the online survey. The greatest number of respondents were from the North West (n=6, 43%); followed by the South West (n=3, 21%); the West Midlands (n= 2, 14%); London (n=2, 14%); and the South East (n=1, 7%).

Respondents were from a range of organisations. Three respondents worked within criminal justice (21%); three were from drug/alcohol services (21%); and three were from health organisations (21%). There were two respondents from Government organisations (14%) and one respondent from education (7%); research/university (7%); and supported housing (7%).

Respondents' organisations were:

- Addaction
- BADAS and WASP area Drug Advisory
- Birmingham Health Education Service
- Department of Health (South West)
- Lancashire Constabulary
- Lancashire Police
- Liverpool YMCA
- London Borough of Lewisham
- London Borough of Richmond upon Thames
- Magistrates Association
- NHS Blackburn with Darwen
- NHS Hampshire
- University of the West of England, Bristol
- Young Addaction, Central Lancashire

Respondents' roles were:

- Community Planning Manager
- DAAT Coordinator
- Drug and Alcohol Support Worker
- Health Improvement Manager
- Magistrate and A&E Consultant
- Partnership Inspector
- Primary Care Improvement and Development Manager
- Professor of Addiction Studies
- PSHE Advisor
- Regional Alcohol Manager
- Team Leader
- V/C WASP and Alcohol Lead, Wiltshire

Seven respondents stated that the scope of their work was local (50%); two regional (14%); one who stated national (7%); and one international (7%). Two respondents stated that the scope of their work was local, regional and national (14%) and one local and regional (7%).

Recommendation 1: price

Table 3.1 below shows the extent to which respondents agreed that recommendation one was helpful, relevant, useful and feasible. The greatest number of respondents *agreed* that recommendation one will help to prevent/reduce alcohol disorders in the population (n=6, 43%); will be relevant to their professional practice (n=7, 50%); will be useful for their professional practice (n=5, 36%); and is feasible to introduce (n=10, 71%). However the second highest response for each of the statements was *strongly disagree* (n=4, 29%; n=4, 29%; n=4, 29%; n=3, 21% respective). No respondents *strongly agreed* with any of the statements in relation to recommendation one.

Table 3.1 Survey respondents' perspectives on recommendation one

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	4 (29%)	3 (21%)	1 (7%)	**6 (43%)**	0 (0%)
This recommendation will be relevant to my professional practice.	4 (29%)	2 (14%)	1 (7%)	**7 (50%)**	0 (0%)
This recommendation will be useful to my professional practice.	4 (29%)	3 (21%)	2 (14%)	**5 (36%)**	0 (0%)
This recommendation is feasible to introduce.	3 (21%)	0 (0%)	1 (7%)	**10 (71%)**	0 (0%)

"I do not agree that this is the way forward. You will get more home brewing, more 'booze' runs, lock-ins and people will purchase the cheapest alcohol with the largest quantities."

"A 50p minimum price will save lives. It will also cut hospital admissions, crimes and days off work. It would save one billion pounds in tax each year…This would also support pubs and restaurants."

Recommendation 2: availability

Table 3.2 below shows the extent to which respondents perceived recommendation two to be helpful, relevant, useful and feasible. The greatest number of respondents *agreed* that recommendation two would help to prevent/reduce alcohol disorders in the population (n=7, 50%); will be relevant to their

professional practice (n=7, 50%); will be useful for their professional practice (n=7, 50%); and is feasible to introduce (n=9, 64%). However the second highest response for each of the statements was *strongly disagree* (all = n=3, 21%). No respondents *strongly agreed* with any of the statements in relation to recommendation two.

Table 3.2 Survey respondents' perspectives on recommendation two

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	3 (21%)	1 (7%)	3 (21%)	**7 (50%)**	0 (0%)
This recommendation will be relevant to my professional practice.	3 (21%)	2 (14%)	2 (14%)	**7 (50%)**	0 (0%)
This recommendation will be useful to my professional practice.	3 (21%)	2 (14%)	2 (14%)	**7 (50%)**	0 (0%)
This recommendation is feasible to introduce.	3 (21%)	0 (0%)	2 (14%)	**9 (64%)**	0 (0%)

"Not sure how effective brief intervention training would be for frontline bar staff, how would the effectiveness be monitored, danger that messages would be inappropriate."

"This forms an essential part of responsible management of the night time economy and should be promoted as such rather than as a restriction on economic development or commercial success. The current licensing legislation should be revised to introduce a licensing objective that requires all applications to consider the impact that the license will have on the local population's health."

Recommendation 3: marketing

Table 3.3 below shows the extent to which respondents perceived recommendation three to be helpful, relevant, useful and feasible. The greatest number of respondents *agreed* that recommendation three would help to prevent/reduce alcohol disorders in the population (n=7, 50%); will be relevant to their professional practice (n=6, 43%); will be useful for their professional practice (n=6, 43%); and is feasible to introduce (n=5, 36%). No respondents *strongly agreed* with any of the statements in relation to recommendation three.

Table 3.3 Survey respondents' perspectives on recommendation three

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	3 (21%)	3 (21%)	1 (7%)	**7 (50%)**	0 (0%)
This recommendation will be relevant to my professional practice.	3 (21%)	3 (21%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation will be useful to my professional practice.	3 (21%)	2 (14%)	3 (21%)	**6 (43%)**	0 (0%)
This recommendation is feasible to introduce.	4 (29%)	1 (7%)	4 (29%)	**5 (36%)**	0 (0%)

"The cynical addition of the words 'please drink responsibly' to adverts is laughable, the first thing alcohol affects is your 'responsibility, inhibition, judgement, and cognitive processing'. Ideally we should follow the anti smoking guidelines for all advertising of alcohol. BAN IT!!"

"Many soap operas are based around a pub scenario so programme makers should be encouraged to promote sensible drinking messages."

"I feel this would be a really difficult area to monitor."

Recommendation 4: licensing

Table 3.4 below shows the extent to which respondents perceived recommendation four to be helpful, relevant, useful and feasible. The greatest number of respondents *agreed* that recommendation four would help to prevent/reduce alcohol disorders in the population (n=8, 57%); will be relevant to their professional practice (n=7, 50%); will be useful for their professional practice (n=6, 43%); and is feasible to introduce (n=8, 57%). No respondents strongly agreed with any of the statements in relation to recommendation four.

Table 3.4 Survey respondents' perspectives on recommendation four

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	4 (29%)	0 (0%)	2 (14%)	**8 (57%)**	0 (0%)
This recommendation will be relevant to my professional practice.	3 (21%)	2 (14%)	2 (14%)	**7 (50%)**	0 (0%)
This recommendation will be useful to my professional practice.	3 (21%)	2 (14%)	3 (21%)	**6 (43%)**	0 (0%)

This recommendation is feasible to introduce.	3 (21%)	0 (0%)	3 (21%)	**8 (57%)**	0 (0%)

"The data collection from all agencies and mapping it out is very difficult, there should be more data provision from A&E and other statutory bodies to ensure that a fuller picture of the problem is realised."

"Sales to those who are intoxicated have been very difficult to prove. The fine is also inadequate given the bonus payments to bar managers that can sometimes be based on volume of sales."

Recommendation 5: resources for screening and brief interventions

Table 3.5 below shows the extent to which respondents perceived recommendation five to be helpful, relevant, useful and feasible. The greatest number of respondents *strongly disagreed* that recommendation five will be relevant to their professional practice (n=6, 43%); will be useful for their professional practice (n=6, 43%) and is feasible to introduce (n=8, 57%). There were six respondents who *strongly disagreed* (43%) and six who *agreed* (43%) that recommendation five will help to prevent/reduce alcohol use disorders in the population. No respondents strongly agreed with any of the statements in relation to recommendation five.

Table 3.5 Survey respondents' perspectives on recommendation five

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	**6 (43%)**	0 (0%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation will be relevant to my professional practice.	**6 (43%)**	2 (14%)	2 (14%)	4 (29%)	0 (0%)
This recommendation will be useful to my professional practice.	**6 (43%)**	2 (14%)	2 (14%)	4 (29%)	0 (0%)
This recommendation is feasible to introduce.	**8 (57%)**	0 (0%)	3 (21%)	3 (21%)	0 (0%)

"Direct funding for alcohol is still an issue for many areas, clarity and direct PCT money must be arranged for all areas on a LONG TERM basis, short term interventions must not be the only focus, T3 and 4 provision must be expanded to at least match drug provision, we still have a seven out of ten client alcohol to drug ratio nationally, funding does not match this at all. We also have more drug staff than alcohol trained staff."

"A lot of this is already happening in our area and has been identified as a priority through the LA and PCT Strategic Plan."

Recommendation 6: supporting children and young people aged 10 to 15 years

Table 3.6 below shows the extent to which respondents perceived recommendation six to be helpful, relevant, useful and feasible. The greatest number of respondents *strongly disagreed* that recommendation six will help to prevent/reduce alcohol use disorders in the population (n=7, 50%). Six respondents *strongly disagreed* (43%) and six respondents *agreed* (43%) that recommendation six will be relevant to their professional practice. Additionally, six respondents *disagreed* (43%) and six respondents *agreed* (43%) that recommendation six will be useful to their professional practice. The greatest number of respondents *agreed* that recommendation six is feasible to introduce (50%). No respondents *strongly agreed* with any of the statements in relation to recommendation six.

Table 3.6 Survey respondents' perspectives on recommendation six

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	**7 (50%)**	0 (0%)	1 (7%)	6 (43%)	0 (0%)
This recommendation will be relevant to my professional practice.	**6 (43%)**	0 (0%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation will be useful to my professional practice.	**6 (43%)**	0 (0%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation is feasible to introduce.	6 (43%)	0 (0%)	1 (7%)	**7 (50%)**	0 (0%)

"The professionals who come into contact with this age group is far wider than alluded to here and should incorporate school teachers, police, sports development and YPS workers to received and implement brief intervention and awareness training."

"This would be a particularly beneficial 'line of attack'."

Recommendation 7: screening young people aged 16 and 17 years

Table 3.7 below shows the extent to which respondents perceived recommendation seven to be helpful, relevant, useful and feasible. Seven of the respondents strongly *disagreed* (50%) and seven *agreed* (50%) that recommendation seven will help to prevent/reduce alcohol use disorders in the population. Equally, six respondents *strongly disagreed* (43%) and six *agreed* (43%) that

recommendation seven will be relevant to their professional practice. The greatest number of respondents *agreed* that recommendation seven will be useful to their professional practice (n=7, 50%). However, the greatest number of respondents *strongly disagreed* that the recommendation is feasible to introduce (n=7, 50%). No respondents *strongly agreed* with any of the statements in relation to recommendation seven.

Table 3.7 Survey respondents' perspectives on recommendation seven

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	**7 (50%)**	0 (0%)	0 (0%)	**7 (50%)**	0 (0%)
This recommendation will be relevant to my professional practice.	**6 (43%)**	0 (0%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation will be useful to my professional practice.	6 (43%)	0 (0%)	1 (7%)	**7 (50%)**	0 (0%)
This recommendation is feasible to introduce.	**7 (50%)**	0 (0%)	1 (7%)	6 (43%)	0 (0%)

"Please can we improve the transit between young and adult services!"

"The AUDIT is cheap and simple to use. It would produce a lot of valuable evidence."

Recommendation 8: motivational counselling with young people aged 16 and 17 years

Table 3.8 below shows the extent to which respondents perceived recommendation eight to be helpful, relevant, useful and feasible. Seven respondents *strongly disagreed* (50%) and seven *agreed* (50%) that recommendation eight will help to prevent/reduce alcohol use disorders in the population. Equally, six respondents *strongly disagreed* (43%) and six *agreed* (43%) that recommendation eight will be relevant to their professional practice. The greatest number of respondents *agreed* that recommendation eight will be useful to their professional practice (50%); however, six respondents *strongly disagreed* with this statement (43%). The greatest number of respondents *strongly disagreed* that recommendation eight will be feasible to introduce (n=7, 50%). No respondents *strongly agreed* with any of the statements in relation to recommendation eight.

Table 3.8 Survey respondents' perspectives on recommendation eight

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will	**7**	0	0	**7**	0

help to prevent/reduce alcohol use disorders in the population.	**(50%)**	(0%)	(0%)	**(50%)**	(0%0
This recommendation will be relevant to my professional practice.	**6 (43%)**	0 (0%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation will be useful to my professional practice.	6 (43%)	0 (0%)	1 (7%)	**7 (50%)**	0 (0%)
This recommendation is feasible to introduce.	**7 (50%)**	0 (0%)	2 (14%)	5 (36%)	0 (0%)

"Working in partnership with education so they can signpost to the relevant agencies will be very useful."

"We find CBT more useful that MC but still a worthwhile method for YP's."

Recommendation 9: screening adults

Table 3.9 below shows the extent to which respondents perceived recommendation nine to be helpful, relevant, useful and feasible. The greatest number of respondents *agreed* that recommendation nine will help to prevent/reduce alcohol use disorders in the population (n=7, 50%) and will be useful to their professional practice (n=6, 43%). However, the greatest number of respondents *strongly disagreed* that recommendation nine will be relevant to their professional practice (n=6, 43%) and is feasible to introduce (n=6, 43%). No respondents *strongly agreed* with any of the statements in relation to recommendation nine.

Table 3.9 Survey respondents' perspectives on recommendation nine

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	5 (36%)	1 (7%)	1 (7%)	**7 (50%)**	0 (0%)
This recommendation will be relevant to my professional practice.	**6 (43%)**	2 (14%)	2 (14%)	4 (29%)	0 (0%)
This recommendation will be useful to my professional practice.	5 (36%)	1 (7%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation is feasible to introduce.	**6 (43%)**	0 (0%)	3 (21%)	5 (36%)	0 (0%)

"A single tool would be helpful, particularly when non health professionals are involved. There is also a role for the police in delivering this."

"What provision for the massive increase in clients that this will uncover?"

Recommendation 10: brief advice for adults

Table 3.10 below shows the extent to which respondents perceived recommendation ten to be helpful, relevant, useful and feasible. The greatest number of respondents *agreed* that recommendation ten will help to prevent/reduce alcohol use disorders in the population (n=8, 57%) and will be useful to their professional practice (n=6, 43%). However, the greatest number of respondents *strongly disagreed* that recommendation ten will be relevant to their professional practice (n=6, 43%) and is feasible to introduce (n=6, 43%). No respondents *strongly agreed* with any of the statements in relation to recommendation ten.

Table 3.10 Survey respondents' perspectives on recommendation ten

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	5 (36%)	0 (0%)	1 (7%)	**8 (57%)**	0 (0%)
This recommendation will be relevant to my professional practice.	**6 (43%)**	1 (7%)	4 (29%)	3 (21%)	0 (0%)
This recommendation will be useful to my professional practice.	5 (36%)	1 (7%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation is feasible to introduce.	**6 (43%)**	0 (0%)	3 (21%)	5 (36%)	0 (0%)

"Brief advice should be available for all adults who have been identified through screening as drinking at hazardous and/or harmful levels. Staff within healthcare services, offender management and other criminal justice system services and social services should be adequately trained to provide this service. Where staff are not able to provide this service they should refer to appropriate service."

"We are developing this work currently and we have found difficulties with non-primary health care staff in delivering and monitoring of the more structured interventions."

Recommendation 11: motivational counselling for adults

Table 3.11 below shows the extent to which respondents *agreed* that recommendation 11 was helpful, relevant, useful and feasible. The greatest number of respondents *agreed* that

recommendation 11 would help to prevent/reduce alcohol disorders in the population (n=11, 79%); will be relevant to their professional practice (n=7, 50%); will be useful for their professional practice (n=7, 50%); and is feasible to introduce (n=8, 57%). No respondents *strongly agreed* with any of the statements in relation to recommendation 11.

Table 3.11 Survey respondents' perspectives on recommendation 11

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*
This recommendation will help to prevent/reduce alcohol use disorders in the population.	2 (14%)	0 (0%)	1 (7%)	**11 (79%)**	0 (0%)
This recommendation will be relevant to my professional practice.	3 (21%)	1 (7%)	3 (21%)	**7 (50%)**	0 (0%)
This recommendation will be useful to my professional practice.	3 (21%)	1 (7%)	2 (14%)	**7 (50%)**	0 (0%)
This recommendation is feasible to introduce.	3 (21%)	0 (0%)	3 (21%)	**8 (57%)**	0 (0%)

"Motivational counselling should be available to those who have been assessed as in need of more structured support."

"Appears like a 'gold standard' after we have delivered and invested in Recommendation 10."

Recommendation 12: referral

Table 3.12 below shows the extent to which respondents *agreed* that recommendation 12 was helpful, relevant, useful and feasible. Six respondents *strongly disagreed* (43%) and six respondents *agreed* (43%) that recommendation 12 will help to prevent/reduce alcohol use disorder in the population. Five respondents *strongly disagreed* (36%) and five *neither agreed nor disagreed* (36%) that recommendation 12 will be relevant to their professional practice. The greatest number of respondents *strongly disagreed* that recommendation 12 will be useful to their professional practice (n=7, 50%) and is feasible to introduce (n=6, 43%). No respondents *strongly agreed* with any of the statements in relation to recommendation 11.

Table 3.12 Survey respondents' perspectives on recommendation 12

Statements	*Strongly Disagree*	*Disagree*	*Neither Agree nor Disagree*	*Agree*	*Strongly Agree*

This recommendation will help to prevent/reduce alcohol use disorders in the population.	**6 (43%)**	0 (0%)	2 (14%)	**6 (43%)**	0 (0%)
This recommendation will be relevant to my professional practice.	**5 (36%)**	0 (0%)	**5 (36%)**	4 (29%)	0 (0%)
This recommendation will be useful to my professional practice.	**7 (50%)**	0 (0%)	4 (29%)	3 (21%)	0 (0%)
This recommendation is feasible to introduce.	**6 (43%)**	0 (0%)	5 (36%)	3 (21%)	0 (0%)

"People assessed as alcohol dependent should be referred to an appropriate specialist alcohol treatment service."

"Best suggestion for specialist services to get referral, assess and then decide course of action with young person. Services are able to do age appropriate work and measure outcomes."