

**National Institute for Health and Clinical Excellence**

**PUBLIC HEALTH PROGRAMME–ALCOHOL-USE DISORDERS (PREVENTION)  
 Consultation on the Draft Guidance from 13<sup>th</sup> October – 10<sup>th</sup> November 2009  
 Comments to be received no later than 5pm on 10<sup>th</sup> November 2009**

**Stakeholder Comments**

Please use this form for submitting your comments to the Institute.

1. Please put each new comment in a new row.
2. Please insert the **section number** in the 1<sup>st</sup> column. If your comment relates to the document as a whole, please put '**general**' in this column

<b>Name:</b>		<b>Helena Chambers</b>
<b>Organisation:</b>		<b>Quaker Action on Alcohol and Drugs (QAAD)</b>
<b>Section number</b>  Indicate <b>section number</b> or ' <b>general</b> ' if your comment relates to the whole document	<b>Page Number</b>	<b>Comments</b>  Please insert each new comment in a new row.
Section 3.5, recommendations 1-2	Page 19	<p>We agree with the PDG's cogent summary of the evidence relating to price and availability. We strongly support all its recommendations relating to price and availability, and all the actions it suggests. A minimum price per unit of alcohol is the only effective method of tackling the problems of over consumption and misuse. There is strong likelihood of displacement to other cheap beverages if partial measures are adopted. A harm-indexed method of pricing across all beverages is necessary if regular consumption over health guidelines is to be tackled. Current figures suggest that numbers so affected are around 10 million.</p> <p>We believe it is particularly critical for the law to be amended to include a public health objective in decisions relating to licensing and outlets. This enables effective decisions to limit harm that are locally sensitive. It also places the availability of alcohol in its proper policy context as a health issue, rather than centering it in DCMS and crime and disorder agendas.</p>

Please add extra rows as needed

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Section 3.11.	Page 20	We strongly agree with Recommendation 4 as regards limitations on alcohol advertising. However, we would go further and endorse Alcohol Concern's proposal that pre-watershed advertising of alcohol no longer take place on television. We believe the associative evidence between children's recognition of advertising and use is sufficiently strong to take a precautionary approach.
	Page 21	We agree with both the recommended and the actions on the conditions for licensing. We further agree that policies relating to preventing under-age sales need to be appropriately resourced if they are to be successful.
	Page 21-22	We agree with these recommendations regarding interventions at all tiers of need. Given the extent of under-assessment and unmet need at present, resourcing will once again be an issue. We would recommend that benchmarking and progress towards goals be part of the commission plan. We would also recommend ring-fenced and/or priming funding, given that alcohol tends to be subordinated to other health needs.

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	Page 22-23	We agree with the recommendations for support to 10-15 year olds. We are aware of a paucity of specialist provision for children with high needs and would like to see piloting work developed to support this vulnerable group.
	Page 23	We welcome the recommendations 7 and 8 for screening and appropriate support for 16-17 year olds.

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

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