National Institute for Health and Clinical Excellence

Alcohol dependence and harmful alcohol use
Guideline Consultation Comments Table
24 June 2010 – 19 August 2010

No	Type	Stakeholder	Order No	Doc	Sec. No	Page No	Comments Please insert each new comment in a new row.	Developer's Response Please respond to each comment
212	SH	AERC Alcohol Academy, The	29.01	FULL	General	General	In the NICE alcohol prevention guidance it states in Recommendation 5: *Commissioners should include formal evaluation within the commissioning framework so that alcohol interventions and treatment are routinely evaluated and followed up. The aim is to ensure adherence to evidence-based practice and to ensure interventions are cost effective.* We fully support the prevention guidance in this recommendation, as the Academy believes evaluation is a critical part of effective commissioning. Therefore the dependence and harmful use guidance should also include this recommendation. This is in fact more important as treatment involves more complicated and expensive approaches than are required for preventative approaches which are harder to evaluate in terms of outcomes (i.e demonstrating something was 'prevented').	Thank you for your comment. However, this is a clinical guideline (rather than public health guidance) aimed at clinicians not commissioners. NICE is currently developing specific commissioning guidance for alcohol which will deal with the matter you raise.
213	SH	AERC Alcohol Academy, The	29.02	FULL	5.11	120	The Academy believes there are a number of further areas of research which require attention to support the knowledge base of effectiveness of alcohol treatment and prevention approaches. The Academy has found that strategic alcohol leads and commissioners often identify that specialist needs face certain population groups who as MoCAM acknowledges, needs specialised treatment approaches. For example, older people (over 65) face a range of	Thank you for your comments. The focus of NICE recommendations is on the efficacy of interventions. Your recommendations suggest a different programme of research focused on needs.

							physiological and social factors which mean alcohol misuse can have disproportionate and varied impacts. For instance, older people are less likely to be able to access services, be more affected by lower quantities of alcohol, more likely to be taking prescription medication and face further prejudice and assumptions into the efficacy or worth of alcohol treatment. The Academy has been working with a number of professionals and experts in this area and it is clear there is a need for further research and development, including in regard to specialised treatment approaches. Another age category of concern may be those in the 55-65 age group, sometimes referred to as 'young olds' – those facing significant changes such as retirement, other health conditions etc will also need specialised considerations for which there has been little research. Addressing combined alcohol and drug use, particularly powder cocaine and new legal highs is also an area of little research. Combined alcohol and cocaine use, which has experienced a significant rise over the last decade, produces a new substance 'cocaethylene'. This has been linked with significantly increased risk of sudden death, liver damage and propensity to violence. The Academy believes that treatment and prevention for alcohol misuse must better recognise combined drug taking behaviours. Further research is needed to support this.	
214	SH	Alcohol and Drug Service, The	28.01	Full	general	general	Overall we think that this draft contains a balanced overview of research evidence and a clear interpretation of how that can best be applied to practice within the MoCAM framework. Below are a few points where we think clarification may be needed.	Thank you for your comment.
215	SH	Alcohol and Drug Service, The	28.02	Full	5.2	95	[Also GENERAL] **Regarding Equality of Opportunity** A positive correlation is noted between severity of dependence & alcohol related problems & so the level of care need & link to appropriate stepped care interventions. However it is noted that this can vary with socio-economic and co-morbid factors. It may be appropriate to consider	Thank you; we agree with this comment and in a number of points in the guideline we have taken into account these factors in developing our recommendations.

							other factors here that increase level of care need such as race (need for interpreters, cultural awareness, attitudes, taboos), disability (complications in accessing/participating in treatment due to speech, sight or hearing problems), age as in older age (deteriorating health and mobility, generational attitudes etc.).	
216	SH	Alcohol and Drug Service, The	28.03	Full	5.20.12	144	This section describes how the level 2 assessment is not necessarily the second assessment but do not think that this is clear in the Short version and think that calling it level 2 will lead to the expectation that this is its position in a care pathway also confusion with MoCAM. No need for it to be given a level descriptor rather the setting and conditions that indicate its use.	Thank you for your comment. The level descriptor helps label the assessment without having to fully outline the title. We will therefore be leaving it in the guideline.
217	SH	Alcohol and Drug Service, The	28.04	Full	5.20.12	143 & 145	[Figure 4] Confusion of terms in with use of tier 2 & 3 referring to services rather than as defined in MoCAM to refer to interventions, so that a service may offer tier 2 & 3 interventions. Point raised within document in 5.3.2 p 97	Thank you for your comment; we have changed the text so that it refers to interventions rather than services.
218	SH	Alcohol and Drug Service, The	28.05	Full	5.27.1.1	195	The identifier "who typically drink over 15 units per day, and/or who score more than 20 on the AUDIT, consider-" seems inconsistent with the guidance that AUDIT is used for ' case identification & initial assessment .. ' and SADQ to assess presence & severity of dependence (5.19.2 p137) and also the 4 levels of assessment detailed, where assessment of presence and severity of alcohol dependence is stage 2, and AUDIT stage 1. (Also in section about level 2 assessment p150.) The order of this comment is also inconsistent with the care pathway diagram on p152 where use of AUDIT precedes the assessment that includes use of SADQ and units per drinking day. Hence perhaps the identifier should read 'typically drinks over 15 units a day & or scores 16 or more on SADQ'.	Thank you for your comment. It is correct that AUDIT score is recommended as an initial assessment tool. It is mentioned here as a method of identifying which patients may require "assessment for and delivery of a community based assisted withdrawal." We believe this will be useful in primary care to determine a threshold for further assessment as primary care personnel may not be familiar or use SADQ. However they are advised to use AUDIT as the step before use of SADQ or referral as in the care pathways in figures 5 and 6.
219	SH	Alcohol and Drug Service, The	28.06	NICE	1.3.2	8 & 17	Point as above	Sorry but we are not sure what point you are referring to.
220	SH	Alcohol and Drug Service, The	28.07	Full	6.21.3	303 -305	We wonder about the assumption (for costing) that the recommended therapies will be delivered by clinical psychologists at a cost of £75 per hour. Our experience is that such therapies are delivered by Alcohol Practitioners/Drug and Alcohol Practitioners with a variety of	Thank you for your comment. The costing adopted here is a conservative one, in that it costs the intervention at towards the higher end of the costs for routine provision. Other staff groups may result in

							professional qualifications (General and mental nursing, counselling, social work, community work etc.) and specific further training at a lower hourly cost.	lower costs but as our purpose was primarily to inform the GDG of the relative costs of the interventions we do not think we need to adjust these costs.
221	SH	Alcohol and Drug Service, The	28.08	Full	5.20.12	144	Relating to competence of practitioners and linking to the above point, mention is made of DANOS and of varying degrees of competence, specialist skills and expertise needed but little detail is given on this. Does it need more clarity and definition?	Thank you for your comment but more clarification and definition would be beyond the scope of this guideline.
222	SH	Alcohol and Drug Service, The	28.09	Full	5.21.1	148	[Figure 5] Possible inconsistency of terminology – ' refer to specialist assessments' – which assessment as level 2, 3, & 4 are all specialist. Should this read 'specialist service' as used elsewhere – if so should this term also be defined – is it a service which focuses on alcohol(& Drugs), could it be 3rd sector or is it medical/NHS?	Thank you. The issue is covered by stating that individual practitioners should be trained and competent. We do not think it would be helpful to specify the "type" of service as this is covered in the introduction and scope.
223	SH	Alcohol Focus Scotland	43.01	NICE	General	General	Alcohol Focus Scotland will not be responding to the questions posed throughout the consultation document, but following consultation with our members, we would like to raise concerns with NICE around some aspects of the guidance. The guidance states 3 categories of drinkers. The first two - mild and moderate, are not credited as being the embryonic stage for the third category – severe. Given the difficulties for many drinkers in identifying or acknowledging that they have a problem, we feel this is an oversight.	Thank you. The guideline refers to hazardous, harmful and dependent drinkers in accordance with ICD-10 and WHO guidance. Within dependence there are moderate and severe categories. However, it is acknowledged that these cut offs are arbitrary in a condition that is in reality a continuum. Also many of the people with milder alcohol use disorders do not progress to the more severe forms as discussed in the introduction. Hence we recommend different levels of intervention for people at different severities of problems throughout the guidelines.
224	SH	Alcohol Focus Scotland	43.02	NICE	General	General	It is clear that ABIs identify those in need of further help with the NICE guidance referring to specialist alcohol services as a referral point, but without actually stating who this service is. For clarity, we feel it would be helpful to give examples of who some of these specialist services are.	Thank you but it is not for a NICE guideline to give examples of named or specific services.
225	SH	Alcohol Focus Scotland	43.03	NICE	General	General	The guidance refers to NHS based services and also gives an acknowledgement of AA services for support, but there does not appear to be any mention of services provided by	Thank you but the guideline is explicit in referring to both NHS provided and NHS funded services. Other non-NHS funded

							local alcohol services/community based counselling services, many of which are provided via third sector. We recognise that services provided by voluntary services make-up a lesser proportion of the total alcohol services available in England and Wales compared to the situation in Scotland, but we feel this is a significant omission which produces a distorted picture of alcohol service delivery.	services may wish to adopt the guideline.
226	SH	Alcohol Focus Scotland	43.04	NICE	General	General	The 'flowchart' outlined for a service user to receive care is very helpful, but in reality not everyone will fit neatly into the steps outlined particularly when delays are experienced by service users in accessing specialist help e.g. gaining an appointment with a psychologist or psychiatrist could take months. We feel this should be acknowledged.	Thank you. The flowchart has now been removed from the NICE guideline.
227	SH	Alcohol Focus Scotland	43.05	NICE	General	General	The NICE guidance looks at cost-effectiveness and suggests that "psychological services" lack evidence of success and are therefore considered not cost-effective. Alcohol Focus Scotland believes that looking at cost-effectiveness of an intervention is only one element and that the wider needs of problem drinkers also need to be considered. Some problem drinkers can require more extensive or complex support, with other social problems requiring attention, which a local alcohol service can greatly help with (such as housing issues or confidence building re employment etc.)	Thank you. However, this is not the case – please see the recommendations for psychological interventions.
228	SH	Alcohol Focus Scotland	43.06	NICE	General	General	Further, we believe the evidence shows that it makes economic sense to invest in services supporting problem drinkers as there are knock-on benefits for their families and communities, employers etc. Indeed, partners or 'carers' of problem drinkers are increasingly being supported by local alcohol services, with much evidence that shows when they seek support, it has a positive knock-on effect on the drinker (Professor Richard Velleman of the University of Bath. Presentation on Interventions to break the cycle of harm, Conference on April 2010.). We would therefore like to see some acknowledgement of this in the Guidelines.	Thank you but we had no convincing evidence of a direct effect on employment and families although we fully expect there to be benefits of the kind you outline.
229	SH	Alcohol Focus Scotland	43.07	NICE	General	General	There are limitations to ABIs for those with more complex needs or who require follow-up care, many of whom are currently referred to local alcohol services. We feel this point should be acknowledged in the Guidelines.	Thank you but we believe what you suggest is very clear in the range of increasingly complex interventions that we recommend in the guideline.

230	SH	Alcohol Focus Scotland	43.08	NICE	General	General	Alcohol Focus Scotland would be concerned with any report that did not take into account the work carried out by local alcohol services, which is much wider than a counselling (or "psychological service"), as this could imply that these services are not recognised or not effective. This could be detrimental to such services looking for future funding when they are indeed very much a useful and helpful community service.	Thank you but the focus of this guide is on effective healthcare interventions for alcohol misuse.
231	SH	Alcohol Focus Scotland	43.09	NICE	General	General	As evidenced in the Audit Scotland report, many local alcohol services have difficulty securing adequate funding, with routes being unduly complicated and often short term. We are concerned that funding may become even tougher over the next few years during the current financial recession. We fear that no acknowledgment of these services could be viewed negatively by local funders when savings are being sought. This would seriously impact on their delivery of services and ultimately on service users and their families.	Thank you but we feel that the role of local alcohol services providing the interventions described has been clearly highlighted throughout the guidelines.
232	SH	Alcohol Focus Scotland	43.10	NICE	General	General	Project Match and UK Alcohol Treatment Trial both showed that "although one treatment is no more effective than any other, the range of treatments available do elicit change, albeit not for every client". Another point of learning from these pieces of research is that whatever service is used, a key indicator of positive change for the services user was the quality of relationship that is established with the 'worker'. A short ABI is unlikely to allow time for a relationship to develop. We feel that the limitations of ABIs in this contact should be acknowledged.	Thank you but we have carefully reviewed the evidence for the differential effectiveness of psychological interventions in this guideline.
233	SH	Alcohol Focus Scotland	43.11	NICE	General	General	We have further concerns about the evidence for ABIs. The guidance refers to the cost-effectiveness of ABIs and suggests that the evidence is robust. We would like to highlight that international evidence around effectiveness of ABIs is based on a description and length of time which is different from that which is practiced in the UK which is usually a 5-10 min session. (see appendix)	Thank you. However, the evidence is that the range of interventions is different to that which you indicate in your comment. A key point is that the population appropriately treated by ABIs is not the population that is the focus of this guideline.
234	SH	Alcohol Focus Scotland	43.12	NICE	General	General	Furthermore, a WHO1 report states that brief advice programmes should be based around the behavioural	Thank you. However, the evidence is that the range of interventions is different to

[1] World Health Organisation. *Effective Interventions to reduce alcohol-related harm*, 2009.

							counselling framework known as “the 5 As” – number 5 is “arrange follow-up support and repeated counselling”.	that which you indicate in your comment. A key point is that the population appropriately treated by ABIs is not the population that is the focus of this guideline.
235	SH	Alcohol Focus Scotland	43. 13	NICE	General	General	APPENDIX From the recently published Alcohol: No Ordinary Commodity2- Chapt 14 Treatment and Early Intervention services: Subsection 14.3 Interventions designed for non-dependent high risk drinkers pgs 218-219 “With the increased interest in clinical preventive services in both developed and developing countries, early intervention programmes have been developed by the World Health Organisation and the national agencies facilitate the management of harmful drinking in primary health care and other settings. Following initial screen to identify risk levels the patient is referred either to a brief intervention or to more intensive specialized treatment. Brief Interventions are characterised by their low intensity and short duration, consisting of one to three sessions of counselling and education. The aim is to motivate high risk drinkers to moderate their consumption rather than promote total abstinence” In Chapt 14 subsection 14.2 pg 218 Researchers have identified more than 40 therapeutic approaches, called treatment modalities, which have been evaluated by means of random clinical trials (Miller et al 1995). Examples include motivational counselling, marital and family therapy, cognitive behavioural therapy, relapse prevention training, aversion therapy, pharmacotherapy and interventions based on the Twelve Steps of Alcoholics Anonymous. These modalities are delivered in a variety of settings including freestanding residential facilities, psychiatric and general hospital settings, outpatient	Thank you for highlighting these areas from this recent publication. As we have pointed out previously, these are outside the scope of this guideline.

[2] Professor Thomas Babor et al. *Alcohol: No Ordinary Commodity*, 2nd edition, 2010.

							programme and primary care” In sub section 14.4 Specialised treatment for persons with alcohol dependence pg 220 “A variety of therapeutic modalities are used within the context of outpatient and residential treatment services. The approaches with the greatest amount of supporting evidence are behavioural therapy, group therapy, family treatment and motivational enhancement (Edwards et al 2003). One example of behavioural therapy is relapse prevention, which focuses on coping with situations that represent high risk for heavy drinking.”	
236	SH	Association for Family Therapy and Systemic Practice (AFT)	21.01	All	General	General	AFT welcomes the recognition of the role of close relationships and addressed in this guideline for adults, children and adolescents who are dependent on alcohol or have harmful drinking, including the children of parents with alcohol problems. Systemic couple and family therapy training in the UK provides different levels of training for people to learn how to address complex relationship and issues associated with alcohol dependence and harmful use, by helping close relatives / support networks to build on their strengths, provide support, and find ways to change the problems so that they understand the needs of partners, parents and their children and begin to find ways to deal with these. Information can be found on the AFT website: *Training framework for family and relationship focused practice'.* The site also provides access to *Current Practice, Future Possibilities* as well as *Report on the evidence base of systemic family therapy*: www.aft.org.uk .	Thank you for your comment.
237	SH	Association for Family Therapy and Systemic Practice (AFT)	21.02	FULL	6.1	214	[Paragraph 3] Suggest that ‘systemic’ is included in the list of psychological interventions, given the value of systemic therapies in the recommendations. ‘Social approaches’ – It would be helpful to include ‘systemic’ therapeutic approaches to couples, families and networks – as well as addressing social issues.	Thank you for your suggestion. ‘Systemic’ has now been added to the list of psychological interventions in this chapter.
238	SH	Association for Family Therapy and Systemic	21.03	FULL	6.2.2	217	Therapeutic competences for systemic therapies should be included. See online: The Competences required to Deliver	Thank you for your comment – the reference here to Pilling, Roth and

		Practice (AFT)					Effective Systemic Therapies by Stephen Pilling, Anthony D. Roth and Peter Stratton. www.ucl.ac.uk/clinical-psychology/CORE/systemic_framework.htm#Map	Stratton (2010) is not to the competence frameworks but to a review of adherence and related issues. It therefore would not be appropriate to mention any specific set of competence frameworks.
239	SH	Association for Family Therapy and Systemic Practice (AFT)	21.04	FULL	6.5	221 -223	Whilst some services in the UK provide the models of systemic therapy recommended in this guideline, other models within UK training and practice for complex family problems include: Flynn, B (2010): Using systemic reflective practice to treat couples and families with alcohol problems. Journal of Psychiatric and Mental Health Nursing (in press). Asen, E + Scholz, M. (2010): Multi-family therapy. Concepts and techniques. Routledge. This model is for complex family problems including substance misuse.	Thank you for this information. However, as you will be aware there is no high quality evidence directly related to these approaches that could be included in the clinical review for this guideline.
240	SH	Association for Family Therapy and Systemic Practice (AFT)	21.05	FULL	6.21	299	Further information about the cost effectiveness of treatments for families and couples in the US are reported in Triston B Morgan and D. Russell Crane (2010): Cost-effectiveness of family-based substance misuse treatment. Journal of Marital and Family Therapy. March. This covers than alcohol and drug misuse treatments.	Thank you. The review includes one study that fulfils the guideline inclusion criteria (Fals-Stewart et al., 2006). This paper has been reviewed and is now included in the relevant guideline section and appendices.
241	SH	Association for Family Therapy and Systemic Practice (AFT)	21.06	FULL	6.26.1	325	[And NICE version 1.3.15 page 16] The importance of competency and supervision is important, but the use of manuals does need to be reviewed, eg Duncan, B. & Miller, S. (2006): Treatment manuals do not improve outcomes. In Norcross, Levant and Beutler (ed): Evidence-based Practices in mental health. Washington D.C., APA Press.	Thank you for your comment – we agree that supervision and competence are important. However, we do not accept that the reference you cite supports their argument, despite its title. The focus of the chapter is on the importance of non-specific factors, in particular, the therapeutic alliance but it does not contain a detailed review of the evidence to support their argument, rather it focuses on the conceptual case against manuals. Other evidence we have considered such as Roth et al (2010), Huppert et al (2006) and Schulte and Eifert (2002) does support the judicious use of manuals. It is also worth pointing out that the current Department of Health supported competence frameworks for

								psychological therapies are based on treatment manuals used in clinical trials.
242	SH	Association for Family Therapy and Systemic Practice (AFT)	21.07	NICE	1.1.2.5	11	Suggest that the parent-child relationship is included because of the impact on relationships and communications when drinking heavily.	Thank you for your comment; we have made the inclusion as you have suggested.
243	SH	Association for Family Therapy and Systemic Practice (AFT)	21.08	NICE	6	35	Related NICE guidelines address interventions needed for parents with alcohol problems: CG: Pregnancy and complex social factors PH: Social and emotional wellbeing of vulnerable pre-school children: home-based interventions	Thank you. This has been added under the related guidance heading.
244	SH	Association of Higher Education Programmes on Substance Misuse	23.01	Full	6.21.5.7	307	The main limitation of this report is that while it thoroughly investigates the relative effectiveness of different psychological treatment modalities, it takes little account of those factors which are known to affect treatment outcomes to a much greater extent than the choice of treatment modality. These are: (a) Individual therapist competence (Bergin 1997, Budd and Hughes, 2009, Project MATCH Research Group 1998) (b) Therapist allegiance to treatment modality (Benish et al. 2008, Berman, Miller and Massman 1985, Henry et al. 1993, Horvath and Bedi 2002, Luborsky et al. 1999, Luborsky et al. 2002, Martin et al. 2000, Robinson et al. 1990, Wampold 2001, Wampold et al. 1997) (c) Client choice of treatment modality (Beck, 1976, Horvath and Bedi 2002, Martin et al 2000, Waddington 2002) (d) The therapeutic alliance (Horvath and Symonds 1991) Client choice of treatment is acknowledged in the Report on P220, but does not appear to be taken into account in the recommendations for psychological treatment on pages 306-308. Therapist allegiance on its own is estimated by some authors to account for far more of the variance in outcome than choice of treatment modality (Luborsky et al. 1999,	Thank you for your comments. The review does in fact take into account a number of the factors that you list in your comments. However, we did not find specific evidence in our reviews that would support detailed recommendations on these areas in the field of alcohol. Many of the references that you cite are not specific to alcohol. We therefore were cautious in making too specific recommendations where we lacked evidence. Of course, a number of the factors you identify such as therapist competence will be of importance for all modalities of treatment – hence the GDG decision to refer to this directly in the recommendations. We agree that the range of choice of evidence based treatments is important (and not only for psychological interventions) and we have therefore amended the recommendations accordingly. However, we do believe that we have been unduly restrictive in our choice. The evidence base was often quite limited and there was a lack of direct

							Martin et al. 2000, Luborsky et al. 2002). Since the four factors listed above account for a substantial amount of the variance in outcome in therapy studies, and the studies used by the Report to derive its conclusions did not control for any of them, the Report's conclusions must be treated with caution, and its estimates of the efficacy of any single treatment modality should be regarded as approximations rather than as exact values. In the Report's analysis of psychological treatment modalities, evidence is presented on the relative efficacy of the following treatments (see pages 222-223): Cognitive behaviour therapies Social behavioural and network therapies Behavioural therapies Twelve-step facilitation Motivational enhancement therapy Social network and environment-based therapies Counselling Couples therapy Family-based interventions Psychodynamic therapy Mindfulness meditation For all these therapies, the Report reveals evidence of relative equivalence of effectiveness, with no clear evidence that any one therapy is more effective than any other (page 214 lines 37-38 and from page 245 line 34 to page 246 line 4). It appears that in the absence of clear evidence of the superiority of any single therapy, the GDG have selected treatments to recommend on the basis of whether they have been compared in effectiveness to "treatment as usual" or a placebo condition in an RCT, irrespective of whether they have shown themselves to be as effective as one of the recommended therapies (page 298 lines 37-44). This is an inappropriately restrictive criterion to use, given the widespread findings of therapeutic equivalence and the	comparisons of a number of different interventions. The GDG considered the strength and weight of the evidence for effectiveness of the various interventions against waitlist/no intervention, treatment as usual and other active interventions. The GDG view was that for a treatment to be recommended we would want to see evidence of effect in all these areas. These criteria in combination with a review of the individual comparisons and the trial populations informed the GDG's decision. This has been clarified in the 'from evidence into recommendations' section of the chapter. In reference to therapist alliance, a number of the references you cite in support of your argument are not directly concerned with the therapeutic alliance per se but rather with the argument that common factors are important and significant in bringing about change. However, this is, in our view not well established, for example you cite the Benish et al (2008) paper as an example but neglect to cite the well-argued refutation of that by paper by Ehlers et al (2010) which identified a significant number of problems with the Benish paper, including most importantly, the selective citation of key papers. The limitations of other studies such as Martin et al (2002) are already dealt with in this chapter.

							failure to control for important known confounding factors. The recommendations on paragraph 6.21.5.7 should therefore be extended to include all the therapies listed above. This point is especially important if commissioners of treatment services use the final guidelines to decommission well-founded treatments staffed by therapists who have given their allegiance to the treatment modality being used, and chosen by a significant proportion of their client base. In such cases, the known factors of therapist allegiance and client choice would predict that treatment outcomes would be negatively affected.	
245	SH	Association of Higher Education Programmes on Substance Misuse	23.02	Full	6.21.5.7 - 6.21.5.8	307	Given the approximate equivalence of outcome for the therapies listed above, and the known substantial effect of the factors of therapist allegiance and client choice, it would be appropriate to add a recommendation between 6.21.5.7 and the existing 6.21.5.8 as follows: Therapists should be free to select whichever of the approved therapies they believe themselves to be most effective in delivering, and clients should be given the maximum possible choice between available therapies that is practicable in the circumstances.	Thank you for your comment. However, in our view this addition would be unhelpful as it could be taken to suggest that a primary determinant of treatment choice should be the therapist beliefs about effectiveness. Surely the client should be the primary determinant of treatment choice and it should be for the healthcare professional to support the client in making a choice by taking into account a range of factors.
246	SH	Association of Higher Education Programmes on Substance Misuse	23.03	Full	5.22.1.2	169	This recommendation states that NHS-funded staff should be competent to identify drinking problems in patients and refer them to appropriate treatment services. This is an excellent recommendation, and one which will do immense good if fully implemented. However, it would be appropriate to add that all staff who are likely to come into direct contact with alcohol-misusing patients should receive a basic training in dealing with the problem. An appreciation of the basic principle of Motivational Interviewing would be valuable in this context. Even a minimal understanding of these principles would be an improvement on telling patients	Thank you for your comment. While training all NHS staff to deliver motivational interventions would be a laudable goal, the GDG felt that basic proficiency in and widespread implementation of identification and referral (as well as brief intervention dealt with by the public health guideline) would be a more achievable starting point.

							"You should stop drinking, it's bad for you"; which is an all too common response from NHS staff to patients with alcohol problems.	
247	SH	Association of Higher Education Programmes on Substance Misuse	23.04	Full	5.28.11	212	Residential rehabilitation is recommended only for homeless people. However, there does not appear to be any research as to which categories of client are likely to benefit more from residential treatment than from community treatment. Until such research becomes available, it is premature to deny the possible benefits of residential treatment to all but homeless people. Recommendation 5.28.11 should therefore be extended to read: For people who are alcohol dependent, consider offering residential rehabilitation for a maximum of 3 months to those who are homeless, or who are considered on assessment to be likely to have difficulties in recovering from alcohol dependence while living in their current situation due to social or psychological factors. Help homeless service users to find stable accommodation before discharge. Examples of factors which might justify residential rehabilitation treatment include a drinking partner, insecure accommodation or a social network composed exclusively of alcohol misusers.	Thank you for your comment. The GDG took the view that in the absence of the superiority of residential over community based treatment, and a lack of evidence of which groups may be more likely to benefit from residential, and in the light of the significant cost differential between community and residential treatment, the indications for residential treatment should be restricted as specified.
248	SH	Association of Higher Education Programmes on Substance Misuse	23.05	Full	6.21.5.4	306	This paragraph recommends that psychological interventions should be delivered in accordance with a relevant evidence-based treatment manual. However, this recommendation is not itself evidence-based. What little evidence there is on the effectiveness of manual-based therapy is in fact negative (Messer and Wampold 2002, Wampold 2001, Westen et al. 2004). Until such time as evidence for the superior effectiveness of manual-based therapy becomes available, this recommendation should be deleted. Note that if adherence to a manual conflicts with therapist allegiance or client choice of therapy, there is already clear evidence that following the manual would have a negative	Thank you. However, we do not agree that the recommendation is not evidence based. Nor do the references you cite support your position. For example you state that "What little evidence there is on the effectiveness of manual-based therapy is in fact negative" and you quote Westen et al. (2004) in support of this. We assume that you are referring to Westen et al., 2004, Psych Bull Vol. 130, No. 4, 631–663 but in their introduction to the review of the use of manuals they state "Furthermore, therapist adherence to manuals has proven only variably

							effect on client outcomes.	associated with outcome—sometimes positively correlated, sometimes negatively, and sometimes not at all." As you will see from this quote it is inaccurate to describe the evidence simply as negative. Furthermore, evidence not included in the reviews you cite, for example, using a process-outcome method has demonstrated that the judicious use of manuals is associated with positive outcomes (e.g. Huppert, et al, (2006) Cog. and Behav. Prac.13 198-204 Schulte D. and Eifert, G.H. (2002) Clin. Psych. Science and Practice 9 312-328). Others [Roth et al, (2010) Behav Cog Psych] have also recently argued that the absence of training and supervision (based on manuals) and lack of outcome monitoring may account for the failure to replicate the results of RCTs in routine practice.
249	SH	Association of Higher Education Programmes on Substance Misuse	23.06	Full	6.21.5.5	306/7	This paragraph calls for routine outcome monitoring. This should include measures of alcohol consumption in order to capture any improvement or deterioration in the client's level of misuse, separately from their drinking status in terms of being abstinent/non-abstinent. In addition, at the start and end of treatment, it would be a good idea to include a measure of general well-being such as the CORE (www.coreims.co.uk) in order to monitor outcomes other than those directly related to drinking. If treatment reduces a client's life problems or increases their functioning in any way, it may be considered to have benefitted them independently of their drinking profile, and it would be useful to know about such outcomes when evaluating treatments and services.	Thank you for your comment. A review of outcome monitoring tools was conducted and is reported in section 5.25.10. The GDG recommend the Alcohol Problems Questionnaire as a measure of alcohol-related problems in addition to drinking status measures. The APQ has adequate reliability and validity data in an alcohol dependent clinical population. A review of non-alcohol related measures was outside the scope of our reviews and so CORE was not considered.
250	SH	Association of Higher Education	23.07	Full	6.26.11.2	334	The recommendation that children and young people with alcohol problems should be assessed by the Child and	Thank you for your comment. We accept that current provision may be varied but

		Programmes on Substance Misuse					Adolescent Mental Health Services (CAMHS), depends on the services being adequately resourced and their staff adequately trained to take on this role. We are not convinced that this is always the case at the moment, and suggest that it may be premature to implement this recommendation across the country until the CAMHS are ready for it.	the purpose of NICE guidelines is to set standards and we think it is important that CAMH services should be providing these assessments. We hope that this issue will be addressed in the NICE commissioning guidance on alcohol.
251	SH	Association of Higher Education Programmes on Substance Misuse	23.08	Full	6.2.6.11.7	335	Recommendations for the treatment of children and young people have been developed in the absence of a comprehensive evidence base specifically relating to children or young people, and hence the GDG has made the assumption that whatever works for adults will work for children (paragraph 6.26.9, page 333). However, this approach has not been consistently followed when it comes to recommendations for psychological treatment (paragraph 6.26.11.7, page 335). The recommendation in paragraph 6.26.11.7 should therefore be extended to include all psychological treatments recommended by these Guidelines for adults.	Thank you for your comment. In the case of pharmacological interventions, we had very little evidence and were therefore required to extrapolate from the adult data set. However, there is more and better quality evidence for children and young people evidence (drawing on the conduct disorder literature for alcohol and drug misuse) that CBT and multi-dimensional family therapies are effective. The GDG therefore did not need to rely on extrapolation alone but had a more directly relevant evidence base.
252	SH	Association of Higher Education Programmes on Substance Misuse	23.09	NICE	KPIs	7	This section of the Summary Report talks about promoting abstinence for people with moderate and severe alcohol dependence, and does not mention any other possible treatment goal. However, the Full Report contains a more detailed and sophisticated analysis of suitable treatment goals (paragraph 5.22.1.8, pages 170/171). Since it is likely that many staff in treatment agencies will read only the Summary Report, this should be updated to bring it into line with the recommendations in the Full Report.	Thank you for your comment; the paragraph you refer to in the full guideline appears in the NICE summary as recommendation 1.2.2.1.
253	SH	Association of Higher Education Programmes on Substance Misuse	23.10	Full	5.28.11	212	Add a Recommendation for Research: What social and psychological factors in a patient's life affect the relative effectiveness of community compared to residential rehabilitation treatment? This should consider such factors as the presence of a drinking partner, employment and housing status, criminal and mental health	Thank you but the GDG did not concur that this is a research priority. They also considered the question as currently worded posed considerable problems for study design.

							history, a social network composed exclusively of alcohol misusers and any other factors considered likely to be relevant by experts in rehabilitation treatment.	
254	SH	Association of Higher Education Programmes on Substance Misuse	23.11	Full	6.21.5.4	306	Add a Recommendation for Research: Do manualised therapists achieve better treatment outcomes than non-manualised therapists with an equivalent training and equal access to supervision?	Thank you for your comment. We do not think this would be a feasible study either on clinical grounds (would patients agree to participate or would clinicians make such a referral?), ethical grounds (could any therapist agree to never vary from a manual or on the other side totally disregard the content of a key treatment manual?) or from the perspective of research design (what would be the role of the supervisor in the different approaches and how would it be accounted for?).
255	SH	Association of Higher Education Programmes on Substance Misuse	23.12	Full	6.21.5.7	307	Add a Recommendation for Research: Are the following treatments more effective than a placebo for treating alcohol dependent clients? Counselling Psychodynamic Therapy Motivational Interviewing Mindfulness Meditation Twelve-Step Facilitation Family-Based Interventions	Thank you. We have made a recommendation regarding a possible research programme in psychological interventions. What you suggest would not be feasible within a single research recommendation.
256	SH	Association of Higher Education Programmes on Substance Misuse	23.13	Full	6.21.6.1	308	Add a Recommendation for Research: Do contingency management programmes for alcohol dependence lead people who have not been alcohol dependent to develop or simulate alcohol dependence in order to access the incentives provided by the programme?	Thank you for your comment. The GDG does not feel that this would be a valuable research recommendation. We have found no evidence to support this idea in the substance misuse literature.
257	SH	Association of Higher Education Programmes on Substance Misuse	23.14	Full	6.21.6	308	Add a Recommendation for Research: What is the potential effectiveness of non-medical treatments for detoxification such as weaning (Wright and Thompson 2002)?	Thank you for your comment. The GDG did not feel that this would be a valuable research recommendation. The experience of the GDG is that this does not work for detoxification but that it might be a reasonable approach for some

								people as a way of a reducing consumption prior to detoxification. However, we do not agree that it is non-medical since alcohol is a drug and some people would need to be monitored for risk of complications.
258	SH	Association of Higher Education Programmes on Substance Misuse	23.15	Full	6.21.6	308	Add a Recommendation for Research: What is the role of "recovery capital" (wiredin.org.uk 2010) in promoting long-term recovery and rehabilitation from the effects of alcohol misuse?	Thank you for your comment but this is a public health issue and outside of the scope of the guideline.
259	SH	Association of Higher Education Programmes on Substance Misuse	23.16	Full	General	General	References Beck, A. T. (1976). *Cognitive Therapy and the Emotional Disorders.* New York: International Universities Press. Benish, S. G., Imel, Z. E. and Wampold, B. E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: a meta-analysis of direct comparisons. *Clinical Psychology Review,* 28, 746-758. Bergin, A. E. (1997). Neglect of the therapist and human dimensions of change: a commentary. *Clinical Psychology: Science and Practice,* 4, 83-89. Berman, J. S., Miller, R. C., and Massman, P. J. (1985). Cognitive therapy versus systematic desensitization: is one treatment superior? *Psychological Bulletin,* 97, 451-461. Best, D. (2010). *Establishing a Recovery Philosophy in Drug Treatment Services and Systems.* University of the West of Scotland/Wales Assembly Government. Budd, R. and Hughes, I. (2009). The Dodo Bird verdict-controversial, inevitable and important: a commentary of 30 years of meta-analyses. *Clinical Psychology and Psychotherapy,* 16, 510-522. www.coreims.co.uk Henry, W. P., Strupp, H. H., Butler, S. F., Schacht, T. E. and Binder, J. (1993). Effects of training in time-limited	Thank you for your references.

							psychotherapy: changes in therapist behaviour. *Journal of Consulting and Clinical Psychology,* 61, 434-440. Horvath, A. O. and Bedi, R. P. (2002). The alliance. in J. C. Norcross (ed.), *Psychotherapy relationships that work: therapist contributions and responsiveness to patients* (pp 37-69). New York: Oxford University Press. Horvath, A. O and Symonds, B. D. (1991). Relation between working alliance and outcome in psychotherapy: a meta-analysis. *Journal of Counseling Psychology,* 38, 139-149. Luborsky, L., Diguer, L., Seligman, D. A., Rosenthal, R., Johnson, S., Halperin, G., Bishop, M. and Schweitzer, E. (1999). The researcher's own therapeutic allegiances: a 'wild card' in the comparison of treatment efficacy. *Clinical Psychology: Science and Practice,* 6, 49-62. Luborsky, L. Rosenthal, R., Diguer, L., Andrusyna, T. P., Berman, J. S., Levitt, J. T., Seligman, D. A. and Krause, E. D. (2002). The Dodo Bird verdict is alive and well- mostly. *Clinical Psychology: Science and Practice,* 9, 2-12. Martin, D. J., Garske, J. P. and Davis, K. M. (2000). Relation of the therapeutic alliance with outcome and other variables: a meta-analytic review. *Journal of Consulting and Clinical Psychology,* 68, 438-450. Messer, S. B. and Wampold, B. F. (2002). Let's face facts: common factors are more potent than specific ingredients. *Clinical Psychology: Science and Practice,* 9, 21-25. Project MATCH Research Group (1998). Therapist effects in three treatments of alcohol problems. *Psychotherapy Research,* 455-474. Robinson, L,A., Berman, J. S. and Neimeyer, R. A. (1990). Psychotherapy for the treatment of depression: a comprehensive review of controlled outcome research. *Psychological Bulletin,* 108, 30-49. Waddington, L. (2002). The therapy relationship in	

							cognitive therapy: a review. *Behavioural and Cognitive Psychotherapy,* 30, 179-191. Wampold, B. E. (2001). The great psychotherapy debate: models, methods and findings. Mahwah, NJ: Erlbaum. Wampold, B. E., Mondin, G. W., Moody, M., Stich, F., Benson, K. and Ahn, H. N. (1997). A meta-analysis of outcome studies comparing bona fide psychotherapies: empirically 'all must have prizes'. *Psychological Bulletin,* 122, 203-215. Westen, D., Novotny, C. and Thompson-Brenner, H. (2004). The empirical status of empirically supported psychotherapies: assumptions, findings and reporting in controlled clinical trials. *Psychological Bulletin,* 30, 631-633. http://wiredin.org.uk/community/blog/entry/2661/the-recovery-academy Wright, N. and Thompson, C. (2002). Withdrawal from Alcohol Using Monitored Alcohol Consumption: a Case Report. *Alcohol and Alcoholism*, 37, 344-346.	
260	SH	British Association for Counselling & Psychotherapy	33.01	Full	General	General	BACP thanks NICE for the opportunity to comment on this draft guideline and is pleased to see that a greater emphasis has been placed on including family and carers of those with alcohol dependence and harmful alcohol use.	Thank you for your comment.
261	SH	British Association for Counselling & Psychotherapy	33.02	Full	5.28.11	212	BACP would suggest that the following research recommendation is included: What social and psychological factors in a patient's life affect the relative effectiveness of community compared to residential rehabilitation treatment? This should consider factors such as the presence of a drinking partner, employment and housing status, criminal and mental health history, a social network composed exclusively of alcohol misusers and any other factors considered relevant by experts in rehabilitation treatment.	Thank you but the GDG did not accept this as a research priority. They also considered the question as currently worded posed considerable problems for study design.
262	SH	British Association for Counselling & Psychotherapy	33.03	Full	6.21.5.4	306	BACP would also suggest a further research recommendation: Do manualised therapists achieve better treatment	Thank you for your comment. Please refer to the response for comment 254.

							outcomes than non-manualised therapists with an equivalent training and equal access to supervision?	
263	SH	British Association for Counselling & Psychotherapy	33.04	Full	5.28.11	212	The guideline recommends that 'for people who are alcohol dependent and homeless, consider offering residential rehabilitation for a maximum of 3 months'. It appears that residential rehabilitation is recommended only for homeless people. BACP wish to seek clarification as to why only homeless people should receive such treatment. There does not appear to be any research as to which categories of client are likely to benefit more from residential treatment than from community treatment.	Thank you for your comment. The GDG took the view that in the absence of the superiority of residential over community based treatment, and a lack of evidence of which groups may be more likely to benefit from residential, and in the light of the significant cost differential between community and residential treatment, the indications for residential treatment should be restricted as specified.
264	SH	British Association for Counselling & Psychotherapy	33.05	Full	6.2.6.11.7	335	BACP acknowledges that recommendations for the treatment of children and young people have been developed with a limited evidence base and that the guideline development group were required to 'extrapolate from a number of data sets which did not directly address the treatment brief alcohol related problems in children and young people including data on adults with alcohol problems (for the withdrawal management) and substance misuse and conduct disorder for the treatment interventions'. However, this approach has not been consistently followed in relation to recommendations for psychological treatment (paragraph 6.26.11.7, page 335), which are limited.	Thank you for your comment. Please refer to the response for Comment 251.
265	SH	British Association for Counselling & Psychotherapy	33.06	NICE	KPIs	7	This section of the NICE version mentions the promotion of abstinence for people with moderate and severe alcohol dependence, and does not mention any other possible treatment goal. However, the full report contains a more detailed and sophisticated analysis of suitable treatment goals (paragraph 5.22.1.8, pages 170/171). Since it is likely that many staff in treatment agencies will read only the NICE version, this should be updated to bring it into line with the recommendations in the full report.	Thank you for your comment; the paragraph you refer to in the full guideline appears in the NICE summary as recommendation 1.2.2.1.
266	SH	British Association for Counselling & Psychotherapy	33.07	Full	6.10.4	254	The guideline states that behavioural therapies were not as effective as other interventions (in this case couples-based therapies), however in the recommendations other therapies such as couples therapy, which was found to be more effective is not at the top of the recommendations as	Thank you for this comment. The recommendations are grouped by:- - Recommendations pertaining to all interventions - not specific to any intervention

							expected on pages 307 and 308. Other NICE guidelines seem to state the most effective therapies more prominently.	- Recommendations for specific interventions for harmful drinkers and mildly alcohol dependent We believe the recommendations for couples therapy appears prominently within this structure.
267	SH	British Association for Psychopharmacology	17.01	full	general	General	We are pleased that psychopharmacology is considered as an option for relapse prevention	Thank you for your comment.
268	SH	British Association for Psychopharmacology	17.02	full	General	General	We consider there needs to be more clarity on the management of detoxification related to the selection and dosing of medication	Thank you - we have made a number of amendments to our recommendations including more specific advice about dosing regimens to address your comment.
269	SH	British Association for Psychopharmacology	17.03	Full	General	General	We consider there needs to be greater emphasis on the essential role of the 'addictions specialist' psychiatrist in safely guiding prescribing, especially in the case of medical and/or psychiatric comorbidity which is so prevalent in this patient group.	Thank you for your comment. We agree but feel that the degree of specificity that you are suggesting is not appropriate for this guideline. NICE is currently developing specific commissioning guidance for alcohol and we draw your comment to the attention of the group developing that guidance.
270	SH	British Association for Psychopharmacology	17.04	Full	General	General	As for point three, we would wish the medical management of psychiatric comorbidity to be given more emphasis.	Thank you for this comment; as you will be aware from reading the guideline, the evidence for the management of any comorbidities is limited and we were therefore cautious about specific recommendations. We have though strengthened the recommendations linking this guideline to other NICE guidance for disorders which are commonly comorbid.
271	SH	British Association for Psychopharmacology	17.05	full	general	general	One issue of clinical importance has not been adequately covered here: **Role of alcohol in polydrug misuse; treatment and management issues** Quite frequently, clients who are addicted to opiates/opioids and who present themselves to both statutory and non statutory agencies misuse with alcohol as well. They are then typically prescribed with methadone/buprenorphine, and as a result they decrease significantly the use of illicit	Thank you for your comment; we agree and have added text to both the full and NICE guidelines.

							opiates/opioids. However, some of them continue misusing with alcohol and this may pose a number of problems in terms of interaction with maintenance treatment medications. No guidelines for treatment and management of these clients are currently available and the evidence from the literature is only minimal.	
272	SH	British Liver Trust	32.01	NICE	General	General	The British Liver Trust welcomes the opportunity to comment on this guidance. The Trust firmly agrees that current access to treatment services for people who are alcohol dependent and drink at harmful levels is very poor. Overall, we believe the guidance is very good, definitive and exhaustive guidance. We would like to know what the impact would be following the Government's White Paper. GP Commissioning is a key component to this and we would expect them to embrace any guidelines on alcohol treatment services by providing adequate funding. We have a number of patient enquiries who request information on alcohol treatment services, more often then not, these people need signposting to these services. Stigma is a huge issue for this cohort of people and is something that needs to be addressed not only be society in general, but in the healthcare system itself. The majority of callers enquiring about alcoholic liver disease (ALD) report facing stigma at some point in their care pathway.	Thank you for your comment.
273	SH	British Liver Trust	32.02	NICE	General	General	The British Liver Trust believes that care and treatment services should be viewed as a continuum or cycle. A linear approach to providing appropriate care for these patients would be short-sighted and potentially cost more. Clinicians and healthcare professionals need to be made aware that patients are very likely to re-enter the care and treatment pathway if the care received hasn't worked and they still harbour an addiction to alcohol, therefore there needs to be appropriate and consistent monitoring mechanisms in place to ensure that this process is seamless and workable.	Thank you. We agree and feel that this coordination of seamless care has been highlighted in the guidance.
274	SH	British Liver Trust	32.03	NICE	General	General	The British Liver Trust firmly believes, and is agreeable with the guidelines, that psychological support is fundamental to the success of alcohol treatment services and should be	Thank you for your comment.

							fully integrated into any continuous care pathway and treatment service. In addition we believe services need to be enhanced so that they are joined up in their approach to treating individuals and information is shared appropriately. This is particularly true for patients who are suffering from co-morbidities and are alcohol dependent. We have examples of people who, because they have not addressed their dependence or addiction to alcohol, they effectively drop out of the healthcare system on all levels, including their liver health care. Lack of Psychiatry input into District General Hospitals. The main problem in this whole area is that there is a major shortage of liaison and addiction psychiatry input into Accident & Emergency Departments and District General Hospitals. The fundamental need is for liaison and addiction psychiatrists, specialising in alcohol, with specific responsibility for screening for depression and other psychiatric disorders, especially suicidal ideation, to provide an integrated acute hospital service. Moreover, psychiatrists and gastroenterologists, hepatologists and other specialists need to work collaboratively, rather than in isolation.	
275	SH	British Liver Trust	32.04	NICE	General	General	Within the guidance it would seem there is emphasis is on diagnosis and management in the community and specialist settings yet little mention of detection in Accident & Emergency Departments, or in District General Hospitals, where the majority of alcohol-related admissions are non-elective. Brief interventions have been shown to be effective in this setting and can potentially signpost services for people who are alcohol dependent and misuse alcohol. Additionally there is an evidence-base for the value of an alcohol specialist worker or alcohol specialist nurse in detecting harmful and dependent alcohol misuse should be included.	Thank you. Brief interventions in general hospitals and EDs are outside the scope of this guideline but have been dealt with extensively in the Public Health guidelines. Liver disease has been covered extensively by the RCP management of medical complications guideline.

							The first mention of screening with the Paddington Alcohol Test is in Appendix D on page 43 (NICE/short). There is little mention of alcohol-related liver disease	
276	SH	British Liver Trust	32.05	NICE	General	General	The British Liver Trust believes there should be national standards for alcohol treatment services. Without standards of care, and given GP local needs assessment commissioning, there is a likelihood that inequitable care may ensue. Only 1 in 18 dependent drinkers receive care, the figures ranging from 1 in 12 in London to 1 in 27 in the North West of England and 1 in 102 in the North East.	Thank you for your comment.
277	SH	British Liver Trust	32.06	NICE	General	General	Funding: It appears that the NHS sometimes regard alcohol treatment services outside their remit as it is often set in the community setting. The Trust feels there needs to be better clarification on who pays for the provision of services and also a sense of responsibility in providing the care. If treatment is difficult to access, we run the risk of individuals arriving at ITU wards and A&E requiring costly care. In addition pharmacological interventions. eg Section 7 page 338(Full) need to be addressed. For instance, many GPs regard the medication as specialised drugs, which should only be prescribed and initiated by alcohol specialists. There needs to be further clarification to who will carry the budget for this. It is important to consider that community alcohol teams have no proper drug budget. There would need to be local agreement.	Thank you. This is outside the scope of the current guideline but will be covered within the implementation guidelines to be subsequently developed by NICE.
278	SH	British Liver Trust	32.07	NICE	1.3.10.6	28	Wernicke-Korsakoff Syndrome. The recommendation is to “offer” long term placement to patients with Wernicke-Korsakoff syndrome. The recommendation should be to “offer and provide” long term placement, since there is a major shortage of such placements. There are major problems with inequality of access in this area. The major problem is that, while there are some placements for older people, there is a major shortage of placements for younger people	Thank you but this will be covered by the NICE commissioning guidelines.
279	SH	British Liver Trust	32.08	FULL	4.4.11	80	[Second paragraph] The guidance might mention the special stigma associated with alcohol misuse in other ethnic groups. In particular the	Thank you for your comment. While our search strategies did seek to identify stigma associated with alcohol misuse in

							Asian community as alcohol dependence and misuse can result in exclusion from places of worship. Link workers, support and translated materials from community elders may be especially helpful.	other ethnic groups, there were no primary qualitative studies which met criteria and which addressed this particular stigma. Most of the studies relating to this topic were quantitative or questionnaire based and therefore were not included in this review. One study by Morjaria and Orford (2002) highlights the differences faced by British and South Indian men in terms of recovery from alcohol dependence. Social stigma is briefly mentioned when discussing the results of this study.
280	SH	College of Mental Health Pharmacy	19.01	NICE	1.3.3.6	19	This is a large dose of chlordiazepoxide to use in the community, who will be monitoring for adverse effects? if they need that much should they not be an inpatient	Thank you for your comment. This dose of chlordiazepoxide was given as an illustrative example. It has now been removed from the recommendation. However, we have amended the recommendation in light of your comment and included a table in the full guideline (Chapter 5; Table 21) which gives various examples of a dosing regimen. This table includes an example of a dosing regimen for those who may require large amounts but stipulates that: “Doses of chlordiazepoxide in excess of 30mg q.d.s. should only be prescribed in cases where severe withdrawal symptoms are expected and the patient’s response to the treatment should always be regularly and closely monitored. Doses in excess of 40mg q.d.s. should only be prescribed where there is clear evidence of very severe alcohol dependence. Such doses are rarely necessary in women and never in the elderly or where there is liver impairment.”

281	SH	College of Mental Health Pharmacy	19.02	NICE	1.3.3.8	19	Withdrawing BZD in chronic users over 3 weeks is very quick and should be tailored to symptoms and discomfort	Thank you; we have amended the recommendation in light of your comment.
282	SH	College of Mental Health Pharmacy	19.03	NICE	1.3.7.1	22	There is a different order for acamprosate and naltrexone here compared with different sections, are you implying a first and second choice?	Thank you for your comment; we have made the order consistent. We were not implying first and second line treatments.
283	SH	College of Mental Health Pharmacy	19.04	NICE	1.3.8.2	22	We believe there is some evidence supporting starting acamprosate during detox.	Thank you. We were aware of the evidence on this but the GDG did not feel it was strong enough to recommend this as part of standard care.
284	SH	College of Mental Health Pharmacy	19.05	NICE	1.3.8.2	22	Acamprosate 1.3332mg per day, would be useful to exactly mention the timing of doses i.e. specify 666mg breakfast and 333mg midday and night.	Thank you but we think this level of detail is not appropriate as it is contained in the SPC.
285	SH	College of Mental Health Pharmacy	19.06	NICE	1.3.8.4	23	The starting dose of naltrexone according to BNF / SPC is 25mg daily	Thank you, we have amended the recommendation in light of your comment.
286	SH	College of Mental Health Pharmacy	19.07	NICE	1.3.10.5	28	We believe it is important to mention IM pabrinex here.	Thank you for this comment. This matter is dealt with in the other NICE guideline on alcohol use disorders (CG100).
287	SH	College of Mental Health Pharmacy	19.08	NICE	1.3.8.9	24	We would like to see this part extended to include the interaction with alcohol such as arrhythmias, hypotension and collapse.	Thank you; we have amended the recommendation to address your concerns.
288	SH	College of Mental Health Pharmacy	19.09	NICE	General	General	There appears to be no mention of combining acamprosate, naltrexone and disulfiram. Which is occasionally used in practice.	Thank you. However, this is a very uncommon combination – we would have concerns about the safety of such a regimen which has not been tested in trials. We therefore cannot make a recommendation on this.
289	SH	College of Mental Health Pharmacy	19.10	Full	5.26.6	193	We do not believe halazepam is available in the UK.	Thank you for your comment. We understand that halazepam is not in the BNF. However, it is mentioned here only in the context of making the point that some rapid-acting benzodiazepines may have a greater potential for misuse than slower-acting ones such as halazepam. It is not part of our recommended treatment of alcohol withdrawal.
290	SH	College of Mental	19.	Full	5.26.6	193	Chlordiazepoxide and diazepam both long acting and long	Thank you for your comment. This has

		Health Pharmacy	11				half life.	been amended.
291	SH	College of Mental Health Pharmacy	19. 12	Full	5.26.7	194	From not fro	Thank you, this has been changed.
292	SH	College of Mental Health Pharmacy	19. 13	Full	5.27.1.1 1	197	Withdrawing BZD in chronic users over 3 weeks is very quick and should be tailored to symptoms and discomfort	Thank you for your comment. This is very dependent on the severity of dependence and the setting (e.g. in inpatient settings this is usually appropriate). This has been changed to "2-3 weeks or longer, depending on the severity of co-existing benzodiazepine dependence."
293	SH	College of Mental Health Pharmacy	19. 14	full	5.27.1.3	196	We believe adolescents and children should be added to the list of groups needing to be detoxed as inpatients as mentioned in 6.26.11.4	Thank you for your comment. This recommendation has been added.
294	SH	College of Mental Health Pharmacy	19. 15	full	6.26.11. 5	335	Would be useful here to mention the children's BNF should be consulted for dosing recommendations	Thank you for your comment; we have added a cross-reference to the SPC, which was considered more appropriate in this context.
295	SH	College of Mental Health Pharmacy	19. 16	full	7.7.8.5	395	Acamprosate 1.3332mg per day, would be useful to exactly mention the timing of doses i.e. specify 666mg breakfast and 333mg midday and night.	Thank you but we think this level of detail is not appropriate as it is contained in the SPC.
296	SH	College of Mental Health Pharmacy	19. 17	full	7.7.8.7	396	The starting dose of naltrexone according to BNF / SPC is 25mg daily	Thank you - we have amended the text in light of your comment.
297	SH	College of Mental Health Pharmacy	19. 18	full	7.11	412	Line 6 says per 5 million pairs, there appears to be a missing sentence about anaphylaxis	Thank you for your comment. This has now been amended.
298	SH	College of Mental Health Pharmacy	19. 19	Full	General	General	Given the importance of medication in alcohol dependence we are disappointed there was no specialist pharmacist on the guideline development group	Thank you. In drawing up the group membership we were conscious of the need to recruit individuals with specialist experience in the pharmacology of addiction; this we did and did not feel that we needed a specialist pharmacist on the group.
299	SH	Department for Education	40. 01	FULL	1.2.2	12	This guidance should also be useful for Children Social Care and Children and family services who are working with parental substance users. We know that alcohol is a significant factor in those families with multiple problems as well as it being a factor in a high proportion of child protection cases.	Thank you for your comment. We agree that it is important for such services to recognise the impact of parental alcohol misuse.
300	SH	Department for	40.	FULL	1.2.3	13	Could one of the aims of the guidelines be to ensure that	Thank you for your comment. We believe

		Education	02				professionals working with clients with alcohol misuse issues to identify and respond to other interrelated problems such as mental health as well as the wider family circumstances to ensure children are properly safeguarded	the issue of safeguarding has been identified throughout the guideline e.g. a number of references are made to formulating a care plan and the assessment of risk. The guideline recommends that an assessment of risk is part of any assessment (see recommendation 1.2.1.1) We also make specific mention of the treatment and management of a number of comorbidities.
301	SH	Department for Education	40.03	FULL	2.1	15	It would be helpful in the introduction to spell out that alcohol; often in combination with domestic violence and mental health issues are a key factor in a high proportion of child protection cases. – it is helpfully mentioned in 2.3.3.	Thank you for your comment. Given the broad nature of the review in Chapter 2.1 we feel this current coverage is adequate.
302	SH	Department for Education	40.04	FULL	2.4.1	20	It is also a key feature in about a third of the 56,000 families known to need an intensive family intervention	Thank you. However, in the absence of a reference source and support for the effectiveness of such interventions, we are reluctant to add this to the text.
303	SH	Department for Education	40.05	FULL	2.7	24 -25	Where families have been referred for an intensive family intervention a whole family assessment is often undertaken which should identify whether there are any unmet needs such as alcohol misuse. We have provided training to family intervention workers to help them better identify and respond to alcohol related issues.	Thank you. We agree and this is discussed in later chapters referring to the evidence base on family interventions.
304	SH	Department for Education	40.06	FULL	2.8	25	Part of the motivation for a parent to stay in treatment is them knowing how important their role is in their child's upbringing and knowing that they can prevent their child going into care if they take help. In order for them to tackle their alcohol related problem their other needs, such as housing, employment, parenting, mental health, poverty, need to be assessed and supported at the same time. Increasingly local areas and partners are adopting this holistic whole family approach. This is also the approach	Thank you for your comment. Some of the issues you raise, such as interventions in housing, are outside the guideline scope. We suggest it will be for broad policy approaches, such as the one you refer to, to ensure that our recommendations are integrated into current practice.

							being advocated in the Drugs (and alcohol) strategy currently being developed and about to be consulted upon. Similarly in terms of local treatment services protocols with children and family services.	
305	SH	Department for Education	40.07	FULL		28	Data provided from the NATMS indicates that around a third of those in treatment are parents with childcare responsibility	Thank you for your comment. We are unable to find a published source for this information. It is not contained in the published NTA report for 2008/09. We have therefore not made any amendment.
306	SH	Department for Education	40.08	FULL		29	Of the 56,000 families identified as in need of an intensive intervention because of their multiple needs at least 1/3 have an alcohol related problem. NatCen evaluated the family interventions (FIPs) and found that whole family interventions, tackling all the problems in a coordinated way, resulted in over 50% reduction in risk associated with alcohol	Thank you for your comment.
307	SH	Department for Education	40.09	FULL		34	Table could include – reduced child protection concerns; less children going into care; better family functioning	Thank you for your comment; this is just an example of the PICO format.
308	SH	Department for Education	40.10	FULL	4.3	58	This section could/should talk more about joined up processes such as whole family assessments, whole family coordinated support and interventions.	Thank you for your comment. However, our searches found no evidence for whole family assessments, and in the view of the GDG, they are not feasible.
309	SH	Department for Education	40.11	FULL		81 -86	Also a stronger focus on young carers who often have to take on a caring role within their family (for siblings and parents) as a result of parental substance misuse. Often this group of young carers remain hidden. Young Carer projects provide a place where young people can talk to others in the same situation as them Research by Saul Becker 2004 – Young Carers UK highlights that where there is a alcohol dependent parent there is a 40% risk that the child will experience difficulties at school	Thank you for your comment. There is a theme entitled 'high levels of responsibility' which includes taking on a caring role (the thematic analysis is now in Appendix 14). As the report by Becker is not a qualitative study we cannot include it in this analysis.
310	SH	Department for Education	40.12	FULL	4.6.7.4	93	Consider the needs of the whole family, i.e. whether there are interrelated problems involving other family members. Consider undertaking a whole family assessment; support plan	Thank you for your comment. However, our searches found no evidence for whole family assessments, and in the view of the GDG, they are not feasible.

							NHS professionals should be effective in identifying, assessing and responding to wider family support needs which are often interrelated. This could mean taking part in a whole family assessment, being part of a team around the family or knowing how to make an effective referral to other services such as children's services or family support services which can help maintain a drug using parent in treatment.	
311	SH	Department for Education	40.13	FULL	General	General	Documents attached to the submission: • Department for children, schools and families (Nov 2009) Anti-social Behaviour Family Intervention Projects Monitoring and Evaluation Research Brief; National Centre for Social Research • Department for children, schools and families (2010) Think Family Pathfinders – Research Update	Thank you for these documents.
312	SH	Department of Health	26.01	Full	2.1	14	Line 6: *"Alcohol is consumed by 87% of the UK population, nearly 40 million people"* The source quoted is Fuller E (2008) Alcohol consumption. In Craig R, Mindell J (eds) *Health Survey for England 2006. Volume 1: Cardiovascular disease and risk factors in adults*. The Information Centre, Leeds, the 87% and 'nearly 40 million' figures relate to England rather than the UK, and are now superseded. More up to date figures are available; for **GB**/England from GLF 2008 (**84%**/85%) or for England from HSE 2008 (87%). The corresponding numbers of people would be, for GB/England from GLF2008 (**41** million / 35 million) or for England from HSE2008 (36 million). Could you please specify that this relates to adults aged 16 years or over.	Thank you for your revised figures. This introductory paragraph has now been updated.
313	SH	Department of Health	26.02	Full	2.1	14	Lines 10 - 15*: "Some 26% of the adult population in England, including 38% of men and 16% of women, consumes alcohol in a way that is potentially or actually harmful to their health or well being (Drummond et al., 12*	Thank you for your revised figures. This introductory paragraph has now been updated and the AUDIT clarification scores you requested have been added

							2005). Of this group, 4% of adults are alcohol dependent (6% men; 2% women) which involves a significant degree of addiction to alcohol, making it difficult for them to reduce their drinking or abstain in spite of increasingly serious harm". The figures quoted are from the 2000 Adult Psychiatric Morbidity Survey. Could you please consider updating these figures, using information from the 2007 survey as follows: *"Some 24% of the adult population in England, including 33% of men and 16% of women, consumes alcohol in a way that is potentially or actually harmful to their health or well being" (McManus et al., Adult psychiatric morbidity in England, 2007: Results of a household survey)*. In our view, it is worth adding that this is defined as scoring 8 or more on AUDIT. We believe that the reference to *"of this group"* is potentially misleading, as the percentages "4%/6%/2%" relate to the whole adult population, and not just the 26%. The figures used are from APMS 2000, but these have not changed in APMS 2007. Could you please clarify whether this is defined as those scoring 16 or more on AUDIT.	in footnote form.
314	SH	Department of Health	26.03	Full	2.1	14	Line 35: could you please note that the internationally agreed name of this disorder is *'Fetal Alcohol Syndrome'.*	Thank you, we have amended this accordingly.
315	SH	Department of Health	26.04	Full	2.1	15	Lines 10 - 13: *"Alcohol related hospital admissions increased by 71% between 2003 and 2007, accounting for to 811,443 admissions with a primary or secondary diagnosis wholly or partly related to alcohol in 2006-07, 6% of all hospital admissions"* Could you please note that these figures have been revised and superseded, and should now read as follows: *"Alcohol related hospital admissions increased by 85% between 2002/03 and 2008/09, accounting for 945,000 admissions with a primary or secondary diagnosis wholly or*	Thank you for the revised figures. The guideline has now been updated.

							partly related to alcohol, 7% of all hospital admissions".	
316	SH	Department of Health	26.05	Full	2.1	15	Line 37: could you please clarify whether this should read *"International Classification of Disease, 10th Revision"*.	Thank you for your comment; we have amended the title.
317	SH	Department of Health	26.06	Full	2.3.1	17	Line 9: *"Alcohol is consumed by 87% of the UK population in the past year (Fuller, 2008)"*. Could you please refer to the comments made in box number 1 above.	Thank you for your comment.
318	SH	Department of Health	26.07	Full	2.3.1	17	Line 27: this mentions the term *'low risk'*. In our view, there is no problem with using this term as it refers to the 1995 Sensible Drinking report, and is a non-technical term used by WHO and others. We feel however that it would be helpful to include and define the terms introduced by our Department at some point. (i.e.*'lower-risk', 'increasing risk'* and *'higher risk'*).	Thank you. The term low risk has been used for the reasons stated with a technical definition provided. The GDG took the view that adding other terms could add confusion.
319	SH	Department of Health	26.08	Full	2.3.1	17-18	Line 43 et seq: *"Most of the data on the English population's drinking patterns comes from the General Household Survey, the Health Survey for England, and the Psychiatric Morbidity Survey (Goddard, 2006; Craig & Mindell, 2008; McManus et al., 2009). In terms of hazardous drinking, in 2005, 25% of adult men were drinking between 22 and 50 units per week and 15% of adult women were drinking between 15 and 35 units (Goddard, 2006). A further 6% of men and 2% of women were harmful drinkers, drinking above 50 and 35 units per week respectively (Jones et al., 2007). In addition 17% of adult men and 7% of women met the Government's criteria for binge drinking. There were regional variations in the prevalence of these drinking patterns. Hazardous drinking varied from 21% in London to 28% in Yorkshire and Humber, and in women from 11% in London to 18% in the North West. Harmful drinking in men varied from 5% in the East Midlands to 7% in the North East, and in women from 1% in East of England to 3% in the South East. Binge drinking varied from 13% in men and 5% in women in London to 23% in men and 12% in women in Yorkshire and Humber (Jones et al., 2007)".* In our view, the sources and figures should be corrected	Thank you for your comments and the revised figures. The guideline has now been updated.

							and updated to read as follows: *"Most of the data on the English population's drinking patterns comes from the General Household Survey, the Health Survey for England, and the Psychiatric Morbidity Survey (Robinson and Bulger, 2010; Craig et al., 2009; McManus et al., 2009). In terms of hazardous drinking, in 2008 21% of adult men were drinking between 22 and 50 units per week and 15% of adult women were drinking between 15 and 35 units; and a further 7% of men and 5% of women were harmful drinkers, drinking above 50 and 35 units per week respectively. In addition 21% of adult men and 14% of women met the Government's criteria for binge drinking. There were regional variations in the prevalence of these drinking patterns. Hazardous drinking among men varied from 24% in the West Midlands to 32% in Yorkshire and Humber, and in women from 15% in the East of England to 25% in the North East. Harmful drinking in men varied from 5% in the East Midlands to 11% in Yorkshire and Humber, and in women from 2% in the East of England to 7% in Yorkshire and Humber. Binge drinking among men varied from 19% in the West Midlands to 29% in Yorkshire and Humber and among women from 11% in East of England to 21% in Yorkshire and Humber"* (Robinson and Bulger, 2010). The new sources are: Robinson, S. and Bulger, C. (2010) General Lifestyle Survey 2008: Smoking and drinking among adults, 2008: Craig, R., Mindell, J. and Hirani V. (2009) Health Survey for England 2008: Volume 1 Physical activity and fitness We feel that there is scope for confusing the references to hazardous and harmful drinking (based on average weekly consumption) with the references at page 18, line 22 (please see earlier comment) to hazardous and harmful [the WHO's AUDIT-based definition]). Please note that, to prevent confusion, we refer to the former as increasing risk and higher risk drinking.	

							With regard to *" the Government's criteria for binge drinking":* Binge drinking is a term that is commonly used to refer to episodes of heavy drinking or episodes of drinking to intoxication. The Government does not have rigid criteria to define binge drinking in individuals but uses, as a proxy measure for binge drinking in a population, the threshold of having drunk more than six units on at least one occasion in the last week for women, or more than eight units for men (as monitored through the General Lifestyles Survey - formerly the General Household Survey).	
320	SH	Department of Health	26.09	Full	2.3.1	18	Lines 22 - 31: *"The Alcohol Needs Assessment Project in England found the prevalence of alcohol dependence to be 4% in 16-64 year old adults: 6% of men and 2% of women (Drummond et al., 2005). This equates to a population of 1.1 million people in England with alcohol dependence. There was considerable regional variation in the prevalence of alcohol dependence from 2% in East Midlands to 5% in the North West. The prevalence of hazardous and harmful drinking and dependence are highest in 16-24 year olds and decrease steadily with age. Hazardous and harmful drinking is 1.6 times greater in the white population than in the black and ethnic minority population. However, alcohol dependence is approximately equally prevalent in these two populations"*. Could you please consider updating this text, using information from the 2007 APMS, to read as follows: *"The prevalence of alcohol dependence was found to be 4% in adults aged 16 or over: 6% of men and 2% of women. This equates to a population of 1.6 million people in England with alcohol dependence. There was considerable regional variation in the prevalence of alcohol dependence from 3% in East Midlands to 7% in the North East. A score of 8 or more on the AUDIT questionnaire is defined by the WHO as hazardous or harmful drinking. The prevalence of*	Thank you. The 2007 APMS uses a different methodology and in our view a less directly applicable one than ANARP and therefore we do not think that we can simply update the figures as you suggest.

							hazardous and harmful drinking and dependence are highest in 16-24 year olds and decrease steadily with age. Hazardous and harmful drinking is 2.3 times greater in the white population than in the black and ethnic minority population". (McManus et al., 2009) Could you please be aware that the statement, that alcohol dependence is approximately equally prevalent in the white, black and ethnic minority populations, is <u>*not*</u> the case for 2007.	
321	SH	Department of Health	26.10	Full	2.3.4	19	Lines 38 - 40: *"Over 512,000 recorded crimes in England were attributable to alcohol in 2006 in the British Crime Survey, accounting for nearly half of all violent crimes (Walker et al., 2006)"*. In our view, this figure: a) is incorrect; b) mixes up recorded crime statistics with BCS statistics; (c) should refer solely to violent crimes, and; (d) relates to England and Wales, rather than England alone. A much more up to date figure is available from the 2009/10 survey: There were 986,000 violent incidents in England and Wales in 2009/10, where the victim(s) believed the offender(s) to be under the influence of alcohol, accounting for 50% of all violent crimes. The source is: Crime in England and Wales 2009/10: Findings from the British Crime Survey and police recorded crime: John Flatley, Chris Kershaw, Kevin Smith, Rupert Chaplin and Debbie Moon	Thank you for your comments and revised figures. The guideline has now been updated.
322	SH	Department of Health	26.11	Full	2.3.4	19	Lines 42 - 44: *"Drink-driving accounts for 5% of road accidents and around 500 deaths per annum, and harmful drinkers are six times more likely to be involved in a road accident (Prime Minister's Strategy Unit, 2003)"*.	Thank you for your comments and revised figures. The guideline has now been updated.

							Please be aware that much more up to date information is available: In 2008, it was estimated that 13,020 reported casualties (six per cent of all road casualties) occurred when someone was driving whilst over the legal alcohol limit. The provisional number of people estimated to have been killed in drink-drive accidents was 430 in 2008 (17 per cent of all road fatalities). The source is: Reported Road Casualties Great Britain: 2008 Annual Report, Department for Transport 2009	
323	SH	Department of Health	26. 12	Full	2.3.5	20	Lines 8 - 11: *"..the 16-24 year old age group had 19 times the risk of alcohol related mortality compared to those aged 75 and over (27% of all deaths in 16-24 year olds, mostly due to acute effects of alcohol: intentional self harm and road traffic accidents)"* The above appears to be incorrect, whilst the reverse appears to be true. Those aged 75+ have nine times the risk, compared to 16-24 year olds. Could you please therefore consider amending the text to read as follows: *"Deaths of 16-24 year olds are 20 times more likely to be the result of alcohol compared to deaths of those aged 75 and over (23% of all deaths in 16-24 year olds), mostly due to acute effects of alcohol: intentional self harm and road traffic accidents"*.	Thank you for your suggested revision. The guideline has now been amended accordingly.
324	SH	Department of Health	26. 13	Full	2.3.5	20	Lines 21 - 26: *"Alcohol related hospital admissions in England increased by 75% between 2002/03 and 2006/07 (NAO, 2008). For conditions directly attributable to alcohol, admissions doubled between 1996 and 2007. In 2006/07 there were 811,443 hospital admissions in England where alcohol was either a primary or secondary diagnosis (NAO, 2008). Alcohol related admissions increase steeply with age, peaking in the 45-64 year old age group (Deacon et al., 2007)".*	Thank you for the revised figures. These have now been updated in the guideline.

							Could you please note that these figures have been revised and superseded, and that they should now read as follows: *"Alcohol related hospital admissions increased by 85% between 2002/03 and 2008/09. For conditions directly attributable to alcohol, admissions increased by 81% between 2002/03 and 2008/09. In 2008/09 there were 945 thousand hospital admissions in England where alcohol was either a primary or secondary diagnosis. Alcohol related admissions increase steeply with age, peaking in the 60-64 year old age group".*	
325	SH	Department of Health	26. 14	Full	2.3.5	20	Lines 28 - 29: *"40% of admissions to accident and emergency (A&E) departments are alcohol related".* Because patients are not actually "admitted" to A&E, we feel that this should refer to "attendances" at A&E, instead of "admissions". The 40% cited here as alcohol-related draws on a single 24-hour snapshot study on a Saturday night, and we feel that this needs to be made clear. As it stands, the guidance uses the 40% figure as if it had equal status with nationally collected data, such as data on hospital admissions. In our opinion, this is potentially very misleading. The 40% could also be misinterpreted as the average for alcohol-related attendances at A&E, rather than on a Saturday night. We feel therefore that it would be more accurate to say: *"One snapshot study found that forty percent of attendances at accident and emergency (A&E) departments were alcohol-related on a Saturday night"* *It might also be helpful to preface this with a line to explain that data on attendance at A&E departments are <u>not</u> collected nationally*".	Thank you for your comments. Changes have now been made to this section.
326	SH	Department of Health	26. 15	Full	2.5	22	Lines 25 - 27*:"A similar UK 25 study found the prevalence of alcohol dependence to be 6% in 16-19 year olds, 8.2% 26 in 20-24 year olds, 3.6% in 30-34 year olds, and 2.3% in 50-54 year olds".* (Drummond *et* 27 *al*, 2005)	Thank you. Please see our previous comments concerning the APMS study (comment 320).

							More up to date figures are available from APMS 2007, and we think that the above should read as follows:: *"A similar UK study found the prevalence of alcohol dependence to be 6.8% in 16-24 year olds, 6.6% in 25-34 year olds, 4.8% in 35-44 year olds, and 2.6% in 45-54 year olds"* (Fuller et al., 2009).	
327	SH	Department of Health	26. 16	Full	2.5	22	Lines 37 - 39: *"Most studies examining the outcome of people attending alcohol treatment find that 70-80% will relapse in the year following treatment…"* A single reference is cited, dating from 1971, and we would query whether more up to date studies could be cited in support of this statement. ANARP uses a lower figure.	Thank you for your comment. A more up to date reference [Raistrick, Heather & Godfrey, 2006, Review of the effectiveness of treatment for alcohol problems] has now been added.
328	SH	Department of Health	26. 17	Full	2.7	24	Line 47: In addition to the Cheeta study cited, other studies need to considered and referenced. The ANARP report investigated GP recognition of alcohol problems in their patients (for example, recognising dependency for one in 28 men, and one in 20 women). The National Audit Office has also reported on GP recognition, finding, inter-alia, that 45% of GPs carry out informal but regular checks on their patients' alcohol use. *Reducing Alcohol Harm: health services in England for alcohol misuse.* NAO, 29 October 2008.	Thank you - the NAO study did include a survey of 1400 GPs. However, the methodology and in particular the sampling methodology is not stated which leaves some doubt about the representativeness of the sample of respondent. The GPRD study on the other hand had a large sample of known reliability, validity and representativeness.
329	SH	Department of Health	26. 18	Full	2.7	25	Lines 14 - 17: *"Around a third of people presenting to specialist alcohol services in England are self-referred, and approximately one third are referred by non-specialist health or social care professionals (Drummond et al., 2005). The remainder are referred by other specialist addiction services".* Can you please note that more up to date statistics are available. For new presentations to treatment in 2008/09, self-referrals (38%) were most common. The second most common source of referrals was from GPs (22%). Referrals from the criminal justice system (consisting of: Arrest referral/DIP, CARAT/Prison, DRR or Probation) made up 8% of all	Thank you. We have now made amendments in light of your comment. However, it is unclear from the NATMS data what proportion of those agencies responding are GPs. A higher proportion of GPs responding compared to ANARP may account for this difference in findings.

							referrals. Most of these were from the Probation Service. Referrals from statutory substance misuse services (which reflect movement between agencies) amounted to 5% of the total, while non-statutory substance misuse services accounted for a further 7%. The source is: Statistics from the National Alcohol Treatment Monitoring System (NATMS): 1st April 2008 – 31st March 2009 National Treatment Agency (NTA) 2010.	
330	SH	Department of Health	26.19	Full	2.9	27	Line 30*: "an annual spend of £217 millions".* Could you please note that there are lower estimates than this. The Strategy Unit Alcohol Harm Reduction project, Interim Analytical Report 2002 found "expenditure is estimated at £95m, with £24m on NHS services and the rest provided by the voluntary sector (su-alcohol@cabinet-office.x.gsi.gov.uk). The NAO report *Reducing Alcohol Harm: health services in England for alcohol misuse.* (NAO, 29 October 2008) found that on average, PCTs were spending £600,000 in 2006-07. Based on this average, 152 PCTs would be spending £91.2m.	Thank you; we have amended the text in light of your comment.
331	SH	Department of Health	26.20	Full	2.9	27	Line 49: The National Alcohol Treatment Monitoring System (NATMS) shows where alcohol is the primary problematic substance. Please refer to the NTA Report for 2008/09.	Thank you for your comment. We agree and this sentence has been changed.
332	SH	Department of Health	26.21	Full	2.9	28	Lines 7 – 10: *"However the 2004 alcohol needs assessment found that only 1 out of 18 people with alcohol dependence in the general population accesses treatment per annum (Drummond et al., 2005). Access varies considerably from 1 in 12 in the North West Region to 1 in 102 in the North East".* In our view, the reference to the ANARP material should be included at the end, so that it is clear that all of this relates to 2004. Could you please show details in the past tense.	Thank you. We agree with your suggestion and the guideline has been updated.

							Could you please consider use of the following text: *"However, the 2004 alcohol needs assessment found that only 1 out of 18 people with alcohol dependence in the general population accessed treatment per annum. Access varied considerably from 1 in 12 in the North West Region to 1 in 102 in the North East"* (Drummond *et al*., 2005)."	
333	SH	Department of Health	26. 22	Full	2.9	28	Lines 10 – 11: *"A low level of access to treatment is regarded as 1 in 10"*. We believe that a caveat is required, as the populations used in ANARP and Rush differ. We would recommend a revised text on the following lines: *"Although not directly comparable because of different methodology, a low level of access to treatment is regarded as 1 in 10"* (Rush, 1990).	Thank you. We agree with your suggestion and the guideline has been updated.
334	SH	Department of Health	26. 23	Full	2.10	28	Line 37 et seq: In our opinion, SMART is not necessarily an *alternative to* AA, as it can be an *adjunct* to it. (Development of SMART in the UK was supported by a two-year grant from the Department of Health up to March 2010, to develop a series of pilots across England. It was delivered through Alcohol Concern).	Thank you for your comment. We agree and the text has been changed to "alternative or adjunct to".
335	SH	Department of Health	26. 24	Full	2.12	29	Line 49: *"This includes costs to the NHS of £1.7 billions. Accident and emergency departments and ambulance services account for 30% of these costs, and acute hospitals, 56% of costs, through admissions and outpatient attendances (NAO, 2008)".* The Department of Health produced an updated estimate of £2.7 billion in 2008: Please see *"the cost of alcohol harm to the NHS in England"* at http://webarchive.nationalarchives.gov.uk/+/www.dh.gov.uk/en/Consultations/Liveconsultations/DH_086412	Thank you. The guideline text has been amended to incorporate the updated estimate from the Department of Health.
336	SH	Department of Health	26. 25	Full	5.1	94	Line 12: MoCAM was developed by the NTA and Department of Health.	Thank you – this has been changed.
337	SH	Department of Health	26. 26	Full	5.3.4	98	Line 44: Could you please note that the correct title should be "*Alcohol Needs Assessment Research Project*".	Thank you - this has been amended as suggested.

338	SH	Department of Health	26. 27	Full	5.3.4	99	Line 2: In our view, there is potential for confusion in the use of the term “brief interventions”. It is quite likely that these specialist agencies were providing ‘extended brief interventions’ as defined as tier 2 interventions in MoCAM (or even some brief structured treatments). Could you please consider adding a caveat in order to minimise potential confusion with MoCAM tier 1 *‘simple brief interventions’*, on the following lines: *“Community agencies most commonly provided advice, brief interventions [that could include extended brief interventions] and structured…”*	Thank you for your comment. This has now been changed from ‘brief interventions’ to ‘briefer treatments’.
339	SH	Department of Health	26. 28	Full	5.3.4	99	Line 10: Could you please note that specialist alcohol treatment is *not* a sector. In the workforce taxonomy, health is a sector and alcohol treatment is a field.	Thank you. This has now been changed from ‘sector’ to ‘field’.
340	SH	Department of Health	26. 29	Full	5.3.4	101	Lines 4 - 10: *“Alcohol misuse is… seldom identified by mental health staff”.* Given that there are opportunities in other areas too (CVD, hypertension, gastritis etc), could you please consider adding the following text: *“Given the wide range of physical co-morbidities associated with alcohol use, there are also potential benefits from improving generic staff competencies in a wider range of healthcare settings.”*	Thank you for your comment. The suggested text has been amended.
341	SH	Department of Health	26. 30	Full	5.3.6	101	Line 25 et seq: . There appears to be some misunderstanding of MoCAM. MoCAM suggests that all of those who receive structured treatment should receive structured care planning and appropriate co-ordination following comprehensive assessment, and with a dedicated key worker using motivational and support skills. This appears to be essentially identical to the description of case coordination proposed, with exact intensity of support or level of co-ordination varying dependent on the needs or complexity of the particular individual drinker.	Thank you for your comments. We agree and the distinction between case coordination and case management has been made clearer.

							Under MoCAM, such care-planned care with a dedicated key worker is not required for harmful drinkers who are assessed as needing simple or extended brief interventions, as appears to be suggested in this section. However, those providing tier 1 or 2 interventions could choose to use care-planned care if it were a suitable approach in any particular case. In our opinion, more assertive approaches can be used as part of care-planned care within this framework.	
342	SH	Department of Health	26.31	Full	5.8.4	117	Line 11: Could you please clarify the distinction, made between "sequenced" and "stepped".	Thank you for your comment. Please refer to the response for comment 100.
343	SH	Department of Health	26.32	Full	5.17.1	127	Line 38: "AUDIT" is the "Alcohol Use Disorders Identification Test" (according to WHO and Baber's manual). AUDIT is also a validated tool, and we feel that NICE should mention this.	Thank you for your comment. We believe this section extensively describes the evidence supporting AUDIT as a validated tool.
344	SH	Department of Health	26.33	Full	5.20.10	142	Line 13: Could you please consider amending the text *"similar effects as cocaine.."* to *"similar effects to cocaine".*	Thank you, this has been amended.
345	SH	Department of Health	26.34	Full	5.20.12	144	Line 24: *"…appropriately skilled staff will only undertake the assessment elements".* Could you please clarify whether this means to say *"only appropriately skilled staff will undertake the assessment elements"*.	Thank you for your comment. This has been amended.
346	SH	Department of Health	26.35	Full	5.20.12	144	Line 25: In our view, DANOS should be attributed to Skills for Health and Skills for Care, as the standards are jointly owned.	Thank you for your comment. We have clarified the reference.
347	SH	Department of Health	26.36	Full	5.20.12	144	Lines 27 – 29: Could you please clarify the final sentence.	Thank you. This sentence has now been clarified.
348	SH	Department of Health	26.37	Full	5.20.12	145	[Figure 4] The diagram boxes refer to *"trained staff…"* We believe that it would be consistent with the preceding section for this to be *"competent staff"* or *"trained and competent staff"*.	Thank you for your comment. This has now been amended to "trained and competent staff".
349	SH	Department of Health	26.38	Full	5.21.1	146	Lines 32 - 33: *"where an alcohol use disorder is suggested, distinguish of harmful drinking or alcohol dependence"* In order to clarify the meaning, could you please consider	Thank you, this has been amended.

							using the following wording: *"where an alcohol use disorder is suggested, distinguish harmful drinking from alcohol dependence"*.	
350	SH	Department of Health	26. 39	Full	5.21.1	148	With reference to figure 5, this diagram recommends brief interventions (probably meaning Simple Brief Interventions) for hazardous (AUDIT 8-15) drinkers, and extended brief interventions for Harmful (AUDIT 16-19) drinkers. Simple Brief Interventions may be all that is required for many of those screened as possibly being harmful drinkers by AUDIT score of 16 -19. Could you please consider using a footnote for this group, stating that it may also be appropriate to offer extended brief intervention (or referral for specialist assessment) if initial simple brief interventions are unsuccessful. We are uncertain of the evidence to justify the clear-cut distinction at the AUDIT score of 16, as suggested in this diagram. We would recommend that the standard care pathway should indicate Simple Brief intervention for all AUDIT <20.	Thank you for your comment. This is outside the scope of this guideline. These are the recommendations of the Public Health Guideline. It is simply re-stated here as part of a more extensive care pathway.
351	SH	Department of Health	26. 40	Full	5.21.2	152	Regarding figure 6, SADQ score 0-4 indicates no dependence. Could you please consider the inclusion of a pathway for this group, offering the group brief advice, possibly with follow-up monitoring.	Thank you for your comment. This issue is outside the scope of this guideline and but is covered in the Public Health guideline.
352	SH	Department of Health	26. 41	Full	5.21.3	153	Line 30: *"The need for need for and agreed plans."* Could you please clarify the meaning of this bullet point.	Thank you for your comment. This point has been clarified.
353	SH	Department of Health	26. 42	Full	5.21.3	153 -154	Lines 41 – 46: adjunctive assessment tools may also include AUDIT as well as SADQ, depending on the nature of the case.	Thank you for your comment. The AUDIT has been added as an example of an adjunctive assessment tool.
354	SH	Department of Health	26. 43	Full	5.21.5	156	Lines 28 - 31: the last sentence of the last bullet appears to be ambiguous. Would you agree that it may be better just to leave reference to the clinicians responsibilities referenced to the DVLA guidance in the first sentence? Being "legally able to do so" may be taken to mean not until below the legal driving limit. However, we believe that one should not drive if impaired, irrespective of the limit.	Thank you for your comment. The two statements are required as they pertain to different aspects of the law regarding driving and alcohol. The first refers to the clinicians' responsibilities to tell the patient that they are required to tell the DVLA that they have an AUD. The second is that if a health professional is

								aware that someone objectively over the legal limit for driving is about to drive they need to inform them they are about to commit an offence. We agree that people who appear to be impaired should also be discouraged from driving, but some patients who are over the legal limit for driving may not appear impaired.
355	SH	Department of Health	26. 44	Full	5.21.6	162	Line L5*: "A history of physical and/or sexual abuse is high in patients…"* We feel that this should be clarified, perhaps to mean *"common".*	Thank you for your comment. This has been amended.
356	SH	Department of Health	26. 45	Full	5.21.9	164	Line19 et seq: *"How should outcome be measured?"* AUDIT or AUDIT-C are discussed, and are promoted as potentially valuable routine outcome-monitoring tools. You may wish to be aware however, that AUDIT was developed as a screening and assessment tool, not an outcome tool. It would appear that a detailed discussion of the range of current potential outcome monitoring tools for alcohol dependence (which is a detailed and complicated topic in itself) is not intended. However, given the positive focus given to AUDIT and AUDIT-C, we feel that there should be a slightly wider discussion of possible limitations to these particular tools. AUDIT and AUDIT-C certainly may be useful as proxies of consumption in some populations to monitor progress, although there seems to be little evidence drawn upon for their use as outcome tools. The first three AUDIT questions do not actually appear to identify fully the frequency and intensity of consumption. Because of this, using AUDIT-C for a heavily dependent drinker (drinking much more than 10 units every day, commonly seen in services) would not allow any progress on consumption to be shown at all until they had begun drinking nine units a day or less, for example, and so it would not be able to identify even major reductions in	Thank you for your comment. The GDG considered the outcome tools you refer to and the chapter now includes a discussion about why the GDG did not feel these tools could be recommended. Our initial review of primary assessment tools concluded that AUDIT, SADQ & APQ should be considered as baseline measures. The GDG felt that outcome should therefore be based on the application of these tools. In addition to this and with regard to drinking measures, we believe that there is sufficient evidence to support the use of the AUDIT and AUDIT-C for outcome monitoring. The AUDIT also has its utility in typical practice compared to other longer more research orientated tools including those mentioned in your comment. The Department of Health clearly indicates a desire for problems to be monitored as an outcome measure and list a number of domains; most of which are contained within the APQ. Our review of primary assessment tools indicated the use of

							consumption in such cases. In our view, the reference made to the alternative use of a drink diary is very important, but rather cursory. We consider that the discussion of AUDIT screening tools for outcome monitoring needs to be re-balanced in order to avoid potential misunderstanding. In our opinion, discussion of other dedicated outcome tools would be appropriate should NICE be intending to make specific recommendations on outcome tools (e.g. TOP, ASI, MAP, CISS, RESULT, Alcohol Star). Most of these contain scales indicating improvement/deterioration in psychological health, physical health, housing and employment (use of time), which are not contained in AUDIT. We believe that it would be helpful to have greater clarity regarding the populations and situations in which NICE considers that the AUDIT-C is a useful outcome tool (whether for mild/moderate/severe dependence and whether aiming for controlled drinking or abstinence etc.), and at what stages of treatment its use is envisaged.	APQ as an outcome tool. To improve clarity, this has now been added to the outcome monitoring section.
357	SH	Department of Health	26.46	Full	5.21.9	165	Lines 1 – 7: Regarding the use of AUDIT as a monitoring tool, can you please refer to the previous point.	Thank you for your comment. Our initial review of primary assessment tools concluded that AUDIT, SADQ & APQ should be considered as baseline measures. The GDG felt that outcome should therefore be based on the application of these tools. In addition to this and with regard to drinking measures, we believe that there is sufficient evidence to support the use of the AUDIT and AUDIT-C for outcome monitoring.
358	SH	Department of Health	26.47	Full	5.21.10	165	Lines 34 – 35: *"it is clear from the literature that for people who are moderate and severe drinkers, the initial goal should be abstinence."* Presumably, this was intended to refer to people who are	Thank you; we have amended the text.

							moderately to severely *dependent.* We feel that references would be useful, given the extent of previous debates on the issue of recommending abstinence in the first instance.	
359	SH	Department of Health	26. 48	Full	5.21.10	167	Line18: *"existing assessment treatment systems "* In our view this is not a recognised term, and perhaps requires clarification.	Thank you – this sentence has been amended.
360	SH	Department of Health	26. 49	Full	5.22	169	Line 25 et seq: Regarding the paragraph relating to the competence of staff there is reference to the Drugs and Alcohol National Occupational Standards (DANOS) earlier in the section. We feel that the same reference would be most appropriate here.	Thank you; this section of the text has been revised.
361	SH	Department of Health	26. 50	Full	5.22.1.4	170	Line 5: *"AUDIT for identification and as a routine outcome measure".* Please see the comments on page 165 lines1-7, and page 164 line19 et seq, above. This does not now differentiate the AUDIT-C, and the conclusion on use as an outcome tool does not appear to have adequate rigour.	Thank you for your comment. Our initial review of primary assessment tools concluded that AUDIT, SADQ & APQ should be considered as baseline measures. The GDG felt that outcome should therefore be based on the application of these tools. In addition to this and with regard to drinking measures we believe that there is sufficient evidence to support the use of the AUDIT and AUDIT-C for outcome monitoring.
362	SH	Department of Health	26. 51	Full	5.26.6	193	Lines 30 - 31: *"It should be noted that screening with AUDIT now forms part of the routine admission programme of the prison service"*. In our opinion, this could be misleading. Could you please consider reflecting the relevant guidance more accurately and clearly. The extract below illustrates the need for greater clarity: *"A Dependency Assessment undertaken by healthcare is an integral element of the initial healthcare assessment process and is offered to all prisoners. This should identify those who are physically dependent on alcohol. Where this is unclear a further assessment is required using the SADQ*	Thank you; we have now amended the text.

							(Severity of Alcohol Dependency) questionnaire to assess whether a detoxification is necessary. *For prisoners who are assessed as being physically dependent on alcohol, an Alcohol Detoxification is considered mandatory under PSO 3550. Its aim is to reduce the dangerous and unpleasant side effects of alcohol withdrawal syndrome. Information on a standard alcohol Detoxification is outlined in the Good Practice Guide section.* *For those who are assessed as not being physically dependent a universal Screening Assessment Tool (AUDIT) is recommended. This is a validated screening tool, which identifies those individuals who are not considered physically dependent on alcohol at the point of reception, yet are at significant risk of harm. The Audit score should always be passed through to the person conducting the triage assessment, as it is a good indicator of level of need".* ALCOHOL TREATMENT / INTERVENTIONS GOOD PRACTICE GUIDE. HM Prison Service & Dept Health (2004). http://www.hmprisonservice.gov.uk/news/index.asp?id=2173,22,6,22,0,0	
363	SH	Department of Health	26.52	Full	5	94-194	The research summaries presented in this section appear to be particularly dense, being somewhat inaccessible in their written style. We feel that this is particularly true of those paragraphs that are so broken by bracketed references and statistics that the meaning of sentences is frequently lost, often requiring second or third readings. In our view, it would be more beneficial to summarise the findings in accessible prose, making reference to attributions and findings data in footnotes or appendices. There appears to be a problem of nomenclature for the various types of brief intervention available. Whilst it is not likely to be possible to resolve all of these, it may be helpful to have some clear statement for the document overall that this terminology can refer to minimal and to simple brief	Thank you for your comment. The referencing style is in accordance with the NICE guideline manual. Brief intervention and extended brief advice is outside the scope of this guideline but is fully dealt with in the NICE public health guideline on alcohol (NICE, 2010a). It is referred to here only as a cross reference. One of the issues in reviewing evidence of this nature is achieving the correct balance between presenting the evidence for decision making/recommendations and providing simple and abridged-prose.

							interventions, to more extended and repeated interventions, and can also be used to refer to short structured treatments. Where possible, the distinct type(s) of brief intervention being considered should be made clear in the body of the document. Many practitioners are most familiar with the terms "identification and brief advice" and "extended brief advice". Could you please consider mentioning these.	The GDG believe we have attempted to address these issues as best given the complexities of the evidence.
364	SH	Department of Health	26. 53	Full	6.1.1	216	Lines 13 - 14: "A number of factors may contribute to the low implementation of evidence-based psychological interventions". One factor is the variation of training. The recommendations (Section 6.21.5 on page 306) set out what people should receive. We feel that there may be benefit from including some discussion on training that may be required, to ensure that workers can deliver this level of care.	Thank you for your comment – we agree that training is an important component and have highlighted this fact. However, we did not consider training methods as these are outside our scope and it is therefore not possible to amend our recommendations as you suggest.
365	SH	Department of Health	26. 54	Full	6.21.4	305	Line 2 et seq. The evidence base, reviewed in the earlier sections of chapter six, appears to apply to the range of dependent drinkers. However, the summary section then focuses on harmful drinkers and 'mild dependence'. In our view, this is potentially confusing.	Thank you for your comment. The majority of participants included in the reviews in chapter 6 were indeed harmful drinkers or those who are mildly dependent drinkers. This section directs the reader to the evidence for pharmacological therapy in combination with a psychosocial intervention for those who have moderate or heavy dependence on alcohol. We have added in some text to the 'clinical evidence summary' in section 6.20 to make it clear that the evidence reviewed pertains to those whom are harmful or mildly dependent drinkers.
366	SH	Department of Health	26. 55	Full	6.21.5	306	Line 23 et seq: To emphasise the importance of competence and training to the delivery of appropriate care, could you please consider amending the text to read: "All interventions for people who misuse alcohol should be	Thank you for your comment. We agree and this has been changed to "All interventions for people who misuse alcohol should be delivered by appropriately trained and competent staff

							delivered by suitably trained and competent staff."	working in specialist alcohol services."
367	SH	Department of Health	26.56	Full	6.21.5	307	Line 11: "Interventions for harmful drinking and mild alcohol dependence". Could you please clarify what access individuals with moderate or severe dependence should have to the psychosocial treatments that are set out here.	Thank you for your comment. Both the main pharmacological interventions are provided in combination with psychological interventions. Evidence for psychological interventions as the sole interventions was very limited for moderate or severe dependence with most psychological interventions focused on harmful and mild dependence. However, the recommendation is clear that pharmacological interventions should be provided in combination with psychological interventions – this is made clear in Chapter 7. However, in light of your comment we have inserted a recommendation that where a person refuses a pharmacological intervention a person may be offered a psychological intervention.
368	SH	Department of Health	26.57	Full	7.7.8.8	396	Line 11: "Do not use blood tests routinely" Naltrexone is potentially hepatotoxic. Other guidelines (BNF, Drug Misuse and dependence: UK guidelines on clinical management, DH 2007) recommend doing liver function tests before and during treatment. Could you please consider reviewing this recommendation	Thank you for your comment, however we do not agree. The DH document is for opioid misusers – the issue of giving naltrexone to opioid misuers is that they might risk taking heroin to overcome naltrexone's antagonism and risk overdose death. This is not the case for alcohol misusers. At 50mg dose for alcohol misuse, liver toxicity is unlikely.
369	SH	Department of Health	26.58	Full	7.7.8.9	396	Line 16 et seq: With regard to disulfiram, could you please clarify whether there is a need to suggest the five-day loading dose, reducing from 800mg to 100-200mg daily.	Thank you for your comment. We did not think that a loading dose was necessary.
370	SH	Drinksense	34.01	NICE	General	General	Overall very helpful. After consultation with key staff universally we feel the document in many instances is overly prescriptive and not all fully evidence based.	Thank you for your comment but we do not feel the guideline is overly prescriptive and it is evidence based.
371	SH	Drinksense	34.02	NICE	General	General	We feel there is a heavy reliance on pharmacological interventions – particularly for young people. Alcohol reduction and management can be achieved through non-pharmacological interventions, based on assessment of	Thank you but we do not think your summary is a fair reflection of what is in the guideline. There is a strong emphasis on psychological interventions throughout

							need and client choice.	the guideline, they are clearly first choice for children and young people.
372	SH	Drinksense	34.03	NICE	General	General	There is little/no mention of evaluation and whilst over prescriptive in the main this major part of all interventions should be standard.	Thank you but we do not agree. There is a great deal of careful evaluation of the evidence throughout this guideline.
373	SH	Drinksense	34.04	NICE	1.1.1.2	10	It would be useful to include something around collaborative working and awareness of local care pathways, including Dual Diagnosis strategies and protocols. “ensure local care pathways and partnerships exist between community based and hospital based services.”	Thank you for your comment but this is a recommendation about working with service users and therefore we do not think it would be appropriate to make the alterations you have suggested.
374	SH	Drinksense	34.05	NICE	1.1.2.1	10	Relatives and carers should only be involved if appropriate. On occasion it is not appropriate to pull people back into the pathology of the drinker if they have withdrawn for their own health. Additionally where the client requires distance from others this may not be appropriate.	Thank you but we think that the current wording of the recommendation allows for this.
375	SH	Drinksense	34.06	NICE	1.1.2.2	11	Proper attention should be paid to the relative or carers right to confidentially. Same point as above.	Thank you for your comments; we have changed the recommendation to account for your concerns.
376	SH	Drinksense	34.07	NICE	1.2.1.4	12	It is not clear whether all of these tools have to be used for all clients	Thank you for your comment; we defined the context for use of the tools in each bullet point and therefore think it is clear that they may not be used for all service users.
377	SH	Drinksense	34.08	NICE	1.2.1.5	12 -13	In these cases other professionals i.e. hepatology should be involved.	Thank you for your comment but this recommendation concerns the assessment of the severity of dependence and therefore applies to all professionals involved, it would not be appropriate to single out any particular group.
378	SH	Drinksense	34.09	NICE	1.3.1.4	16	How will this resolve the complex issues including lack of housing? Residential rehab for 3 months for homeless clients will defer and postpone issues upon coming out. We have considerable experience of working with homeless alcohol misusers. Is there evidence that this is sufficiently effective to warrant this as a first line intervention?	Thank you. The residential rehabilitation in itself will not resolve housing issues hence the additional recommendation of helping the individual to find stable accommodation before discharge.

379	SH	Drinksense	34.10	NICE	1.3.1.7	17	We would support this but match to client need –twelve step and self help models do not suit all clients, and comprehensive assessment of need will identify interventions which will work for the client.	Thank you. We agree that assessment should help determine the most appropriate intervention but the choice of interventions should be from those evidence based interventions identified in this guideline.
380	SH	Drinksense	34.11	NICE	1.3.2	17	Whole section seems to be too prescriptive, does not seem to include the service users views. Reduction plans often fall outside these prescribed parameters.	Thank you but we do not agree. We are careful in our early recommendations which raise the issue of client choice and we are not prescriptive but suggest that services should be offered. The specification of the duration of the programme relates to the evidence based interventions from which this recommendation was developed.
381	SH	Drinksense	34.12	NICE	1.3.2.1	17	Can you advise on why 15 units is a number for the intentions proposed.	Thank you. This is because our review of the evidence has considered the properties of the measure and various studies on appropriate cut off points. They support the adoption of the cut off score. The use of validated tools to determine care rather than clinical judgement alone is that clinical judgement can be very variable. To avoid the issue of slavish adherence to cut offs which are arbitrary, the term “consider” is included. Clearly practitioners have to be competent and trained to interpret test results and make treatment decisions taking into account a wide range of clinical factors.
382	SH	Drinksense	34.13	NICE	1.3.3.5	19	There is no mention of Vitamin B, C, Thiamine, Pabrinex etc.	Thank you for your comment, but this is covered in more detail in NICE guideline 100.
383	SH	Drinksense	34.14	NICE	1.3.3.6	19	We wonder about the safety of this regime in a community based setting.	Thank you for your comment; however fixed dose regimens are not limited to community based settings.
384	SH	Drinksense	34.15	NICE	1.3.3.9	19	Too prescriptive, this is not practical or necessary for most clients.	Thank you but we disagree. We believe this is prudent and safe clinical practice

								for people who may be at high risk practice.
385	SH	Drinksense	34.16	NICE	1.3.6	21	Too prescriptive and not based on what may be suitable for the individual client – one size does not fit all	Thank you; the recommendations in fact reflect the nature of the interventions offered in the trials. We have also offered examples of “typical” treatment length, as such this suggests an indicate duration not a detailed specification of a precise number of sessions. This is in line with all clinical guidelines which are aids to and not a substitute for clinical judgement.
386	SH	Drinksense	34.17	NICE	1.3.7.1	22	Too much reliance on pharmacological assistance post withdrawal – many clients will not need or want this	Thank you but we are not sure you are correct. Current provision of medications is currently very low and given their relative effectiveness their use should be increased. We should also point out that medication in this guideline is provided in conjunction with a psychological intervention.
387	SH	Drinksense	34.18	NICE	1.3.8.7	23	We would expect 6 monthly reviews as recommended in BNF possibly to include follow up LFTs	Thank you; we have now added a bullet point to this recommendation (now 1.3.6.11) so it reads ‘Make sure that service users taking disulfiram….. • are medically monitored at least every 6 months after the initial 6 months of treatment and monitoring’.
388	SH	Drinksense	34.19	NICE	1.3.8.10	24	Benzodiazepines could be included here as they are not a treatment for alcohol misuse, they are only effective for managing withdrawal symptoms.	Thank you for your comment – we have added a recommendation as you have suggested.
389	SH	Drinksense	34.20	NICE	1.3.9.2	24	All children under 10 to be referred to CAMHS. Where does this fit within Safeguarding frameworks and CAF where approaches may be different? Additionally this appears to conflict with national recommendations that traditional CAMH services be broadened to encompass a range of other support to include early intervention and other specialists.	Thank you but this is beyond the scope of the guideline and it is concerned both with statute and formal guidance from the DH.
390	SH	Drinksense	34.	NICE	1.3.9.4	25	Seems to suggest offering inpatient detox to all children	Thank you for your comment. The

			21				over 10 years who are dependent. May not be suitable or appropriate	recommendation is for those who need assisted withdrawal and the use of the word 'offer' means it is not compulsory and can be offered where suitable or appropriate.
391	SH	Drinksense	34.22	NICE	1.3.9.5	25	Is the guidance clinically sound? Most drugs are used are questionable for children. Of the drugs proposed has the risk to developing organs been fully considered? We have researched the guidance referenced and can see no evidence for use with young people. What regimes are you proposing to be used – our clinicians are most concerned without seeing further detail on this proposal.	Thank you. We think this guideline is clinically sound and has been very carefully considered by the GDG. Dependence is rare in children, however, should there be a child with dependence then the evidence that is applied to adults can be extrapolated with sufficient reduction in dose, careful monitoring etc. We suggest that young people should first be offered psychological intervention but for those who do not take up such intervention but remain at a very high risk, we considered the use of medication may be of real value.
392	SH	Drinksense	34.23	NICE	1.3.9.8	26	There is insufficient evidence that Acamprosate is sufficiently effective to warrant the possible pathologising of a 16-18 year old by prescribing these medications for them.	Thank you for your comment. Our concern in making this recommendation is not to pathologise the condition but to try and help. We are clear that this should be used by specialists as a second line option and provided in conjunction with a psychological intervention.
393	SH	Drinksense	34.24	NICE	General	27	Proposals for family support limit the range of support options. Additional interventions to support the family function and the needs of the child would be welcomed.	Thank you. We provide recommendations for general advice and information to be given to families but we can only recommend additional interventions where we have evidence to support them. You have not specified the interventions to which you refer nor the evidence to support their recommendation in this guideline.
394	SH	Drinksense	34.25	NICE	General	27	MST is as yet not fully evidence based and in most areas have no links to specialist alcohol provision due to the underlying beliefs within the MST model. Research suggests selective not random trials.	Thank you. However, MST has a very well established evidence base and includes specific adaptations for drugs and alcohol e.g. MST-CM.

187	PR	Duncan Raistrick	5.01	NICE	general	general	It would be helpful if it was clear who the guidance is aimed at. Most of the territory covered will be very familiar to specialists but probably not to those working in other fields. It seems to be assumed that readers will be familiar with a general schema for the treatment of alcohol problems and the concepts involved therein, but this is probably not the case for people working outside the addictions field.	Thank you. It is aimed at those working in the NHS and related services who are concerned with the treatment of harmful and dependent alcohol misuse. As this covers a broad spectrum and knowledge will vary considerably – we took this into account in developing the recommendations.
188	PR	Duncan Raistrick	5.02	NICE	general	general	There are several references to staff being competent to deliver interventions, this is a very important point, however, there is no indication as to what competence might mean.	Thank you. However, this is not the case in the full guideline; there is reference to a number of competence frameworks. As with other evidence, it is not possible to include this detail in the NICE guideline.
189	PR	Duncan Raistrick	5.03	NICE	KPIs	9	There is mention of using naltrexone or acamprosate post detox. If abstinence is the goal then supervised disulfiram is superior and should be included here.	Thank you but we disagree. The data for disulfiram based largely on open label trails is not superior to that for the other drugs you mention.
190	PR	Duncan Raistrick	5.04	NICE	1.2.2.3	14	The Audit includes items on dependence – there is no need for further measurement of dependence using SADQ or LDQ.	Thank you. The AUDIT is a useful screening and initial assessment tool, but is less useful for withdrawal assessment. SADQ is more useful for this purpose as it is specific to alcohol dependence.
191	PR	Duncan Raistrick	5.05	NICE	1.3.2.1	17	There seems to be an undue reliance on using The Audit or SADQ to determine the type of alcohol detoxification. No doubt these scales correlate with the severity of withdrawal but the setting for detoxification is much more importantly determined by a risk assessment with an emphasis on the available social support. The danger of using cut offs is that inexperienced practitioners with slavishly follow them to the detriment of best care for the service users.	Thank you. The reason for suggesting validated tools to determine care rather than clinical judgement alone is that clinical judgement can be very variable. To avoid the issue of slavish adherence to cut offs which are arbitrary the term “consider” is included. Clearly practitioners have to be competent and trained to interpret test results and make treatment decisions taking into account a wide range of clinical factors.
192	PR	Duncan Raistrick	5.06	NICE	1.3.2.3	18	As for 1.3.2.1 above – there is no option for home detoxification.	Thank you for your comment. This recommendation for assisted withdrawal in the community includes assisted withdrawal at home (please see 1.3.4.2).

193	PR	Duncan Raistrick	5.07	NICE	1.3.3.6	19	See 1.3.2.1 above – clinicians will normally assess the severity of actual withdrawal symptoms, for example using CIWA as described, and taking account of past history and blood alcohol at the time of detox.	Thank you; we have amended the recommendation in light of your comment.
194	PR	Duncan Raistrick	5.08	NICE	1.3.6	21	Psychological interventions have more in common with each other than they have differences. It seems that the intensity of therapy suggested reflects those used in trials, but the intensity of treatment should be commensurate with the overall severity of the addiction problem rather than linked to a particular kind of treatment. A rational approach to treatment is the use of stepped care which has not been mentioned.	Thank you; the intensity of treatment in our recommendations does in fact reflect the severity of the disorder as our recommendations followed a broadly stepped care approach where the nature of the interventions varies in line with differing patients' need. We have also offered examples of "typical" treatment length, as such this suggests an indicate duration not a detailed specification of a precise number of sessions. This is in line with all clinical guidelines which are aids to and not a substitute for clinical judgement.
195	PR	Duncan Raistrick	5.09	NICE	4	30 -34	It is rather strange to have research recommendations as part of clinical guidelines. To do so is bound to be restrictive and reflect the views and interests of the panel. It would be better to delete this section and leave researchers and practitioners in the field to determine for themselves where evidence is lacking and where research can give value for money in terms of updating guidance. The research ideas presented are disappointing in that they focus on specific treatments rather than bringing new ideas to the table.	Thank you for your comment. This is a standard template set by NICE in which research recommendations always come at the end of the guidance. These are based on areas of the review which showed promise but lacked evidence. We also are required to use the PICO format which means treatments need to be specific.
196	PR	Duncan Raistrick	5.10	NICE	App. D	43	This is a further caution against using cut offs. The Audit was designed for use in primary care and the use of cut scores to send people down different treatment routes probably works reasonably well in this setting. The Audit has been used in other settings, for example, general hospitals, and the evidence base to support the same care pathways is much weaker.	Thank you. It is unclear why AUDIT is applicable in one medical setting and not another as it is measuring the same elements of need which determine the care pathways. We agree it has not been studied as widely in general hospitals, but this is lack of evidence rather than evidence that it is not appropriate.
197	PR	Duncan Raistrick	5.11	NICE	App. E	44	Similar comment to section D above but with reference to SADQ. The SADQ was designed to assess whether people are suitable for controlled drinking – it does reflect current	Thank you for your comment. The SADQ was also developed as a clinical tool to assess need for withdrawal management

							drinking but is not a substitute for a proper risk assessment. Guidelines need to take account of the available evidence, nonetheless, in the real world there are very limited facilities for inpatient or indeed day patient detoxification – most clinicians have experimented with home or other forms of community detoxification. So, even severe withdrawal, including a history of seizures and delirium and co morbidity may be handled at home or in the community depending on the facilities available.	and has evidence of predictive validity in withdrawal. But we agree it is not a substitute for risk assessment which is why the guideline (e.g. 1.3.2) describes the full range of issues that should be considered.
395	SH	Kaleidoscope	20.01	Full	5.25.3 -5.25.5	177 -181	[177:Line 2 to 181: Line 31] NICE offer no clinical evidence why severely dependent drinkers, particularly if they have had complicated withdrawals before, should not be detoxified in the community. Severely dependent drinkers are at greater risk of dying from their drinking than from any hypothetical risk of a community detoxification.	Thank you for your comment. As we are sure you are aware, the evidence base for this topic is limited and most literature is observational in nature. We believe that the review of the literature provides sufficient evidence for the safety and efficacy for community based withdrawal management. However, as we stipulate in this section, many of the studies excluded participants with psychiatric and medical comorbidities and a previous history of seizures. These patients were typically referred for inpatient withdrawal management. We believe that the tone of the review suggests that for the majority of patients, withdrawal management in the community is appropriate. However, consideration should be given to some issues which may indicate that inpatient withdrawal management may be necessary (see section 5.29.6).
396	SH	Kaleidoscope	20.02	Full	4.2.2 -4.3.3	52 -65	[52: Line 30 to 65: Line 7] Three severely dependent subjects gave a personal account. Two of the three attributed their current sobriety to Alcoholics Anonymous. Two carers gave their accounts. One carer derived great help from Al-Anon as sister fellowship to AA and one carers partner derived great help from AA and NA. Yet page 221 lines 41-2 says “An evaluation of the classic AA approach is outside the scope of this guideline”. Some explanation is essential otherwise a	Thank you for your comment. The personal accounts were for illustration only. In the final draft of the guideline we have removed them from the chapter and have placed them in Appendix 14 so it is clear that the accounts did not contribute to the formation of recommendations.

							prejudice against AA on the part of the guidelines may well be inferred.	
397	SH	Lundbeck	15.01	NICE	1.3.1.2	15	[And Full version 6.21.5.2 – page 306] Lundbeck welcomes the GDG recommendation in the general principles, for all people who misuse alcohol to offer interventions to promote abstinence or moderate drinking as appropriate and prevent relapse, in community-based settings. Reducing from high to moderate drinking levels is in line with the well established evidence base demonstrating that alcohol related harm is reduced through lower drinking levels. We believe this supports the increasing recognition of 'reduction in alcohol consumption' as a valid treatment goal associated with clinical benefit. [D.R Gastfriend et al (2007). Reduction in heavy drinking as a treatment outcome in alcohol dependence. Journal of Substance Abuse Treatment, 33, 71-80; L. C. Sobell et al (2003). Assessing drinking outcome in alcohol treatment efficacy studies: selecting a yardstick of success. Alcoholism: Clinical and Experimental Research, 27(10), 1661-1666]	Thank you for your comment.
398	SH	Lundbeck	15.02	NICE	Introduction	4	The introduction (paragraph 5 on page 4) summarises several reasons for the relatively low treatment rate of 6% per year for alcohol dependence. In addition we would suggest including abstinence as a further reason because: For some people the treatment goal of abstinence may be perceived as unrealistic and deter them from engaging with and/or continuing with treatment. Although current pharmacological treatment options aim to keep patients abstinent, only 25-60% of treated patients maintain their abstinence for a year. [Kaplan HI. Kaplan and Sadock's Comprehensive Textbook of Psychiatry. 8th ed., Lippincott Williams and Wilkins, 2005. Vol. 1, p 1184. Miller WR, et al. How effective is alcoholism treatment in the United States? J Stud Alcohol 2001;62:211-220] Longer-term follow-up studies in Europe give similar rates. [Gual A, et al. Five-year outcome in alcohol dependence: a naturalistic study of 850 patients in Catalonia. Alcohol &	Thank you. Many factors are likely to be involved in the low levels of access to treatment. However, we are not aware of any evidence that treatment goal is responsible for this. The recent ANARP study found that the majority of treatment agencies in England offer a goal of controlled drinking.

							Alcoholism 1999;34(2):183-192. Bottlender M, Soyka M. Outpatient alcoholism treatment: predictors of outcome after 3 years. Drug Alcohol Depend 2005;80:83-89. Feuerlein W, Kufner H. A prospective multicenter study of in-patient treatment for alcoholics: 18- and 48-month follow-up (Munich Evaluation for Alcoholism Treatment, MEAT). Eur Arch Psychiatr Neurol Sci 1989;239:144-157. Mann K, et al. The long-term course of alcoholism, 5, 10 and 16 years after treatment. Addiction 2005;100:797-805] In addition the source/reference for the 6% treatment rate is not easily identifiable from the evidence in the draft Full guideline and would benefit from clarification.	
399	SH	Lundbeck	15.03	Full	7.1.3	340	There are important differences between nalmefene and naltrexone which we would recommend the GDG include in this section. (i) The current wording states that 'nalmefene is a mu antagonist and possibly partial agonist'. The evidence demonstrates that nalmefene has a different receptor subtype affinity compared with naltrexone. Nalmefene is a potent opioid antagonist, with affinity at all opioid receptor subtypes (μ, κ, and δ receptors),(Michel et al., 1985) and showing full antagonism at μ and δ receptors(DeHaven-Hudkins et al., 1990; Bart et al., 2005) and partial agonism at κ receptors.(Bart et al., 2005) (ii) The current wording states 'Both of these medications, though naltrexone is more widely used, can reduce the pleasurable effects of alcohol'. This wording should specify that the wider use of naltrexone is in maintenance of abstinence in alcohol dependence. Furthermore the wording should highlight that the anticipated licensed indication for nalmefene is reduction of alcohol consumption in alcohol dependent patients.	Thank you. The GDG decided not to include nalmefene in its review as it is not licensed for use in the UK and there is little experience in the use of the drug in the UK. We have reviewed the section you refer to and are content it properly addresses the important issue in relation to the use and pharmacology of these drugs.

							[Michel ME, Bolger G, Weissman BA. Binding of a new opiate antagonist, nalmefene, to rat brain membranes. Methods Find Exp Clin Pharmacol 1985; 7 (4): 175–177. DeHaven-Hudkins DL, Brostrom PA, Allen JT, et al. Pharmacological profile of NPC 168 (naltrexone phenyl oxime), a novel compound with activity at opioid receptors. Pharmacol Biochem Behav 1990; 37: 497–504. Bart G, Schluger JH, Borg L, et al. Nalmefene induced elevation in serum prolactin in normal human volunteers: partial kappa opioid agonist activity? Neuropsychopharmacology 2005; 30: 2254–2262]	
400	SH	Lundbeck	15.04	Full	7.8.6	399	The GDG have concluded 'only a few medications currently still show promise for potential routine use in the clinic including…nalmefene'. Lundbeck would like to update the GDG on the current status of the phase III clinical development programme for nalmefene. In 2008, H. Lundbeck A/S announced the initiation of three Phase III, randomised, placebo-controlled, parallel-group clinical trials investigating the effect of 'as needed' use of nalmefene (20 mg/day) versus placebo in patients with alcohol dependence. The clinical Phase III program is progressing as planned and is expected to enrol 1,800 patients in total. Lundbeck expects to file a marketing authorisation application to the EU regulatory authorities in 2011.	Thank you for your comment. The outcome of the programme may well inform an update of the guideline.
401	SH	Lundbeck	15.05	NICE	7	37	The guideline states 'NICE clinical guidelines are updated so that recommendations take into account important new information. New evidence is checked 3 years after publication, and healthcare professionals and patients are asked for their views; we use this information to decide whether all or part of a guideline needs updating. If important new evidence is published at other times, we may decide to do a more rapid update of some recommendations'. The current timelines for the ongoing nalmefene phase III clinical trial programme indicate that important new evidence is likely to be available within the 3 year guideline review period. Lundbeck are currently	Thank you for your comment.

							liaising with the National Horizon Scanning Centre to ensure that nalmefene is properly considered by the Department of Health in the future NICE review programme. This will ensure that nalmefene is made available to patients as soon as possible after UK license approval.	
402	SH	Lundbeck	15.06	NICE	Introduction	4	The 3rd paragraph states 'Alcohol dependence affects 4% of people aged between 16 and 65 in England, and over 26% of this population consume alcohol in a way that is potentially or actually harmful to their health or well-being'. Please can the GDG clarify whether the 26% refers to the 4% of people or the total population aged between 16 and 65.	Thank you. This refers to the total population between 16 and 65.
403	SH	Lundbeck	15.07	NICE	Introduction	3	Last paragraph: Please clarify how the categories for alcohol dependence chosen by NICE (mild, moderate, severe), should be interpreted in relation to the WHO risk-levels, cf. "International guide for monitoring alcohol consumption and related harm" (WHO 2000).	Thank you. However, these categories are relevant to clinical decision making only and do not relate to WHO risk levels.
404	SH	Lundbeck	15.08	NICE	Introduction	4	Please consider adding a paragraph which brings into perspective the current discussions among regulators and key opinion leaders towards changing the treatment paradigm for alcohol dependence. This change has been reflected in the recently published EMA guideline on development of treatment for alcohol dependence (CHMP/EWP/20097/08), which states that where an alcohol dependent patient is not able or willing to become abstinent a clinically significantly reduced alcohol intake with subsequent harm reduction can be a valid treatment goal. In this context, it should be mentioned that new treatments, such as nalmefene, are currently being developed, which will provide pharmacological interventions as one option to aid the reduction of alcohol consumption for the patient, with associated clinical benefit. The clinical development programme for nalmefene was developed by Lundbeck following Scientific Advice from the EMA (with the MHRA as rapporteur).	Thank you. Nalmefene is not licensed for the treatment of alcohol misuse. However, the available efficacy evidence was considered in the evidence chapter. It was the GDG's view that it would not be appropriate to include this issue in the NICE guideline.
405	SH	Lundbeck	15.09	NICE	Introduction	397	The paragraph concerning nalmefene would seem to be incomplete. Please consider an update of this paragraph with more recent scientific evidence as published by S. Karhuvaara et al: "Targeted Nalmefene With Simple Medical	Thank you for your comment. This paper is already included in the evidence summary of the full guideline and Chapter 7discusses pharmacotherapy for less

							Management in the Treatment of Heavy Drinkers: A Randomized Double-Blind Placebo-Controlled Multicenter Study. “ This study concludes that “nalmefene appears to be effective and safe in reducing heavy drinking, even when accompanied by minimal psychosocial support.” The article  2007 karhuvaara.pdf is enclosed for ease of reference.	dependent or non-dependent drinkers.
406	SH	National Treatment Agency for Substance Misuse	38.01	NICE	General	General	The NTA welcomes the publication of the guidelines for the assessment and management of harmful drinking and alcohol dependence. The guidelines offer comprehensive & helpful evidence based guidance for services to enhance treatment outcomes for service users and their social networks.	Thank you for your comment.
407	SH	National Treatment Agency for Substance Misuse	38.02	NICE	General	General	The prominence given in the guidelines to engaging with service users’ families and social networks to support and maintain change is welcomed.	Thank you for your comment.
408	SH	National Treatment Agency for Substance Misuse	38.03	NICE	General	General	The guidelines make reference to issues of co-existing physical and psychological health problems, but there are only a few references to co-existing illicit drug use. Combined drug and alcohol misuse is widespread. For instance, The National Treatment Outcome Research Study (NTORS) found that 33% of those entering drug treatment services were drinking at levels above those recommended as safe. The NTA would welcome the inclusion of a clear statement, early in the document, that the guidance is applicable to the alcohol treatment of service users with co-existing drug and alcohol problems. Given the likely common biological, psychological and social pathways to substance use problems and an overlap of common elements in interventions, this group of service users should be offered holistic and integrated care & treatment.	Thank you for your comment; we have made further reference to drug misuse in the recommendations. However it should be noted that the term ‘psychiatric comorbidity’ used frequently in the document incorporates drug misuse.
409	SH	National Treatment	38.	NICE	1.2.1.3	12	Include: assessment of other drug use	Thank you; assessment of comorbid

		Agency for Substance Misuse	04					psychological and drug problems is covered later in the guidance.
410	SH	National Treatment Agency for Substance Misuse	38. 05	NICE	1.2.1.3	12	Include: assessment of psychological problems	Thank you; assessment of comorbid psychological and drug problems is covered later in the guidance.
411	SH	National Treatment Agency for Substance Misuse	38. 06	NICE	1.3.9	24 -27	The NTA would welcome mention of the role of specialist substance misuse services for young people in assessment and delivering the interventions included in the guideline. These specialist services are available in each local authority area in England and work closely with CAHMS to support young people who have alcohol and other substance misuse problems.	Thank you; we considered this issue but did not feel able to be so specific about the precise configuration of services – where specialist alcohol services might be nested in or separate from other CAMH services. This meant that it might not be possible to make such a referral. We think it is better for local services to resolve rather than for NICE to make specific recommendations about it.
412	SH	National Treatment Agency for Substance Misuse	38. 07	NICE	1.3.9.2	24	Add 'and young people's substance misuse treatment services' after '(CAMHS)'	Thank you; we considered this issue but did not feel able to be so specific about the precise configuration of services – where specialist alcohol services might be nested in or separate from other CAMH services. This meant that it might not be possible to make such a referral. We think it is better for local services to resolve rather than for NICE to make specific recommendations about it.
413	SH	National Treatment Agency for Substance Misuse	38. 08	NICE	1.3.9.12	27	There should be a recognition that multisystemic therapy is not available in all parts of the country	Thank you. The purpose of NICE guidelines is to set standards for treatment. Such interventions may not always be available but there have been significant developments in MST services in England. We will draw this issue to the attention of those developing the NICE commissioning guidelines on alcohol.
414	SH	National Treatment Agency for Substance Misuse	38. 09	NICE	1.3.10.3	27	The bullet on the treatment needs of those also misusing drugs is relevant and important but does not belong in 1.3.10.3, which is concerned with co-morbid mental health disorders. Drug misuse is a condition comorbid with alcohol misuse, but not a comorbid mental health disorder, and as such requires as separate point.	Thank you but drug and alcohol problems are mental disorders in all established diagnostic systems and we think it is appropriate to leave the recommendation as currently drafted.

415	SH	National Treatment Agency for Substance Misuse	38.10	NICE	1.3.10.3	27	Service users may have treatment needs relating to the misuse of illicit substances other than “opioid, cocaine or benzodiazepine”, e.g. amphetamines, cannabis.	Thank you for your comment - we have made some adjustment to the recommendation in light of your comment.
416	SH	NETSCC-HTA Ref 1	6.01	Full	4.1.1	417	[Appendix 1] In relation to children there does not appear to be any evidence relating to those aged 10-15 and it would be useful to make this clear.	Thank you but the very limited evidence for those under 15 is referred to in any sections that discuss children and young people. This population is considered under the title of ‘special populations’ at various points in the guideline. We believe the limitations of the evidence are adequately stated within these sections.
417	SH	NETSCC-HTA Ref 1	6.02	Full	4.3.1o	419	[Appendix 1] Although the qualitative literature includes relevant equity issues there are no specific recommendations.	Thank you for your comment. The recommendations do cover specific issues regarding discrimination and providing information in appropriate languages. The NICE guideline also contains a section on ‘person-centred care’ which covers wider ‘equity’ issues, such as taking account of ‘physical, sensory or learning disabilities, and .. people who do not speak or read English.’
418	SH	NETSCC-HTA Ref 1	6.03	Full	General	General	The health economics literature was restricted to studies from 1998 on the general grounds of relevance. However, there is a very small literature in total and the clinical review was considering older studies. This results in a situation where studies in the clinical review (Hayashida et al; O’Farrell et al) were not considered in the health economics review. Modelling studies published after 1998 and included in the review may have been on older effectiveness data. Where there is a small literature it would be better to consider all studies on their merits.	Thank you. Health economic studies published from 1998 onwards that reported data from the financial year 1997/98 onwards were included. This date restriction was imposed in order to obtain data relevant to current healthcare settings and costs. The same restrictions were not applied to the systematic review of clinical effectiveness data. For the clinical review “date restrictions were not applied, except for searches of systematic reviews, which were limited to research published from 1993 onwards.”
419	SH	NETSCC-HTA Ref 1	6.04	Full	General	General	Consideration might also have been given to whether economic studies on substance abuse treatment (of which there are more recent studies) might have sufficiently	Thank you. Studies evaluating substance abuse treatment were not considered in the guideline scope (see Appendix 1).

							generalisable results to inform the relative cost-effectiveness of alcohol treatment options	These criteria were also applied to health economic studies.
420	SH	NETSCC-HTA Ref 1	6.05	Full	3.2.19	48	Although there is reference in the text to studies not meeting the inclusion criteria, I could not find any information on economic studies excluded. Therefore, the following studies may have been considered by the reviewers and excluded on quality/relevance grounds. Although, again considering the limited literature, some of the findings may have been worth reporting. Holder, H. D., Cisler, R. A., Longabaugh, R., Stout, R. L., Treno, A. J. & Zweben, A. (2000) Alcoholism treatment and medical care costs from Project MATCH, *Addiction*, Vol. 95, No. 7, pp. 999-1013. Humphreys,K. and Moos,R. (2001): Can encouraging substance abuse patients to participate in self-help groups reduce demand for health care? A quasi-experimental study. *Alcoholism: Clinical & Experimental Research,* 25(5):711-716. Marques,A.C. and Formigoni,M.L. (2001): Comparison of individual and group cognitive-behavioral therapy for alcohol and/or drug-dependent patients. *Addiction*, 96(6):835-846. Nalpas,B., Combescure,C., Pierre,B., Ledent,T., Gillet,C., Playoust,D., Danel,T., Bozonnat,M.C., Martin,S., Balmes,J.L., and Daures,J.P. (2003): Financial costs of alcoholism treatment programs: a longitudinal and comparative evaluation among four specialized centers. *Alcoholism: Clinical & Experimental Research*, 27(1):51-56. Pettiniati, H. M., Meyers, K., Evans, B. D., Ruetsch, C. R., Kaplan, F. N., Jensen, J. M. & Hadley, T. R. (1999) Inpatient alcohol treatment in a private healthcare setting: Which patients benefit and at what cost? *The American Journal on Addictions*, Vol. 8, pp. 220-233.	Thank you. The studies by Humphreys et al. (2001) and Marques et al. (2001) include patients with substance abuse rather than alcohol abuse. Therefore, both studies are outside of the guideline scope. The study by Nalpas et al. (2003) is not a comparative analysis but describes health care costs across four alcohol detoxification centres in France. Therefore, this study did not meet the inclusion criteria for economic studies. The studies by Holder et al. (2000) and Pettinati et al. (1999) have been reviewed and are now included in the relevant guideline sections and appendices.
421	SH	NETSCC-HTA Ref 1	6.06	Full	5.8.6	118	The health economics summary on stepped care does not refer back to the effectiveness review which concluded that the stepped care model studied was not applicable to the guideline.	Thank you. The health economics summary has been amended in order to refer back to the clinical effectiveness review earlier in the chapter.
422	SH	NETSCC-HTA Ref 1	6.07	Full	6.21.1	299	The study by Alwyn et al does not seem to be in the evidence tables but no indication is given of formal	Thank you. This study is now included in the economic evidence tables in the

							exclusion.	appendix.
423	SH	NETSCC-HTA Ref 1	6.08	Full	General	General	This is a very lengthy guidance document and the presentation must have posed considerable challenges. The order of the material might be reconsidered in terms of the order set out in the scope and it would be useful to have a chart relating the sections of the guidance to each other.	Thank you for your comment. We have grouped our reviews in order to present them in a clear and coherent manner. We believe this facilitates the reading of the guideline. We do not think that following the framework set out in the scope would bring any advantages nor would the chart you suggest.
424	SH	NETSCC-HTA Ref 1	6.09	Full	5	94 -213	[Particularly 5.12 onwards] Section 5 poses particular problems as it addresses different issues which are not always clearly signposted and the section on assessment does not appear to follow the same format as others in terms of evidence reviews. The order of the material in this section might be reconsidered with 5.21onwards possibly coming earlier. The text moves seamlessly from an effectiveness review of care settings (5.25.4) to discuss indicators for inpatient care (5.25.5) without clearly indicating that a different form of evidence is being drawn upon.	Thank you for your comment. The 'Studies considered' section of this review has now been amended to better signpost the later discussion about indicators for inpatient care.
425	SH	NETSCC-HTA Ref 1	6.10	Full	5.28.8	212	There is also a problem in relation to the different sections of the guidance and appropriate cross referencing – so that the discussion on care settings includes reference to psychosocial treatment packages but that evidence has not yet been presented.	Thank you for your comment. In relation to this section, we are unsure what cross-referencing issue you are referring to. Cross-referencing to chapters that are still to come is sometimes necessary to avoid repetition.
426	SH	NETSCC-HTA Ref 1	6.11	Full	General	General	The document requires careful proof reading as there are a number of problems with spelling, punctuation, apparently missing words etc. Some of this is minor but in some cases potentially misleading –see below	Thank you for your comment. This draft has not yet been through an editorial check but such errors will be rectified for the next draft.
427	SH	NETSCC-HTA Ref 1	6.12	Full	6.21.4	305	In this extract below (lines 26-30) I think a phrase such as 'as a component' has been missed out at * "As can be seen from the clinical summary the GDG considered that TSF and motivational-based interventions should be provided * as the evidence, particularly against treatment as usual or similar controls was not strong enough to support their use as a standalone intervention for harmful and mildly dependent drinkers who seek treatment."	Thank you, this has been rectified.

428	SH	NETSCC-HTA Ref 1	6.13	Full	5.11	120	Although the particular recommendation is clear, what is not clear is the process by which certain evidence gaps translate into research recommendations and other do not. The importance of the research question is set out but not its *relative* importance, in terms of other potential research. In the relevant sections of chapter 5, there is also a lack of evidence shown with respect to case management and stepped care. For stepped care, there is some indication of cost-saving potential but there is no research recommendation	Thank you for your comment. The relative merits of the various recommendations are decided on by the GDG. A key criteria is whether the research will inform future developments of the guideline.
429	SH	NETSCC-HTA Ref 1	6.14	Full	General	General	This point can be extended to other areas where there is an absence of evidence but which are not included in the research recommendations.	Thank you. You have provided no section reference so we are not clear about what your query relates to.
430	SH	NETSCC-HTA Ref 2	7.01	Full	general	general	It has fulfilled the scope well, despite the challenges of lack of evidence in places.	Thank you for your comment.
431	SH	NETSCC-HTA Ref 2	7.02	Full	5.19.2	137	I think that there are some issues about the role of assessment tools. First, there is a need for better assessment in primary care and a barrier is the often lack of any assessment tool at all there, for instance because no tool is routinely available during a standard consultation. There needs to be more clarity about who is assessing for what purpose. Would GPs use AUDIT? Is anything better than nothing?	Thank you for your comment. In the algorithm in Figure 5 we are suggesting use of AUDIT as a secondary tool to assess need for treatment after being screened using brief measures such as FAST SASQ. This is consistent with current DH guidance for primary care and NICE guidance. All practitioners offering specialist assessment and treatment will need to follow the principles in this guideline regardless of the setting they work within.
432	SH	NETSCC-HTA Ref 2	7.03	Full	5.21	146	Again with a focus towards primary care staff and other non specialists, some direction is needed about what diseases, signs and situations suggest that the practitioner should inquire about alcohol. It is such a long list that guidance would be very useful.	Thank you for your comment. The various presentations which should prompt a primary care practitioner to inquire about alcohol or complete a brief case identification questionnaire (e.g. the AUDIT) is discussed at length in the NICE public health guideline PH24 (NICE, 2010a).
433	SH	NETSCC-HTA Ref 2	7.04	Full	5.22.1.2	169	Assessment tools should also be available at the right moment! In the cupboard in another room may be no use at all.	Thank you but this is a matter for local services to determine.
434	SH	NETSCC-HTA Ref 2	7.0	Full	general	general	I am a little unclear as to the intended readership of the full	Thank you – you are correct in your

			5				guidance. I have read and looked at a number of equivalent reviews and this seems to be the house style. I take it that it is a reference document that few will read and some may look at sections of. It is to support the briefer guidance. It is also a fantastic mine of information.	assumptions.
435	SH	NETSCC-HTA Ref 2	7.06	Full	general	general	A inherent difficulty is that much of the alcohol literature is not up to systematic review and meta-analysis methods. The narrative reviews conducted instead are thoughtful and sensible however.	Thank you for your comment.
436	SH	NETSCC-HTA Ref 2	7.07	Full	5.18.2	135	There are a number of brief questionnaires which are NOT mentioned, such as CAGE, MAST and ASMA. It could be helpful to explain why they are not considered.	Thank you for your comment. A review of brief questionnaires such as CAGE and MAST which are usually used for screening has been conducted by the NICE public health guideline (NICE, 2010a).This has been made clear in the aim of the review.
437	SH	NETSCC-HTA Ref 2	7.08	Full	general	general	The statistical meta analysis techniques seem fine, but they cannot often be applied properly	Thank you for your comment. As no specific reference has been given as to where these have not been applied we cannot provide a full response.
438	SH	NETSCC-HTA Ref 2	7.09	Full	general	general	Except, throughout, I wonder about the wisdom and appropriateness of using meta analysis methods when there are very small numbers of studies being considered? This happens in many tables.	Thank you for your comment. Using the GRADE methodology, if it is appropriate to combine data from more than one study the evidence can be downgraded if this is going to cause problems that are likely to add bias to the evidence. The meta-analyses methods, and hence the use of forest plots is a useful way of presenting data even for single studies. Where it is appropriate to use meta-analysis, regardless of the number of studies, this approach was followed. This is appropriate when using GRADE.
439	SH	NETSCC-HTA Ref 2	7.10	Full	general	general	The health economics estimates are also at standard, when they can be applied at all, but they are subject to the usual problems of relying on estimates of estimates in wide use but of dubious quality. For instance, why is a clinical psychologist assumed to cost £75 an hour? The other problem, which besets the health economics of	Thank you. The unit cost of £75 per hour is taken from the widely cited Unit Costs of Health and Social Care (Curtis, 2009) - a useful source of national unit cost estimates for the UK. It is not possible to respond to the second

							psychological interventions is that the estimated costs of non treatment are always so high and the estimated costs of treatment so low that the intervention is always worth it.	comment as the reviewer does not cite any specific examples to support their statement.
440	SH	NETSCC-HTA Ref 2	7.11	Full	general	general	Given the challenges of working with diverse areas of research that mainly fall short of NICE standards, I am happy with most of the recommendations.	Thank you for your comment.
441	SH	NETSCC-HTA Ref 2	7.12	Full	4	92 -93	The recommendations regarding experience of care are sensible, but I fail to see how they emerge from the qualitative literature.	Thank you for your comment; we have redrafted the 'From evidence to recommendations' section in light of your comment.
442	SH	NETSCC-HTA Ref 2	7.13	Full	6.26	336	A major difficulty is that there is a grave shortage of people qualified to conduct systemic and family therapy in the UK.	Thank you. We agree that there may be resource issues that arise from this recommendation. NICE will be producing commissioning guidance and we will draw this to the attention of the group responsible for the guidance.
443	SH	NETSCC-HTA Ref 2	7.14	Full	6.26.12	337	The research recommendation, and perhaps the rest of this chapter, perhaps does not consider seriously enough the impossibility of separating out alcohol and drugs amongst younger people. It would be a challenge to find anyone in the UK under 30 who has an alcohol problem and who has never used drugs.	Thank you. We accept that there is considerable comorbidity but we believe that this is well covered in the relevant section and the recommended interventions address both drugs and alcohol.
444	SH	NETSCC-HTA Ref 2	7.15	Full	4	51 -93	**The use of personal accounts and qualitative data is commendable but there are problems.** First, the personal accounts are, by qualitative research standards, unacceptably weak and unanalyzed. They are the equivalent of pasting a raw data spreadsheet into a quantitative report.	Thank you for your comment. The personal accounts were for illustration only, as we stated in the introduction to the chapter, and for that reason they were unanalysed. However, given your concerns we have removed them from the chapter and have placed them in Appendix 14 so it is clear that the accounts did not contribute to the formation of recommendations.
445	SH	NETSCC-HTA Ref 2	7.16	Full	4	51 -93	Second, **the literature search methods used in Chap 4 may have missed qualitative research that appears in non medical/ health/ psychology sources, such as public policy and law and WILL have missed the number of book treatments of qualitative research germane to alcohol.** This comment applies to a lesser	Thank you for your comment. We feel we accomplished our protocol goal as well as possible given the challenges presented to us and made compromises only where necessary. For clarity, the systematic search for qualitative research entailed a

							extent to other searches. For instance, George Valliant's book is not referenced, neither is Richard Velleman's, but both have relevant material.	sift of over 5000 references; evidence of books and book chapters on psychology and psychological aspects of related disciplines (including law, education and sociology) was sourced from PsycINFO; reference lists of potentially relevant studies were manually searched; in addition, the GDG advised of any works not identified from the formal search of the literature. For the qualitative analysis of personal experiences, a number of key websites were searched for any relevant information and discussion. Although the search strategy was comprehensive, limitations in time and resources prevented us from looking at additional resources covering a wider range of disciplines - for this, and the clinical searches.
446	SH	NETSCC-HTA Ref 2	7.17	Full	4	51 -93	Third, the original qualitative data is useful but the methods of analysis used are not described in sufficient detail and it is conventional to put participant identifier numbers after each quote.	Thank you for your comment. It would be useful to know what other detail you would like to see explained in the methods. We have added patient identifier numbers. Please note that this section now appears in Appendix 14.
447	SH	NETSCC-HTA Ref 2	7.18	Full	2	14 -30	**Chapter 2 is relatively weak in a number of regards and in my opinion needs a rewrite to ensure that it represents the state of the science.** It makes a number of overly simplistic claims and cites a number of sources, such as the Prime Minister's Strategy Office that are not credible sources of information about alcohol.	Thank you. The references in this chapter have now been revised.
448	SH	NETSCC-HTA Ref 2	7.19	Full	2	14 -30	Chapter 2 needs conclusions of some kind	Thank you. This chapter follows the standard format for NICE guidelines and we do not think a conclusion would be appropriate in this chapter.
449	SH	NETSCC-HTA Ref 2	7.20	Full	3	31 -50	[And throughout the report] Because the report involves a number of different reviews of different topics, the review methods described are highly repetitive and I suggest that the core methods are described	Thank you for your comment. The core methods used in this guideline are described in Chapter 3. The way in which the methods are described needs to be

							once, particularly as the state of the evidence is largely insufficient for meta analysis except regarding pharmacology	standardised across guidelines and thus will not be changed. Furthermore, we are aware that not everyone will read the entire guideline from cover to cover and may skip to sections relevant to their needs. Therefore, it would be inappropriate to state the method used for the overall guideline in only one place. In addition, the methods utilised may have also varied across reviews and chapters. Therefore, it is appropriate to describe specific methods for each review (i.e. the review protocols) in each chapter.
450	SH	NETSCC-HTA Ref 2	7.2 1	Full	general	general	Because most of the reviews are “narrative” reviews the report would be easier to read if it faced up to this and did not mechanically use the systematic review format. This makes for tedious and repetitive reading.	Thank you for your comment. Some topic areas are notoriously difficult to evaluate using meta-analyses and must be done using a narrative synthesis method. However, it is important that a narrative synthesis is also carried out systematically and that the reporting of findings as well as the study inclusion/exclusion criteria is transparent in order to reduce bias. When it was appropriate to use meta-analysis or to use a narrative review, this was done (and clearly stated).
451	SH	NETSCC-HTA Ref 2	7.2 2	Full	6	214 -337	This chapter would benefit from more pulling together of the evidence for different types of intervention. The tables are rather overwhelming. I’d like to see a simple table or chart that lists ALL the possible interventions in rank order of the evidence that they are effective.	Thank you for your comment. We do not think it would be useful to have such a table in the guideline.
452	SH	NETSCC-HTA Ref 2	7.2 3	Full	general	general	The research recommendations are all sensible	Thank you for your comment.
453	SH	NETSCC-HTA Ref 2	7.2 4	Full	general	1 -43	1st 43 pages all numbered p43	Thank you for your comment. This has now been rectified.
454	SH	NETSCC-HTA Ref 2	7.2 5	Full	2	14	[Lines 7-9] Do many people drink without any harmful effects AT ALL?	Thank you. This sentence has now been re-worded.

							This sounds like government propaganda and is contradicted immediately thereafter	
455	SH	NETSCC-HTA Ref 2	7.26	Full	2	14	[Line 22] “beverage alcohol” is confusing on first read	Thank you, this has been changed.
456	SH	NETSCC-HTA Ref 2	7.27	Full	2	14	[Lines 21-35] This is too brief and simplistic to be evidence based	Thank you but the issue of safe and harmful limits has been comprehensively covered by the NICE public health guidelines and it is beyond the scope of this guideline to review this in detail. It is mentioned here as part of a general scene setting chapter. The main source is a recent key WHO expert committee report which reviewed all the available evidence.
457	SH	NETSCC-HTA Ref 2	7.28	Full	2	14	[Lines 37-38] Define “rapidly” compared to what?	Thank you. This effect of alcohol is well recognised and described. As it is a small molecule and consumed in liquid form it is more rapidly absorbed than many other drugs. It is worth noting this is a general introduction designed to give the reader a general overview of knowledge in this area rather than being a detailed review of the pharmacology of alcohol.
458	SH	NETSCC-HTA Ref 2	7.29	Full	2	14	[Lines 37-40] Issues of tolerance in dependence make this too simplistic	Thank you - please see response to comment 457 above.
459	SH	NETSCC-HTA Ref 2	7.30	Full	2	14	[Line 40] Suggest naming benzodiazepines given major problems of alcohol + benzodiazepines amongst the young.	Thank you for your comment. We agree and have added to the sentence e.g. benzodiazepines.
460	SH	NETSCC-HTA Ref 2	7.31	Full	2	15	[Line 2] Risk = ‘risks’	Thank you for your comment but ‘risk’ is appropriate in this context.
461	SH	NETSCC-HTA Ref 2	7.32	Full	2	15	[Lines 1-6] Mention impairments of memory and learning	Thank you for your comment. We have added “impairments of memory and learning” to this section.
462	SH	NETSCC-HTA Ref 2	7.33	Full	2	15	[Line 4] “can lead to” suggests cause when there may just be a strong association for some problems.	Thank you for your comment. ‘Lead’ has now been replaced with “contribute.”
463	SH	NETSCC-HTA Ref 2	7.34	Full	2	15	[Line 6 and throughout] The Prime Minister’s Strategy Unit work was authored by	Thank you. The PMSU interim report referred to original data sources and

							clever young civil servants with no prior knowledge of alcohol, with a brief to spin things towards alcohol problems being concentrated in a minority of problematic drinkers. It is not a credible scientific source.	these references have now been added.
464	SH	NETSCC-HTA Ref 2	7.35	Full	2	15	[Line 8] This is physical harms (most clearly at least)	Thank you for your comment. This line does relate to physical harm. This has been clarified in the sentence.
465	SH	NETSCC-HTA Ref 2	7.36	Full	2	15	[Line 20-23] What is the evidence that the ratio of problem drinkers to drinkers is lower with alcohol? This is based largely on spurious inflation of the ratio of problem cocaine or opiate users to users, by biased sampling methods.	Thank you but we disagree with your assertion. We cite in support of the statement the work of Kandel et al. (1997).
466	SH	NETSCC-HTA Ref 2	7.37	Full	2	15	[Lines 30-33] That such 'vulnerable groups' are more prone to harm is one of those 'false truisms' One should be specific about specific harms, not make generalizations about risk and harm as if the risks and harms are unitary (this applies to this entire page really)	Thank you. We agree that this page contains some generalisations such as socially disadvantaged people are more at risk of alcohol related harm. However, this is uncontentious, supported by evidence and authoritative citations are provided. This is a scene setting chapter to provide the reader with a general overview rather than being a comprehensive review of evidence of the relationship between alcohol and harm. Nevertheless, authoritative reference sources have been given for the interested reader to learn more about the complexities of the subject.
467	SH	NETSCC-HTA Ref 2	7.38	Full	2	16	ICD-10 – why ICD rather DSM and it would lengthen the shelf life to mention DSM-V's proposals.	Thank you. The GDG made a decision to use ICD-10 as it is currently in common use in the NHS, whereas DSM4 is more common in research, as this is a clinical guideline. Furthermore, as DSM5 is being developed, the proposals are currently no more than that, and may change before final publication which will be some time after publication of this guideline.
468	SH	NETSCC-HTA Ref 2	7.39	Full	2	17	[Line 9] What is the error of the 87% estimate?	Thank you. The error estimates are not provided for this data in the Health Survey for England. However it was

								based on a sample size of around 15,000 subjects using standardised methodology. The GDG's view is that this is the most reliable available data on the proportion of drinkers in the adult population.
469	SH	NETSCC-HTA Ref 2	7.40	Full	2	17	[Lines 16-20] Anderson and Baumberg's report (cited elsewhere in the present report) calculates that the mean intake in Europe by drinkers (ie excluding teetotalers) exceeds 21 units a week	Thank you. We note this information but should point out that this guideline refers to England and Wales rather than Europe.
470	SH	NETSCC-HTA Ref 2	7.41	Full	2	17	[Lines 22-41] It would be helpful to state the extent to which these definitions are themselves evidence based, rather than merely going along with them.	Thank you for your comment. This is the introductory chapter so we do not feel these definitions of drinking levels need to be justified in terms of quality of evidence. The relevant sources have been cited (which include both governmental and clinical findings).
471	SH	NETSCC-HTA Ref 2	7.42	Full	2	19	This page is full of percentages etc without any confidence intervals. E.g. "Half of homeless people…" Such factoids have no place in a NICE guideline and being presented this way is in marked contrast to the way the main review material is handled.	Thank you for your comment. This is a general introduction to the topic of harmful drinking and alcohol dependence, therefore confidence intervals would not be appropriate here.
472	SH	NETSCC-HTA Ref 2	7.43	Full	2	21	[Lines 27-29] Why so snooty about "addiction counsellors" without any evidence? I have heard many other non specialist health care professionals, psychology undergraduates etc, offer similar ignorance.	Thank you. Without a specific estimate "many" has been changed to "some". However, it is clear from many publications that some addiction counsellors hold this view.
473	SH	NETSCC-HTA Ref 2	7.44	Full	2	21	[Lines 32-38] This handles ASPD too simply for a state of the science review. First, there are links between alcohol problems and other "personality disorders." Second, whether different "personality disorders" are diagnostically discrete is a contested issue. Third, a lot of the research on Antisocial Personality is weak and confounds anti-social behaviour with antisocial personality, which inflates the correlation between alcohol and ASPD	Thank you - please see the response to comment 470.
474	SH	NETSCC-HTA Ref 2	7.45	Full	2	21	[Line 46] Effects surely "worsen" rather than "increase" these disorders?	Thank you for your comment; we have amended the sentence to which you refer.

475	SH	NETSCC-HTA Ref 2	7.46	Full	2	22	[Lines 1-11] There is a serious problem of specificity here, as these life events, traumas and stressors cause a wide variety of adult mental health problems.	Thank you for your comment. However, just because a factor may have a causal impact on a number of disorders does not mean it does not have relevance to a specific disorder.
476	SH	NETSCC-HTA Ref 2	7.47	Full	2	23	[Line 6] The referent for “this population” is hard to work out.	Thank you. However, the referent is the age adjusted mortality for people without alcohol dependence.
477	SH	NETSCC-HTA Ref 2	7.48	Full	2	23	[Line 16-18] A state of the science review should be more precise than this.	Thank you for your comment. However, as this is the introductory chapter, we do not feel the precision you are suggesting would be justified.
478	SH	NETSCC-HTA Ref 2	7.49	Full	2	23	[Lines 35-42] A brief mention of relevant neuropsychological models would be useful here.	Thank you for your comment. However, as this is the introductory chapter, we do not feel it warrants such a detailed consideration of the evidence.
479	SH	NETSCC-HTA Ref 2	7.50	Full	2	24	[Lines 24-27] A reference supporting the phenomenon of reinstatement is required.	Thank you. The correct reference for this [Edwards & Gross (1976)] has now been added.
480	SH	NETSCC-HTA Ref 2	7.51	Full	2.8	25	This section seems to be jumping the gun – isn’t this the main purpose of this report and guidance?	Thank you. However, this is an overview of current treatment and management of alcohol use disorders, no specific interventions or recommendations are made.
481	SH	NETSCC-HTA Ref 2	7.52	Full	2	28	[Line 11 - needs to be more consideration of the fact that “dependence” is epidemiologically slippery] I do not think Rush’s 1/10 guideline can be applied to alcohol. If 87% of the UK drink and about 1/10 drinkers show signs of alcohol problems (as some surveys suggest) then, say 8% of the UK population might need some form of treatment for alcohol problems. That is about 4.8 million people. There needs to be more consideration of the fact that “dependence” is epidemiologically slippery.	Thank you for your comment. However, Rush’s 1/10 guideline was developed only in relation to alcohol. Also, this guideline does not refer to the whole of the UK. The term ‘dependence’ was defined within the ANARP report and is referenced here for the interested reader.
482	SH	NETSCC-HTA Ref 2	7.53	Full	2	30	How about some conclusions to section 2?	Thank you for your comment. However, we believe a summary of this section is not necessary as it is an introductory chapter. The relevant information needed in this chapter is discussed in

								each sub-section.
483	SH	NETSCC-HTA Ref 2	7.54	Full	4	70	[Line 21] Typo m e = me	Thank you, this has been rectified.
484	SH	NETSCC-HTA Ref 2	7.55	Full	5	95	[Line 11] Suggest “The introductory chapter highlighted”	Thank you - this has been amended as suggested.
485	SH	NETSCC-HTA Ref 2	7.56	Full	5	107	Table 8 and other tables cuts off at the right margin	Thank you - this has been rectified.
486	SH	NETSCC-HTA Ref 2	7.57	Full	110	23 -26	Incorrect paragraph break	Sorry but we cannot locate the section reference.
487	SH	NETSCC-HTA Ref 2	7.58	Full	7.1	339 -342	It would be useful to link the material on neurochemicals to work on neuropsychopharmacology, particularly work on the dual affect systems.	Thank you but we are unable to answer your comment as we are unclear to what you are referring to, in particular the dual affect system.
488	SH	NETSCC-HTA Ref 2	7.59	Full	7.7.8	395 -396	The authors are excited about pharmacology because they can get properly stuck into the systematic review and meta-analysis methods. It would be useful to mention that some drinkers are hesitant about pharmacological therapy because of wishing to aim to be substance free	Thank you. We do not consider this to be a fair or accurate comment. We have undertaken a number of similar reviews of other data sets e.g. psychological interventions.
489	SH	NETSCC-HTA Ref 2	7.60	Full	7.10.2	402	[Line 25] Consider = considered	Thank you, this has been revised.
490	SH	NHS Blackpool	31.01	NICE	1.3.9	24	Where can we send young people for detox as the only unit that catered for this age group is closed. NICE guidance should be available in the real world.	Thank you. We accept this can be very difficult. NICE guidelines set standards for care but if services are not meeting these standards then it should a matter for local commissioners to address. As you will be aware, detoxification is not without considerable risk and this is especially the case with young people. We should not limit our recommendations by the limitations of particular services.
491	SH	NHS County Durham and Darlington	25.01	NICE	General	General	There is only mention of CBT based psychosocial interventions, it doesn’t mention alcohol specific counselling.	Thank you. However, we found no good quality evidence for alcohol specific counselling. Also, we recommend a range of interventions, not just CBT.
492	SH	NHS County Durham and Darlington	25.02	NICE	1.3.1.5	8	Ethical implications of video need to be considered, will affect therapeutic alliance in counselling. It is however perceived that this would be an effective way to monitor delivery of interventions, welcomed by managers,	Thank you – this is a matter for local determination. We believe that such an approach can be very helpful to both practitioners and supervisors. It is part of

							not as welcomed by practitioners.	the delivery of effective interventions in trials, in training and in a number of well-developed clinical services.
493	SH	NHS County Durham and Darlington	25.03	NICE	1.2.2.1	13	It is an interesting shift to have abstinence as a recommendation in guidance, It is agreed that this commitment to recovery should be promoted.	Thank you for your comment.
494	SH	NHS County Durham and Darlington	25.04	NICE	1.3.2.3	18	There would be a huge funding implication if all clients drinking over 30 units or scoring 30+ on SADQ were referred into assisted withdrawal.	Thank you; we agree. This will be covered by the NICE commissioning and implementation work streams.
495	SH	NHS County Durham and Darlington	25.05	NICE	1.3.5.2	21	Couples therapy is a specialised field, and creates a training need across the workforce.	Thank you; there will be a number of other recommendations which may have training implications – these are for the NHS to consider.
496	SH	NHS Direct	18.01	Full	General	General	NHS Direct welcome the guideline and have no comment on its content.	Thank you.
497	SH	NHS Lothian	13.01	Full	7.8	396 -399	No ref. given for Leone et al (Cochrane Review) on GHB, tho' mentioned in text. No mention of oxybate (GHB) efficacy, tho', risks are mentioned. It is effective in relapse prevention. If patient prepared to take the risk of dependence! Adjust p.399, line 96 to reflect this? It is not included in Table 88, surprising, when you have included benzos and even antipsychotics, which have been shown in RCTs (e.g. olanzapine, flupenthixol) to increase relapse!!	Thank you for your comment. The GDG are aware of the Leone 2010 Cochrane review. However, the GDG were concerned about two factors concerning GHB – first its efficacy and secondly safety concerns – there is the risk of dependency as you suggest but also the risk associated with over dose. This risk is also stated clearly in the Leone review. The safety risks of GHB are discussed early on in the chapter. On the basis of this, the GDG did not think it appropriate to give further attention to GHB and decided on a 'do not use' recommendation due to its safety profile.
498	SH	NHS Lothian	13.02	Full	6.13	270 -277	No mention of the use of disulfiram supervised by partner. This was a component in several of the studies quoted (O'Farrell), and potentially important in promoting abstinence in these couple studies. Likewise, Neto et al (2008) showed that it was the systematic involvement of family members at each stage of the assessment and follow-up which was important (and the use of disulfiram) "Effectiveness of Sequential Combined Treatment in Comparison with Treatment as Usual in Preventing Relapse	Thank you for your comment. The experimental groups did not differ in the number of participants using disulfiram in the O'Farrell (1992) study included in this section. As this section is a review of the clinical effectiveness of psychological interventions, a discussion about the use of disulfiram or the involvement of the family was not appropriate here. The

							in Alcohol Dependence" Alcohol & Alcoholism 2008: 43: 661–668,	same could be said for any other study assessed in this chapter in which all participants were receiving pharmacotherapy. We address the issue of disulfiram and the impact of other carers in the delivery of the drug in the chapter on pharmacological interventions.
499	SH	NHS Lothian	13.03	Full	6.26.8	332	[Line 35-39] "Results indicated that on day 90 of treatment, 20 of the placebo treated patients compared with 7 disulfiram treated patients had been continuously abstinent (p=0.0063). Additionally, the duration of mean cumulative abstinence was significantly higher in the disulfiram group (68.5 days) than in the placebo group (29.7 days) (p=0.012)." Check figures 7 placebo and 20 Disulfiram , NOT 20 AND 7 ???	Thank you for your comment. This was an error in typing and should have read 2 and 7 not 20 and 7. This has now been rectified.
500	SH	NHS Lothian	13.04	Full	7.1.2	339	[Line 29] Better to say 'for muscle spasm', rather than 'antispasmodic' which often refers to gut or ureteral spasm?	Thank you for your suggestion, this has been changed.
501	SH	NHS Lothian	13.05	Full	General	General	How strange!..... 'service user', ...what about sick people who do not 'use services'?	Thank you for your comment. This is a commonly used term that was agreed to be appropriate by the GDG, which consists of health professionals, service users and carers. However, to address your concerns, at certain points in the guideline we have used the term 'person' if it is clear from the context that the person is not engaged with services.
502	SH	NHS Lothian	13.06	full	7.7.6	393	[Line 46] How, ethically, can you perform a double-blind trial of disulfiram? It will encourage patients to test it out and risk a reaction. And part of the effect of disulfiram is that the patients know they are taking it! Have you quoted the Krampe study with 7 year outcome and 50% abstinence?	Thank you. We agree that you cannot have a patient blinded to whether or not they are on disulfiram but can have them blinded to dose (patient has to know that they are on disulfiram due to risk of significant adverse effects if they drink alcohol). We have therefore amended the wording to remove double-blinded and put appropriate controlled trials instead.
503	SH	NHS Lothian	13.07	full	7.7.5	392	[Lines 16-18] Grammar?	Thank you, this has been reworded.
504	SH	NHS Lothian	13.	full	7.7.5	393	[Lines 16-18]	Thank you. There are indeed two De

			08				You quote, correctly in the ref list, but not here, two De Sousa RCTs of disulfiram, one v. Naltrexone, one v. acamprosate, all with supervision, both showing superior outcomes with disulfiram, on GGT and family/self reports of abstinence.	Sousa open label RCTs of disulfiram, one vs. naltrexone (De Sousa, 2004) and one vs. topiramate (De Sousa, 2008). There was also one trial of disulfiram vs. acamprosate and naltrexone (Laaksonen, 2008). The latter did not report data on relapse to heavy drinking, and therefore could not be considered in the network meta-analysis which provided the clinical data for the economic analysis. Topiramate was not considered as an option in the economic analysis, and therefore the data from De Sousa (2008) were not included in the network meta-analysis.
505	SH	NHS Lothian	13. 09	Full	7.7.8.9	396	[Line 17] Suggest : "If a dose of 200mg, taken regularly for at least the preceding week, is found by the patient who risks drinking to not result in an alcohol-interaction of sufficient unpleasantness to act as a future deterrent to drinking, consider in consultation with the patient increasing the dose"	Thank you for your comment. This suggestion has now been included in the recommendation.
506	SH	NHS Lothian	13. 10	Full	7.7.7	394	[Line 45] Open-label' is not correct. The studies were 'single blind', i.e. blind raters, patients not blind.,	Thank you for your comment. The trials comparing disulfiram with an active intervention were open-label [for example DeSousa (2004), DeSousa (2008) and Laaksonen (2008)]. The text has been updated to better reflect this.
507	SH	NHS Lothian	13. 11	Full	6.8.4	235	[Line 39] A word missing? ?"improve"	Thank you, this has been rectified.
508	SH	NHS Lothian	13. 12	Full	7.4.2	375	[Lines 28-29] Gual not Gaul	Thank you, this has been rectified.
510	SH	NOFAS-UK	10. 02	Full	General	General	There is no reference anywhere in the Document to the permanent brain damage that alcohol can cause to the unborn child when drunk at any stage during pregnancy. Women do not have to be an alcoholic to cause damage by drinking alcohol during pregnancy.	Thank you for your comment. Pregnant women are a population excluded from the scope of this guideline. Alcohol misuse in pregnancy is covered in the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
511	SH	NOFAS-UK	10.	Full	2.1	19	Since 44% of women were problem drinkers in your survey,	Thank you for your comment. We agree

			03				there is cause for serious concern as many will be of child bearing age.	this is an important issue, however pregnant women are not covered in the scope of this guideline. Please see the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
512	SH	NOFAS-UK	10.04	Full	2.3.2	19	Mental Health symptoms are the same for those suffering from FAS & FASD.	Thank you for your comment; however FAS is outside of the guideline scope. Please see the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
513	SH	NOFAS-UK	10.05	Full	2.3.3	19	Social Problems are the same for those suffering from FAS & FASD.	Thank you for your comment; however FAS is outside of the guideline scope. Please see the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
514	SH	NOFAS-UK	10.06	Full	2.3.4.	19	Criminality is the same for those suffering from FAS & FASD.	Thank you for your comment; however FAS is outside of the guideline scope. Please see the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
515	SH	NOFAS-UK	10.07	Full	General	General	It is possible that “Children & Young People” are causing problems because they are actually suffering from FAS & FASD which has not been properly diagnosed. Those affected have a tendency to “enjoy” alcohol more than is appropriate.	Thank you for your comment; however FAS is outside of the guideline scope.
516	SH	NOFAS-UK	10.08	Full	General	General	These are the same symptoms as for those suffering from FAS and FASD – these young people may be undiagnosed.	Thank you for your comment; however FAS is outside of the guideline scope.
517	SH	NOFAS-UK	10.09	Full	General	General	**It is vital that alcohol during pregnancy is considered in this Document.**	Thank you for your comment. Pregnant women are a population excluded from the scope of this guideline. Alcohol misuse in pregnancy is covered in the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
518	SH	NOFAS-UK	10.10	Full	2.6	23	Pharmacology of Alcohol does not mention alcohol crossing the placenta.	Thank you. However, this is outside of the scope of this guideline. Please see the NICE Pregnancy and complex social

								factors guideline: http://guidance.nice.org.uk/CG110
518	SH	NOFAS-UK	10.11	Full	General	General	NOFAS-UK has many studies (in English) completed from many countries around the world of the damage that alcohol causes to the foetus.	Thank you for your comment; however this is outside of the guideline scope. Alcohol misuse in pregnancy is covered in the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
509	SH	NOFAS-UK[3]	10.01	Full	2.1	14	This is the only fleeting reference to Foetal Alcohol Syndrome (FAS) and there is no mention of Foetal Alcohol Spectrum Disorder (FASD) in the whole of the Document.	Thank you for your comment. There is only fleeting reference as FAS is outside of the guideline scope but is dealt with in the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
519	SH	Nottinghamshire Healthcare NHS Trust	36.01	NICE	General	General	This guideline is a comprehensive document with available evidence for treating and managing alcohol use disorders in adult group and children. There is a separate section for alcohol (6.25) use in children. Unfortunately there is hardly any mention of alcohol use in older people except a casual mention in couple of sentences in 2.1, page15; and 7.1.1 line16; 5.20.10 line34; 5.21.2 Level 2: page 151, line1. There are few references that describe alcohol use in older people but it is not clear where they have been referenced in the guideline. Although Korsakoff's syndrome is described well (7.11) Alcohol related Brain Damage is mentioned only twice without any detail. These client groups have complex needs and require great skills and resources to look after them. The evidence and references are given below. Prevalence of alcohol abuse in older people: 6 to 23% Primary care pts. >60yrs - 15% men and 12% women drank >1 drink a day (Adams, Barry et al 1996) 5% men, 2.5% women >75 yr, exceeded 21 &14 units limit-active social lifestyles, better health. 17% never had a drink	Thank you. The management of AUD in older people is discussed only where it differs from the management of working age adults. We felt that older people should have access to the same range of services as younger people unless otherwise contraindicated. The same policy has been applied to children. ARBD is a complex phenomenon and often cases with apparent ARBD are at post mortem found to have brain damage from vascular, traumatic or other causes. Thus there is a good case not to stigmatise people who drink excessively and who also have brain damage by denying them access to the same services as people with brain damage where alcohol is not an apparent or presumptive cause.

[3] National Organisation for Fetal Alcohol Syndrome

							Moderate drinkers less likely to be severely cognitively impaired (Hajat et al, 2004) 15358 people…53 UK GP practices.. 3rd commonest psychiatric diagnosis 30 fold increase in psych admissions for alcohol related disorders in the past 30 years 1988, 13% of men aged 65 and over drank more than the weekly guideline of 21 units; the figure had increased to 17% in 2000. The number of women drinking over the recommended guideline (14 units per week) increased from 4% in 1988 to 7% in 2000 (Office for National Statistics, 2001). Neuropthology: Better correlation with CVA, SDH. 2.6 fold ↑ in hip # & ↑mortality 1 yr ; 1/2 of elderly with cirrhosis die in 1 yr; increased incidence of Alcohol bowel disease. 2 x risk of stroke and cognitive impairment Oslin et al 1998 described an entity named “Alcohol related dementia” Deterioration of memory + 1 other higher cortical function, not explained by delirium, substance misuse or withdrawal. But there was no consensus for this. ARBD: Accounts for 10% of the dementia population & 12.5% of dementias <65yr Related to- high alcohol related illnesses & those with high socio-economic deprivation Males > Females (75%) Females – account for 6th of ARBD population Earlier in onset Short alcohol abuse history ARBD- Alcohol related brain damage. Profiles & Trends across give care homes. Social research Team, 2003, Glasgow OUTCOME: 25% ◊ no improvements in 2yrs	

							25% ◊ complete recovery 25% ◊ significant recovery 25% ◊ slight recovery -MacRae & Cox (2003). Meeting the needs of people. ARBD : A literature review, University of Sterling. Outcome of interventions in Elderly: Fleming et al(1999) and Blow & Barry (2000) used brief intervention in randomised clinical trials in primary care settings to reduce hazardous drinking among older adults. These studies show that older adults can be engaged in brief intervention, that they find the technique acceptable and that it can substantially reduce drinking among at-risk drinkers. Acute alcohol withdrawal syndrome is more protracted and severe in elderly people than in younger patients with drinking problems of equal severity (Brower et al, 1994). Out-patient detoxification may not be appropriate for older adults who are fragile, live alone with limited family support or who have multiple medical problems and prescribed medications (Liskow et al, 1989). In view of this and the high degree of medical co morbidity in elderly people, it has been recommended that elderly alcohol-dependent patients undergo in-patient detoxification (O'Connell et al, 2003). Alcohol use disorders in elderly people: fact or fiction? Karim Dar ; Advances in Psychiatric Treatment (2006) 12: 173-181	
198	PR	Professor Nick Heather	4.01	NICE	General	General	The Guideline is an extremely useful document with clear and, on the whole, well-supported recommendations. All members of the GDP should be congratulated.	Thank you for your comment.
199	PR	Professor Nick Heather	4.02	NICE	General	General	The role of Motivational Interviewing (MI) and its adaptations (in particular, Motivational Enhancement Therapy [MET]) is neglected. The only place where 'motivational intervention' is mentioned is in section 1.3.1 on 'General principles for all interventions'. While this is commendable, it neglects: (i) the more specific role of MI as a preparation for other forms of treatment; (ii) the use of MI or MET as a stand-alone	Thank you for your comment. We have sourced the primary studies included in the Vasilaki review. A number of studies included were excluded from our review as the population could not be classified as harmful or dependent drinkers. Even then, in the Vasilaki review, MI was only

							treatment or as a first treatment in a stepped-care approach, particularly for those with moderate dependence; (iii) the indication for MET as the treatment of choice for clients showing high levels of anger at intake, as evidence by the one of the few client-treatment matching effects coming out of Project MATCH. More generally, this neglect of MI and its offshoots (eg, in the repeated list of validated psychological interventions – cognitive behavioural therapies, …. etc.) - seems out-of-step with its acceptance as a valuable form of treatment especially suitable for addictive disorders and the enthusiasm for it in the research and treatment community. This is likely to be criticised on publication. See 12 below for further comment.	more effective than the control up to the 3 month follow up and not after 6 months. The abstract of the review also states that the efficacy of MI improved when dependent drinkers were removed from the analyses. Lastly, the review included both treatment-seeking and non-treatment seeking samples. The authors provide a discussion of the efficacy for these two groups. However, this discussion simply involves stating the number of studies included in which the participants were treatment-seeking or non-treatment seeking and relating this to the efficacy of MI. No formal analysis appears to have been conducted to support the statements made. See page 332 of the Vasilaki review. The Lundahl review is quite substantial and broad in scope. It covers alcohol, drugs and nicotine use and does not have alcohol specific analysis or drinking outcomes. The results of these reviews are not directly comparable to our review which focuses on harmful/dependent treatment seeking drinkers.
200	PR	Professor Nick Heather	4.03	NICE	General	General	The discussion of and recommendations concerning drinking goal – abstinence or moderation – are somewhat confused. Under 'General principles for all interventions' it is stated that interventions to promote abstinence should be offered to people with moderate and severe alcohol dependence who have i) very limited social support; ii) complex physical or psychiatric comorbidities; and iii) not responded to initial community-based interventions. There are cross-references to sections later in the Guideline where the issue of drinking goal is dealt with more fully but	Thank you for your comment. We believe our approach to goal setting is appropriate. As you will see a number of recommendations refer to the necessary engagement with service users regarding appropriate treatment goals; recent evidence which some have argued should lead to a revision of the approach you argue for is based on post hoc analyses of trial data. We would like to

							the earlier section is a poor summary of this material since it implies that people who do not fit the criteria above should or need not be offered abstinence. It also says nothing whatever about the role of moderation as a general principle of intervention. Regarding the later sections, the Guideline seems to lean towards the recommendation of abstinence in a way that is not supported by the evidence and seems old-fashioned. For example, in 1.2.2.1 it is stated that 'For harmful drinking and mild dependence the aim should be abstinence or a moderate level of drinking etc..' This would be better as: '… the aim should normally be for a moderate level of drinking unless the service user prefers abstinence or there are other reasons for recommending abstinence.' The main advantage of including the moderation goal as an option in treatment is that people with less severe problems are not deterred from seeking and accepting treatment, thus making treatment more accessible and impactful. This well-accepted point seems to be missed in the Guideline. The text in 1.3.1.2 and 1.3.1.3 is unobjectionable. However, I think there should be an additional point on the specific indications for a moderation goal, eg, where the service user refuses to consider abstinence, where there is good family and social support for this goal, where dependence and problems are mild (see above). One last gap regarding about drinking goals is the use of an 'attenuated drinking goal' for individuals (eg homeless street drinkers) for whom there is very little prospect of adherence to an abstinence goal. This is an application of harm reduction principles, in the true sense of that phrase, to the treatment of alcohol problems but does not seem to have found a place in the Guideline. Se 13 below for further comment on this issue.	see a prospective approach to this issue tested.
201	PR	Professor Nick Heather	4.04	NICE	Introduction	4	The definition of severe alcohol dependence here is an SADQ score of 30 or more but elsewhere it is stated to be more than 30 (eg, 1.3.2.3). The former is correct. This kind of mistake occurs several times in the Guideline (see below).	Thank you, this has been amended.
202	PR	Professor Nick Heather	4.05	NICE	KPIs	8	Assisted withdrawal is recommended for service users who, inter alia, score more than 20 on the AUDIT. If this is	Thank you for this clarification. The recommendation has been amended.

							intended to reflect WHO guidance on the designation o. 'probable dependence' from the AUDIT, this should be 20 or more (or 20+). This mistake is repeated (eg, 1.3.2.1).	
203	PR	Professor Nick Heather	4.06	NICE	KPIs	8	The phrase 'For harmful drinkers and people with mild dependence' is potentially confusing to lay readers since it implies that harmful drinkers do not have mild dependence, whereas the majority, of course, do. The earlier text on p.3 on the continuum of severity of dependence is most welcome but could be improved making it clear that harmful drinkers, as defined, may show mild or even moderate dependence without meeting DSM or ICD criteria.	Thank you for this comment; we agree that people can move between both of these categories. However current systems in widespread use in the UK make use of the distinction between harmful drinking and mild dependence, as indeed does the evidence base. We therefore think it appropriate to continue to use this distinction. Nevertheless, we do discuss the dimensional and overlapping nature of harmful drinking and dependence in the introductory chapter.
204	PR	Professor Nick Heather	4.07	NICE	1.1.2.2	11	The meaning of the 2nd dot-point here is unclear.	Thank you for your comment; this has been amended.
205	PR	Professor Nick Heather	4.08	NICE	1.2.2.3	14	1st dot-point: can the history of alcohol misuse be assessed by the AUDIT, as seems to be implied here?	Thank you, we have changed this to pattern.
206	PR	Professor Nick Heather	4.09	NICE	1.3.1.7	17	1st dot-point: Given the recent dissemination of the mutual-aid group SMART Recovery in England, and given the need to provide an alternative to AA for many individuals, please mention SMART Recovery in the examples in brackets in addition to Alcoholics Anonymous.	Thank you for your comment; we have added SMART Recovery to the recommendation as you have suggested.
207	PR	Professor Nick Heather	4.10	NICE	1.3.6	21 -22	12 weeks is recommended here as the length of treatment for several modalities. What evidence is this recommendation based on? See 14 below.	Thank you; the recommendations in fact reflect the nature and duration of the interventions offered in the trials. When recommending interventions we believe it is important to support in the NHS the replication of what was delivered in the trails as we think this is likely to be associated with the delivery of more effective interventions. We have also offered examples of "typical" treatment length, as such this suggests an indicate duration not a detailed specification of a precise number of sessions. This is in line

								with all clinical guideline which are aids to and not a substitute for clinical judgement.
208	PR	Professor Nick Heather	4.11	NICE	4	30 -34	The research recommendations here have some merit. The recommendation on the assertive community treatment model and the return to the vexed but important question of residential vs. community based treatment is welcome, although one is less thrilled by the recommendations on contingency management and acupuncture. But all these recommendations are highly conventional in encouraging 'first past the post' RCTs. This seems completely to miss a groundswell of opinion among alcohol treatment researchers, represented by key articles by Morgenstern & McKay (Addiction, 102, 1377-89, 2007), Orford (Addiction, 103, 875-85, 2008) and by others. To pay no attention to this call for a paradigm change in alcohol treatment research, or to the unsatisfactory state of the science that led to it, appears either perverse or out-of-touch. At the very least, one would have expected some recommendation on the need to identify the common factors(s) that underlie similar outcomes for a range of theoretically distinct modalities.	Thank you for your comment. We are primarily concerned with efficacy and it could be argued that research on underlying process is outside of our brief. We should also point out that we do recognise the limits of RCTs and not all our recommendations are first past the post RCTs – we suggest a cohort design to answer the residential question.
209	PR	Professor Nick Heather	4.12	Full	6.7	223 -231	The conclusions of the review here seem inconsistent with other reviews and meta-analyses. For example, Vasilaki et al. (Alcohol & Alcoholism, 41, 328-335, 2006) concluded that brief motivational interviewing is an effective intervention and is more effective among you adults who are heavy- or low-dependence drinkers and who voluntarily seek help. Lundhal et al. (Research on Social Work Practice, 20, 137-160) reviewed the effects of MI for a range of conditions, including alcohol problems, and concluded that it was superior to control conditions and other weaker interventions but equal in effects to other specific treatments. The same could be said of cognitive-behavioural therapy in general and other psychosocial treatments recommended for implementation in the Guidelines. So it is not obvious why MI or MET has not also been recommended on this basis, particularly in view of the fact that it is almost always shorter in duration and therefore	Thank you for your comment. We have sourced the primary studies included in the Vasilaki review. A number of studies included were excluded from our review as the population could not be classified as harmful or dependent drinkers. Even then, in the Vasilaki review, MI was only more effective than the control up to the 3 month follow up and not after 6 months. The abstract of the review also states that the efficacy of MI improved when dependent drinkers were removed from the analyses. Lastly, the review included both treatment-seeking and non-treatment seeking samples. The authors provide a discussion of the efficacy for these two groups. However, this

							more cost-effective from the treatment deliverer's perspective. These are points for the GDG to consider.	discussion simply involves stating the number of studies included in which the participants were treatment-seeking or non-treatment seeking and relating this to the efficacy of MI. No formal analysis appears to have been conducted to support the statements made. See page 332 of the Vasilaki review. The Lundahl review is quite substantial and broad in scope. It covers alcohol, drugs and nicotine use and does not have alcohol specific analysis or drinking outcomes. The results of these reviews are not directly comparable to our review which focuses on harmful/dependent treatment seeking drinkers.
210	PR	Professor Nick Heather	4.13	Full	5.21.7	162 -163	The text in this section refers to research by colleagues and myself on the issue of drinking goal in treatment (Heather et al, 2010; Adamson et al. 2010). The summary of the results of this research is accurate as far as it goes but misses the point that those who chose non-abstinent goals at intake to treatment had less severe problems but showed outcomes nearly as good as those who preferred abstinence. Thus, except for cases of severe dependence or complications, there is no reason not to support a moderation goal, initially at least, if that is what the client prefers. This does not seem to be reflected in the Guideline (see 3 above).	Thank you for your comment. We believe this is consistent with the text in 5.32.9.
211	PR	Professor Nick Heather	4.14	Full	General	General	I have searched the document but cannot find any evidence-based justification for recommending a general duration of treatment of 12 weeks. My impression is that this is longer than current practice in most services but that is only an impression. I am not suggesting that no such justification exists, merely that I cannot find it. And if there is not justification in research evidence, then, accepting that some such recommendation has to be made, it could be supported by 'clinical wisdom'. However, if that is the case, I	Thank you for your comment. This is taken from the duration of the treatment delivered in the trials. Across the various treatments and studies included in the review, the duration of treatment ranged from 1 week to 6 months (in one trial). For example, the duration of treatment for motivational techniques was 1-6 weeks, TSF was 12 weeks, cognitive behavioural

							feel it should be stated explicitly. Apologies if I have missed something here.	therapies was 2 weeks to 6 months with most ending at 12 weeks, behavioural therapies was 6-12 weeks, social network and environment based therapies ranged from 8-16 weeks, and couples therapies ranged from 4-12 weeks. Shorter durations were mostly observed in lower intensity interventions (e.g. some studies using motivational techniques). The GDG discussed this and a consensus-based decision was agreed on a general duration of 12 weeks. We do except that this is not made clear in the text and we have now made the necessary amendments in the clinical evidence summary for this chapter.
520	SH	Public Health Wales NHS Trust	1.01	All	General	General	This organisation responded with no comments to make.	Thank you.
522	SH	RCGP Wales	11.02	Full	2.7	24	[Line 19] Use of word 'denied' seems inappropriate. If the patient raised the issue it would hopefully be addressed. Its more that the opportunity to intervene earlier was missed.	Thank you – 'denied' has been changed to 'do not get'.
523	SH	RCGP Wales	11.03	Full	2.8	26	[Line 19] Assisted alcohol withdrawal may be achieved in non-NHS settings. Remove 'NHS' as implies it cannot occur elsewhere [eg private centres]	Thank you but this sentence says 'such as a specialist NHS inpatient addiction treatment unit' therefore it is not exclusive.
524	SH	RCGP Wales	11.04	Full	2.9	28	[Line 5] There are no enhanced alcohol schemes currently running in Wales – but there are a number of GPs who do alcohol detoxs currently. Not under enhanced schemes alone.	Thank you for your comment. The NATMS refers to England. We have been unable to find data on the activity of GPs in Wales in relation to alcohol detoxification.
525	SH	RCGP Wales	11.05	Full	4.4.6	70	[Line 21] Remove space m e – should read me	Thank you, this has been rectified.
526	SH	RCGP Wales	11.06	Full	5.3.3	98	[Line 8] Again many areas do not commission GP enhanced service in alcohol but that doesn't mean that some GPs don't do community alcohol detoxs. May be as part of enhanced service but not exclusively.	Thank you. The precise mechanisms for commissioning such services or the development of nationally enhanced services are outside the scope of the guideline and are a matter for local and national determination. We will however draw this matter to the attention of the

								NICE commissioning group.
527	SH	RCGP Wales	11.07	Full	5.3.3	100	[Line 12] Some GPs prescribe for detox done in conjunction with voluntary sector service.	Thank you for your comment. We agree and this is what the sentence aims to convey.
528	SH	RCGP Wales	11.08	Full	5.19.1	136	[Line 8] Drinking misspelt	Thank you, this has been amended.
529	SH	RCGP Wales	11.09	Full	5.25.7 5.27	184 & 195	[Line 40 & Line 16]Older age seems too vague. Although care is taken to ensure detox is safe to do in non-residential setting in someone who is older – age alone is not a reason not to detox. If age is included then specific age parameters should be mentioned. Its about assessing each individuals risk, not the age they are.	Thank you for your comment. We have made mention of other vulnerable groups such as those with significant comorbidities and of course children and young people. Given the increasing number of older people with alcohol related problems we think it is important to make specific mention of them in this section.
530	SH	RCGP Wales	11.10	Full	6.5.1	222	[Line 8] Need to remove 'error! Ref...' and put relevant section in.	Thank you, this has been rectified.
531	SH	RCGP Wales	11.11	Full	6.21.3	303	[Line 15] Formatting needs correcting	Thank you, this has been rectified.
532	SH	RCGP Wales	11.12	Full	6.21.4	305	[Line 8] Mild should be mildly	Thank you, this has been rectified.
533	SH	RCGP Wales	11.13	Full	7.1.1	338	[Line 26] Space required after 2007	Thank you, this has been rectified.
534	SH	RCGP Wales	11.14	Full	7.7.7.	395	[Line 3] need to add to after aim.	Thank you, this has been added.
535	SH	RCGP Wales	11.15	Full	7.11	412	[Line 6] Doesnt make sense – suggest part of sentence is missing re Pabrinex	Thank you for your comment. This has now been amended.
536	SH	RCGP Wales	11.16	Full	General	General	A very comprehensive document. Good analysis of all available data with sensible recommendations. Sometimes difficult to navigate through to get to relevant information – but I can understand the difficulties faced by the authors in trying to present this wealth of information in a 'user friendly' way.	Thank you for your comment. It was a challenge to present all of the data in a coherent way, and we hope this will become clearer with further refinement.
537	SH	RCGP Wales	11.17	NICE	General	General	Comprehensive summary collating salient points from full document. Clearly presented.	Thank you for your comment.
521	SH	RCGP Wales[4]	11.	Full	2.0	15	[Line 11] Word 'to' needs removing	Thank you, this has been rectified.

[4] Royal College of General Practitioners, Wales

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539	SH	RCP & BSG	35.02	All	General	general	**Emphasis.** The emphasis is on diagnosis and management in the community and specialist settings. There is little mention of detection in Accident & Emergency Departments, or in District General Hospitals, where the majority of alcohol-related admissions are non-elective. The evidence-base for the value of an alcohol specialist worker or alcohol specialist nurse in detecting harmful and dependent alcohol misuse should be included. The first mention of screening with the Paddington Alcohol Test is in Appendix D on page 43 (NICE/short). There is little mention of alcohol-related liver disease.	Thank you. The guideline describes diagnosis and management in all NHS provided and/or funded services, including acute hospital settings. Acute hospitals are mentioned at several points throughout the guideline. However, the role of screening in A&E departments and acute hospitals is covered by the published NICE public health guideline (NICE, 2010a). Nevertheless we agree that the role of specialist alcohol liaison staff in acute hospitals, in relation to diagnosis and management, should be highlighted. The precise configuration and organisation of these services will be more directly and appropriately addressed in the specific commissioning guidance for alcohol which NICE is currently developing.
540	SH	RCP & BSG	35.03	All	General	general	**Lack of Psychiatry input into District General Hospitals**. The main problem in this whole area is that there is a major shortage of liaison and addiction psychiatry input into Accident & Emergency Departments and District General Hospitals. The fundamental need is for liaison and addiction psychiatrists, specialising in alcohol, with specific responsibility for screening for depression and other psychiatric disorders, especially suicidal ideation, to provide an integrated acute hospital service. Moreover, psychiatrists and gastroenterologists, hepatologists and other specialists need to work collaboratively, rather than in isolation.	Thank you. We agree that the role of liaison and addiction psychiatry in A&E and acute care and the need for collaborative care between psychiatrists and physicians should be highlighted, as in our previous comment, we think this will be best dealt with in the specific commissioning guidance for alcohol which NICE is currently developing.
541	SH	RCP & BSG	35.04	All	General	general	**Staff competency**. There are a number of references that "staff should be competent to assess and manage patients". Examples are sections 1.2.1.6 on page 13, 1.3.1.5 on page 16 and 1.3.3.2 on page 18 (NICE/Short). The recommendations fall short of initiating any competency assessment processes. The recommendations are not specific enough. There should be national, standardised,	Thank you. However, the recommendation of specific systems for competency appraisal is outside the scope of the guideline. These are for the relevant training and regulatory bodies to develop.

							competency qualifications. Current frameworks, such as DANOS, are not relevant to the acute hospital setting, including alcohol specialist nurses and ward staff. If standardised care is to be achieved, there has to be a national competency framework in situ, which will also support the grading and banding of staff.	
542	SH	RCP & BSG	35.05	All	General	general	**Service Delivery.** Should there be national standards? If not, and given GP local needs assessment commissioning, this will inevitably lead to inequitable care. Only 1 in 18 dependent drinkers receive care, the figures ranging from 1 in 12 in London to 1 in 27 in the North West of England and 1 in 102 in the North East.	Thank you for your comment. We agree national standards would be helpful. NICE is developing national quality standards for alcohol dependence as a separate exercise from this guideline. These quality standards are due for publication in 2011 and should be helpful in supporting implementation of these clinical guidelines.
543	SH	RCP & BSG	35.06	All	General	general	**Pharmacological Interventions.** eg Section 7 page 338(Full). Many GPs regard these as specialised drugs, which should only be prescribed and initiated by alcohol specialists. Who will carry the budget for this? Community alcohol teams have no proper drug budget. There would need to be local agreement.	Thank you for your comment. We agree that implementation of pharmacotherapy for alcohol use disorders is currently sub-optimal, which is why we have highlighted their efficacy in this guideline. The limited implementation is partly due to lack of historical budgets for pharmacotherapy in specialist alcohol services, but also due to lack of awareness of their effectiveness. Our hope is that this guideline will improve availability and uptake of pharmacotherapies. It is not in our scope to make specific recommendations about NHS budgets.
544	SH	RCP & BSG	35.07	NICE	1.3.3.6	19	Use of high dose chlordiazepoxide. Is the evidence good enough to recommend an initial dose of chlordiazepoxide 60mg, four times daily in patients with severe alcohol dependence? There will be a reluctance to exceed British National Formulary Guidelines, particularly if there are complications. Will the NICE guidelines supersede the BNF guidance? Many clinicians would use Lorazepam or Haloperidol if chlordiazepoxide was required in a dose of greater than 40 mg. four times daily.	Thank you; we considered this very carefully in the GDG and are aware of the issue you raised. We do not think that the use of combined drugs such as chlordiazepoxide and haloperidol or lorazepam is good practice. We also were concerned about the risk associated with inadequate doses for people who are highly dependent and at serious risk of a seizure.

545	SH	RCP & BSG	35.08	NICE	1.3.10.6	28	Wernicke-Korsakoff Syndrome. The recommendation is to "offer" long term placement to patients with Wernicke-Korsakoff syndrome. The recommendation should be to "offer and provide" long term placement, since there is a major shortage of such placements. There are major problems with inequality of access in this area. The major problem is that, while there are some placements for older people, there is a major shortage of placements for younger people	Thank you but this will be covered by the NICE commissioning guidelines.
546	SH	RCP & BSG	35.09	Full	4.4.11	80	[Second paragraph] **Ethnicity.** The guidance might mention the special stigma associated with alcohol misuse in the Asian community. This can result in exclusion from places of worship. Link workers and support from community elders may be especially helpful.	Thank you for your comment. While our search strategies did seek to identify stigma associated with alcohol misuse in other ethnic groups, there were no primary qualitative studies which met criteria and which addressed this particular stigma. Most of the studies relating to this topic were quantitative or questionnaire based and therefore were not included in this review. One study by Morjaria and Orford (2002) highlights the differences faced by British and South Indian men in terms of recovery from alcohol dependence. Social stigma is briefly mentioned when discussing the results of this study.
547	SH	RCP & BSG	35.10	Full	5.27.1.9	197	**Use of high dose chlordiazepoxide**. Is the evidence good enough to recommend an initial dose of chlordiazepoxide 60mg. four times daily in patients with severe alcohol dependence? There will be a reluctance to exceed British National Formulary Guidelines, particularly if there are complications. Will the NICE guidelines supersede the BNF guidance? Many clinicians would use Lorazepam or Haloperidol if chlordiazepoxide was required in a dose of greater than 40 mg. four times daily.	Thank you for your comment. This dose was initially included in order to provide an example dose where withdrawal from alcohol is severe. However, this example has now been removed. We have now included a more specific dosing regimen in the full guideline (Chapter 5; Table 21) which provides more information about appropriate dosing and cautions.
548	SH	RCP & BSG	35.11	Full	7.11	410	Wernicke-Korsakoff Syndrome. The recommendation is to "offer" long term placement to patients with Wernicke-Korsakoff syndrome. The recommendation should be to "offer and provide" long term placement, since there is a	Thank you but this is matter for local services to determine.

							major shortage of such placements. There are major problems with inequality of access in this area. The major problem is that, while there are some placements for older people, there is a major shortage of placements for younger people.	
538	SH	RCP & BSG[5]	35.01	All	General	General	We are grateful for the opportunity to comment. Overall, we believe this to be very good, definitive and exhaustive guidance. The recommendations will need to be considered in the light of the new Government White Paper, with its emphasis on GP commissioning. This will be particularly relevant regarding service and drug budgets.	Thank you. NICE is currently developing specific commissioning guidance for alcohol which will deal with the matter you raise.
549	SH	Royal College of Midwives	37.01	All	General	General	It would be helpful if more explicit reference could be made throughout the document to the other NICE guidance on alcohol-related problems.	Thank you for your comment. We have frequently referenced the other two alcohol guidelines throughout this guideline.
550	SH	Royal College of Midwives	37.02	NICE	KPIs	6	Need to clarify what is meant by paediatric care. Is this just from a medical perspective? Do you mean those young people who are in treatment including those leaving care.	Thank you for your comment, but this is standard NICE text.
551	SH	Royal College of Midwives	37.03	NICE	KPIs	7	It is not clear what groups of professionals you are referring to or which groups are included under 'staff working in services provided by the NHS'. Please clarify.	Thank you; we have clarified this.
552	SH	Royal College of Midwives	37.04	NICE	1.1.2.2	11	'offer a carer's assessment of their caring….needs' This is not a clearly worded sentence; please explain.	Thank you for your comment; we have reworded the sentence.
553	SH	Royal College of Midwives	37.05	NICE	1.2.2.5	11	It would be useful to have a list of potential co-morbidities such as domestic abuse; other drug misuse.	Thank you for your comment but comorbidities are dealt with elsewhere – for example see section 1.3.8.
554	SH	Royal College of Midwives	37.06	NICE	1.3.1.3	16	'very limited social support' is an unclear phrase - can this be defined more clearly?	Thank you for your comment; we have added an explanation to the recommendation.
555	SH	Royal College of Midwives	37.07	NICE	1.3.1.4	16	'Helping to find stable accommodation before discharge' is probably an unrealistic recommendation. At whom or what service is this recommendation targeted at.	Thank you but this might not always be possible. However, we do think that it is good practice and there is evidence that stable housing is associated with better outcomes. The agency should liaise with relevant housing authorities and agencies

[5] Royal College of Physicians & British Society for Gastroenterology

								to help the service user access accommodation. However, some residential agencies have access to “dry” housing funded through housing benefits.
556	SH	Royal College of Midwives	37.08	NICE	1.3.1.5	16	‘staff should consider using competence frameworks’ this phrase needs to be more prescriptive and explain which of the frameworks you are referring to and in what context.	Thank you; these frameworks have been developed specifically for the field (ref to DANOS), for psychological interventions (Skills for Health) and drugs (RCPsych) and form part of the training curricula of staff. We therefore feel these are well established and that they do not need specific referencing.
557	SH	Royal College of Midwives	37.09	NICE	1.3.8.1	22	The consideration of contraindications for pharmacological interventions - this should have a higher profile in the document, as well as a direct linking to other guidance that apply to particular groups e.g. pregnant or breastfeeding women.	Thank you – this is an important issue. We have included reference to pregnancy in other recommendations but feel it is important that clinicians also consult the SPC.
558	SH	Royal College of Midwives	37.10	NICE	1.3.9.2	24	The referral to CAMHS is clear and helpful and should be consistent throughout, especially in reference to young people.	Thank you for your comment.
559	SH	Royal College of Nursing	42.01	Full	2.1	14	It is positive to see that alcohol free days are strongly mentioned here in relation to weekly consumption. This element of the message is often lost in the units recommended.	Thank you for your comment.
560	SH	Royal College of Nursing	42.02	Full	2.4.3	21	Again positive to see here confirmation that the evidence does not support an ‘addictive personality’ theory.	Thank you for your comment.
561	SH	Royal College of Nursing	42.03	Full	2.8	26	Another positive comment that it is good to see the importance attached to ongoing treatment after detox acknowledged. Although it would have been better for this to be expanded, to mention what this may entail. For example that it could be either psycho social or prescribed medication or a combination of both.	Thank you for your comment. This issue is covered later in the full guideline. It should be noted that chapter 2 is an introductory chapter providing an overview of the topic area.
562	SH	Royal College of Nursing	42.04	NICE	1.2.1.2	12	This for me is a very important point and one that requires linkage back through commissioning. Ensuring that all these staff have the required skills means that a person may be able to obtain support with their alcohol issues wherever and whenever they attend for treatment, meaning that opportunistic interventions are more likely to be able to meet	Thank you. We agree. This should be covered by separate work by NICE on development of commissioning guidelines.

							alcohol issues early in the process.	
563	SH	Royal College of Nursing	42.05	NICE	1.3.2.1 & 1.3.2.2	17	My worry is that this is potentially a very risky part of treatment and the support and information given here is rather confusing and not easy to understand. There does not appear to be a great deal of rationale, other than the use of AUDIT, to have a detox of varying intensity and support.	Thank you but we offer considerable advice on the nature and content of an assessment other than the use of the AUDIT. We do not spell out how to conduct the various assessments we recommend but we are sure you will appreciate that this is outside the scope of any guideline.
564	SH	Royal College of Nursing	42.06	All	General	General	It is very positive to see some guidance for alcohol treatment, that is mainly clear, easy to read and also relatively easy to implement across all services.	Thank you for your comment.
565	SH	Royal College of Paediatrics and Child Health	24.01	Full	General	General	The draft guideline is an extremely long document. The sections relevant to children and young people over the age of 10 years are contained within chapters that relate mainly to adults (largely within chapter 6, but also other chapters). It would be very helpful to have a specific chapter devoted to the issues relevant to the paediatric population, as this would make it easier to locate this information within the document.	Thank you for your comment. However, the GDG felt it would be more appropriate to consider children and adolescents within each section of the guideline. To facilitate reading of the guideline and make information easier to find, any section relevant to children and young people has been included under a new heading 'Special Populations' throughout each chapter of the guideline. Such an approach also helps readers where there has been extrapolation from related adult data sets.
566	SH	Royal College of Paediatrics and Child Health	24.02	Full	General	General	There are some very important reminders within the guideline of the potential child protection issues that should be considered when dealing with individuals and the families of those who are alcohol dependant or have harmful alcohol use.	Thank you for your comment.
567	SH	Royal College of Paediatrics and Child Health	24.03	Full	2.1	14	The guideline mentions harm to the foetus of alcohol in pregnancy which may result in foetal alcohol syndrome (FAS), but no mention is made of the range of deficits that may occur within the spectrum of foetal alcohol spectrum disorders and which may occur with lower levels of alcohol consumption than needed to produce FAS	Thank you for your comment. There is only fleeting reference as FAS is outside of the guideline scope but is dealt with in the NICE Pregnancy and complex social factors guideline: http://guidance.nice.org.uk/CG110
568	SH	Royal College of Paediatrics and Child Health	24.04	Full	5	195	The list of additional factors which the GDG felt should be considered in determining whether an individual should be admitted for assisted withdrawal does not include those in	Thank you for your comment. The location of the section discussing children and young people has now been moved

							the paediatric age group. Children and young people age 10 – 18 years were excluded from discussion in Chapter 5; however, this is a recommendation in Chapter 6. The College believes that the guideline should include a cross reference to this should be made for clarity and to ensure that the reader is aware of the recommendation in relation to children and young people	and signposted for improved clarity. A new heading of 'Special populations' which addresses any additional issues that need to be considered for children and young people is now consistently used throughout the guideline. However, these sections do review the available clinical evidence. In the absence of clinical evidence, the GDG expert consensus was also considered when making recommendations for children and young people.
569	SH	Royal College of Paediatrics and Child Health	24.05	Full	5.27.1.10	197	Despite the previous comment that children and young people aged 10 – 18 appear to have been excluded from Chapter 5, there is a recommendation at 5.27.1.10 that benzodiazepine dose may need to be adjusted for children and young people	Thank you for your comment. We have re-structured the guideline to include a discussion of children and young people in each chapter (where evidence is available) and appropriate recommendations are also included in each chapter. Expert GDG consensus was considered in the absence of clinical evidence when making recommendations for children and young people.
570	SH	Royal College of Paediatrics and Child Health	24.06	Full	6.16.11.1	334	It would be helpful, as in the recommendation for adults, to specify an appropriate threshold score on the AUDIT tool which would be an indication for referral for further assessment in children and young people, as there is no obvious mention of scores in this section	Thank you for this comment. We agree in principle that a clearly specified threshold would be helpful but we were unable to locate evidence of sufficient quality to help us in determining that threshold, hence a more cautious recommendation to adopt a lower threshold was used.
571	SH	Royal College of Paediatrics and Child Health	24.07	Full	6.25.5	323	The penultimate sentence of the second paragraph of this section states "consent for assessment and treatment must be obtained from the child and their guardian" This sentence needs clarifying and elaborating to indicate that a young person may be competent to give his/her own consent. Where appropriate, consent should also be sought from a person with parental responsibility.	Thank you for your comment. We have amended this section as you have suggested and this is now in Chapter 5.
572	SH	Royal College of Paediatrics and Child Health	24.08	Full	6.26.11.4	335	The recommendation here is for inpatient treatment for children and young people requiring assisted withdrawal from alcohol. The College is very pleased to see this	Thank you. We agree that there will be both resource and training issues arise from this recommendation. NICE will be

							recommendation, but it may have implications for current inpatient services. Discussion with CAMHS and CAMHS 16-19 services may be required at local level to determine the most appropriate setting for undertaking inpatient assisted withdrawal for the children and young people covered by this guideline. Appropriate training will also be required to assess and monitor patients during assisted withdrawal	producing commissioning guidance so we will draw this to the attention of the group responsible for the guidance.
574	SH	Royal College of Paediatrics and Child Health	24.09	Full	7.7.8.10	396	This should be “carry out liver function test and urea and electrolytes” to assess for liver or renal impairment.	Thank you for your comment. This recommendation has now been changed.
575	SH	Royal College of Psychiatrists	44.01	Full	General 6.24 6.25	General 316 -337	Although NICE guidance in this area of alcohol misuse is welcomed by the Faculty, the document appears to have pre-empted any discussion surrounding people aged 65 and over, by setting the scene for those in the 16-65 age group in the introduction. Furthermore, there is further attention drawn to those aged 10-16 later in the document, but not to older people. It is now more widely recognised that the number of older people with harmful drinking and alcohol dependence is rising and that the diagnosis, assessment and management of harmful drinking and dependence in this age group is required to address an unmet need in this population.	Thank you for your comment. The introductory chapter only refers to the 16-65 age range as this refers to specific available data on prevalence. We did not however limit any reviews to that age bracket. We agree with your point about older people and alcohol dependence/harmful alcohol use. However, the evidence base for this population is limited. We have now added a section called ‘Special Populations’ through each of the chapters that will present any evidence/special considerations (if any) that need to be made for older people as well as for children and young people.
576	SH	Royal College of Psychiatrists	44.02	Full	General	General	We recommend that the **key priorities for implementation** should include identification and assessment using screening tools that have higher validity and sensitivity in older people, such as the Short Michigan Alcohol Screen Test-Geriatric Version (S-MASTG). The delivery of interventions should also be delivered by staff who have expertise in the assessment of age-appropriate assessment by paying particular attention to social support, which is all the more critical in maintaining independence in older people.	Thank you for your comment. However, tools used for screening are outside the scope of this guideline. Please see the public health guideline (NICE, 2010a) for a review of screening tools. Furthermore, we could not recommend the use of the S-MAST-G for routine use as it has not been adequately validated [for example, see Conigliaro, J., Kraemer, K., & McNeil, M. (2000) - screening and identification of older adults with alcohol problems in primary care - *Journal of Geriatric*

								Psychiatry and Neurology, 13(3), 106-114]. We agree that all staff should be competent to deliver assessments and we also make recommendations about social support which we think address the issues you raise.
577	SH	Royal College of Psychiatrists	44.03	NICE	1.1.1.2	10	Within Section 1.1.1.2 (Building a trusting relationship and providing information) we would recommend including a bullet point stating that when working with people who misuse alcohol, take into account the impact of mental incapacity.	Thank you for your comment; we agree that taking account of mental incapacity is important but this is covered in the 'person-centered care' section of the NICE guideline.
578	SH	Royal College of Psychiatrists	44.04	NICE	1.1.2.1	10	Within Section 1.1.2.1 (Working with and supporting families and carers), we would recommend a separate sub-section that addresses the protection of vulnerable adults with alcohol, including those at risk of elder abuse.	Thank you but we do not think that a specific section on this is warranted. We have drawn attention to the need of a number of vulnerable groups, including older people, and we think this is a sufficient level of detail.
579	SH	Royal College of Psychiatrists	44.05	NICE	1.2.1.5	12	We are encouraged to note that in Section 1.2.1.5, the need to adjust the criteria for dependence when considering older people is highlighted.	Thank you for your comment.
580	SH	Royal College of Psychiatrists	44.06	NICE	1.2.2.4	14	As part of a comprehensive assessment, in Section 1.2.2.4, we could recommend that the use of over the counter medication is specified under 'other drug misuse', as this group of drugs is commonly misused in older people, in conjunction with alcohol.	Thank you for your comment; we have changed the recommendation as you have suggested.
581	SH	Royal College of Psychiatrists	44.07	NICE	1.2.2.9	15	Section 1.2.2.9 states that consideration be given to brief measures of cognitive functioning to help with treatment planning (for example, MMSE) and that formal measures of cognitive functioning should typically only be performed if impairment persists after a period of abstinence or a significant reduction in alcohol intake. We would recommend that consideration still be given to formal measures of cognitive functioning where there has been functional decline in addition to a drop in MMSE score and where there is a high index of suspicion for incipient dementia.	Thank you but we feel this is already covered by 1.2.2.11 as this would be another example of persisting impairment.
582	SH	Royal College of	44.	NICE	1.3.2.3	18	Within the Section Assessment and interventions for	Thank you. The recommendation covers

		Psychiatrists	08				assisted alcohol withdrawal, we would recommend that sub-section 1.3.2.3 includes older people who are risk of delirium.	people who are at risk of delirium in relation to delirium tremens, and in relation to delirium due to significant psychiatric or physical comorbidities.
583	SH	Royal College of Psychiatrists	44.09	NICE	1.3.3	18	In Section 1.3.3 (Drug regimens for assisted withdrawal), awareness of the need for a reduction in benzodiazepine doses for older people is to commended.	Thank you for your comment.
584	SH	Royal College of Psychiatrists	44.10	NICE	1.3.4	20	In Section 1.3.4 (Care coordination and case management), it should be noted that the involvement of old age psychiatry services may be required where there is the need for expertise in areas such as the management of cognitive impairment, as well as complex social problems.	Thank you. This is true of a host of subgroups including young, old, mentally ill, physically ill in relation to a wide range of services and is implicit in care coordination. It would be inappropriate to single out one particular sub group.
585	SH	Royal College of Psychiatrists	44.11	NICE	General	General	The guidance fails to include the management of people with alcohol-related dementia, as opposed to amnestic states such as Wernicke-Korsakoff syndrome.	Thank you but this was outside of the scope of the guideline.
586	SH	Royal Pharmaceutical Society of Great Britain	27.01	Full	General	General	The RPSGB welcomes these guidelines	Thank you for your comment.
587	SH	Royal Pharmaceutical Society of Great Britain	27.02	Full	7.7.8	395 -400	If these recommendations for pharmacological interventions are accepted will the BNF section 4.1 on Alcohol dependence be amended? This comment is made on the basis that Naltrexone is not included in the current edition of the BNF. Also Benzodiazepines, including Chlordiazepoxide and Chlormethiazole are currently recommended by the BNF and that advice will presumably need to be amended.	Thank you - we will raise these issues with the BNF.
588	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.01	Full	1.2.3	13	[Line 7] why no 'alcohol' before dependence when there is for the other lines	Thank you for your comment. This has been changed.
589	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.02	Full	2.1	15	[Line 21] why no mention of Misuse of Drugs Act? It may imply that it refers to class A drugs generally where it is not the case for a number of them (eg ecstasy, hallucinogens such as LSD, magic mushrooms)	Thank you for your comment. This has been changed from 'Class A drugs' to "illegal drugs."
590	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.03	Full	2.3.1	17	[Line 9] 'was' not is	Thank you, this has been rectified.
591	SH	South Staffordshire &	8.0	Full	2.3.4	19	[Line 43] deaths	Thank you but the sentence this word

		Shropshire NHS Foundation Trust	4					was in has been removed.
592	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.05	Full	2.6	23	[Line 21] My understanding is that it goes further ie first alcohol dehydrogenase then acetaldehyde dehydrogenase then to carbon dioxide and water through the Kreb's cycle (albeit there are different pathways for metabolism)	Thank you for your comment. The dehydrogenases are enzymes, the products of metabolism are acetaldehyde and acetate. However, as this is the introductory chapter, we do not feel it warrants such a detailed consideration of the evidence.
593	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.06	Full	2.8	25	[Line 37] 1.10 should be 2.10	Thank you, this has been changed.
594	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.07	Full	5.20.3	139	[Line 24] first drinking daily on daily basis [omit on daily basis]	Thank you, this has been amended.
595	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.08	Full	5.21.4	156	[Line 10] aspects of a person health [person's]	Thank you, this has been amended.
596	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.09	Full	5.21.9	165	[Line 6] The AUDIT as the [was]	Thank you – this has been changed.
597	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.10	Full	5.21.10	165	[Line 17] The AUDIT which asses both [assesses]	Thank you – this has been changed.
598	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.11	Full	5.21.10	165	[Lines 34-35] It is clear from the literature that for people who are moderate and severe drinkers, the initial goal should be one of abstinence. [maybe - moderately and severely dependent drinkers) also on pg 168 line 27	Thank you – this has been changed.
599	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.12	Full	5.21.10	166	[Line 32] determining comorbid mental health problem is caused by or consequent [if a comorbid…, is consequent]	Thank you for your comment. This has been re-worded.
600	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.13	Full	5.23	173	[Line 27] are sees as more [seen]	Thank you, this has been changed.
601	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.14	Full	6.2.1	217	[Line 1] as 'the dodo-bird hypothesis' (Luborsky et al., 1975). [people tend to associate 'dodo' with 'dead' so this might be confusing unless the Lewis Carroll reference is explained ie	Thank you for your comment. However, the "dodo bird hypothesis" is a well understood term so we do not think it requires further explanation.

							‘everybody has won and all must have prizes’]	
602	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.15	Full	6.7.1	224	[Line 16] in rapid internally motive changes [internal? Motivated?]	Thank you, this has been rectified.
603	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.16	Full	6.9.4	246	[Line 26] additional of motivational enhancement [addition]	Thank you, this has been rectified.
604	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.17	Full	6.10.1	250	[Line 12] as single entity of the purposes of the review. [a single entity for the purposes]	Thank you, this has been rectified.
605	SH	South Staffordshire & Shropshire NHS Foundation Trust	8.18	Full	6.19.1	295	[Line 6] goal off developing [of]	Thank you, this has been rectified.
606	SH	Specialist Clinical Addiction Network (SCAN)	39.01	NICE	General	General	[Also Full 1.2.2 page 12] Although specified in full version: 1.2.2;’for whom is this guideline intended: ‘…covers the care provided by primary, community, secondary, tertiary and other healthcare professionals who have direct contact with, and make decisions concerning the care of, adults with alcohol dependence and harmful alcohol use.’ It may be helpful to clarify which healthcare professionals specifically. Most of the territory covered will be very familiar to specialists but probably not to those working in other fields. It seems to be assumed that readers will be familiar with a general schema for the treatment of alcohol problems and the concepts involved therein, but this is probably not the case for people working outside the addictions field.	Thank you. However, this conforms to the NICE standard template for guidance. We do not specify as a rule which professionals it may relate to unless there is a profession specific recommendation.
607	SH	Specialist Clinical Addiction Network (SCAN)	39.02	NICE	1.2.1.2	12	There are several references to staff being competent to deliver interventions, which is a pertinent point. However, there is no indication as to what competence might mean.	Thank you. This is described in the full guideline and as you will be aware a number of competence frameworks relevant to this area have been developed by the NTA, Skills for Health and the RCPsych.
608	SH	Specialist Clinical Addiction Network (SCAN)	39.03	NICE	4	30	[Also Full 1.1.2 page 10] Although qualified in Full version: 1.1.2 uses and limitations of clinical guidelines; ‘guidelines…can be limited in their usefulness and applicability by a number of different factors: including the availability of high-quality research evidence’.	Thank you. The research recommendations arise from identified gaps in the evidence. The GDG are uniquely placed to address these issues and so perform an important role.

							Do recommendations for areas for further research activity need to be part of clinical guidelines? To do so may be restrictive and could be reflecting the views and interests of the panel. It may be better to review this and leave researchers and practitioners in the field to determine for themselves where evidence is lacking and where research can give value for money in terms of updating guidance. The research ideas presented focus on known specific treatments rather than bringing any new ideas to the table.	Decisions on funding of any recommendations are not made by the GDG but by independent funding bodies.
609	SH	Specialist Clinical Addiction Network (SCAN)	39.04	NICE		4	'People with SADQ score of 30 or above may always need assisted alcohol withdrawal in an inpatient or residential setting'. Possibly not always? Occasionally there can be initial attempts to reduce alcohol consumption down in the community first, which can be, albeit rarely, successful.	Thank you for your comment. The recommendation says 'consider inpatient or residential assisted withdrawal' not always.
610	SH	Specialist Clinical Addiction Network (SCAN)	39.05	NICE	1.2.2.1	13	"For moderate and severe dependence or significant medical or psychiatric co-morbidity the aim should be abstinence in the first instance". Although the most desirable, this may not necessarily always be the goal of the assessment as reduced drinking could be a consideration if abstinence was not achievable.	Thank you for your comment. As you say, reduced drinking could be considered if abstinence is not achievable, meaning that abstinence should be considered as a first option (whether actually trying it or just considering it first).
611	SH	Specialist Clinical Addiction Network (SCAN)	39.06	NICE	1.2.2.3	14	The Audit includes items on dependence –surely there is no need for further measurement of dependence using SADQ or LDQ?	Thank you. The AUDIT is a useful screening and initial assessment tool, but is less useful for withdrawal assessment. SADQ is more useful for this purpose as it is specific to alcohol dependence.
612	SH	Specialist Clinical Addiction Network (SCAN)	39.07	NICE	1.2.2.4	14	There is no reference specifically to nutritional status and risk of Wernickes encephalopathy	Thank you. However, this is outside the scope of this guideline but fully dealt with by CG100.
613	SH	Specialist Clinical Addiction Network (SCAN)	39.08	NICE	1.3.2.1	17	There seems to be reliance on using The Audit or SADQ to determine the type of alcohol detoxification. No doubt these scales correlate with the severity of withdrawal but the setting for detoxification is much more importantly determined by a risk assessment with an emphasis on the available social support. The danger of using cut offs is that inexperienced practitioners with slavishly follow them to the detriment of best care for the service users.	Thank you. The reason for suggesting validated tools to determine care rather than clinical judgement alone is that clinical judgement can be very variable. To avoid the issue of slavish adherence to cut offs which are arbitrary, the term "consider" is included. Clearly practitioners have to be competent and trained to interpret test results and make treatment decisions taking into account a wide range of clinical factors.

614	SH	Specialist Clinical Addiction Network (SCAN)	39. 09	NICE	1.3.2.3	18	As for 1.3.2.1 above – there is no option for home detoxification.	Thank you for your comment. This recommendation for assisted withdrawal in the community includes assisted withdrawal at home (please see 1.3.4.2).
615	SH	Specialist Clinical Addiction Network (SCAN)	39. 10	NICE	1.3.3	18	It is expected that some patients receiving community based detoxification would require prophylactic pabrinex. Guidance regarding safe provision of nutritional supplementation in the community is necessary.	Thank you. This area is covered by CG 100.
616	SH	Specialist Clinical Addiction Network (SCAN)	39. 11	NICE	1.3.3.6	19	See 1.3.2.1 above – clinicians will normally assess the severity of actual withdrawal symptoms, for example using CIWA as described, and taking account of past history and blood alcohol at the time of detoxification.	Thank you; we have amended the recommendation in light of your comment.
617	SH	Specialist Clinical Addiction Network (SCAN)	39. 12	NICE	1.3.6	21	Psychological interventions have more in common with each other than they have differences. It seems that the intensity of therapy suggested reflects those used in trials, but the intensity of treatment should be commensurate with the overall severity of the addiction problem rather than linked to a particular kind of treatment. A rational approach to treatment is the use of stepped care which has not been mentioned. Any consideration of potential pros and cons of combinations of psychological therapy?	Thank you; the intensity of treatment in our recommendations does in fact reflect the severity of the disorder as our recommendations followed a broadly stepped care approach where the nature of the interventions varies in line with differing patients' need. We have also offered examples of "typical" treatment length, as such this suggests an indicate duration not a detailed specification of a precise number of sessions. This is in line with all clinical guidelines which are aids to and not a substitute for clinical judgement.
618	SH	Specialist Clinical Addiction Network (SCAN)	39. 13	NICE	1.3.8.2	22	BNF states that acamprosate may be considered in cases where drinking is intermittent to help control consumption. NICE states it should be stopped if drinking resumes after 4-6 weeks Any further advice regarding this?	Thank you; this is an area where there is considerable uncertainty and there is little good quality evidence to guide the GDG. In these circumstances the GDG decided not to make a recommendation.
619	SH	Specialist Clinical Addiction Network (SCAN)	39. 14	NICE	1.3.8.8	23	Though not ideal, could it be possible to prescribe disulfiram for patients who do not have a family or carer to oversee the administration of the drug?	Thank you for your query. Yes it is possible to prescribe disulfiram under these circumstances although it is obviously more beneficial to have somebody witnessing the administration.
620	SH	Specialist Clinical	39.	Full	7.10.3	406	There is mention of using naltrexone or acamprosate post	Thank you but we disagree. The data for

		Addiction Network (SCAN)	15				detoxification. Although disulfiram is considered, if abstinence is the goal, supervised disulfiram is superior and should be considered. Mention however is made of the benefit of disufiram in comorbid alcohol dependence with cocaine in the full version.	disulfiram based largely on open label trails is not superior to that for the other drugs you mention.
621	SH	Specialist Clinical Addiction Network (SCAN)	39. 16	NICE	1.3.10.1 & 1.3.10.3	27	[Also page 9] "Treat the dependence first" is strictly correct regarding access to specialist structured psychological therapies for anxiety or depression. However many general healthcare or MH workers (especially the less well-trained, or those who do not guard against their own stigmatisation of problem drinkers) interpret wording like this as "come back when you're sober" and risk disengaging the service user. Emphasis needs to be placed on risk management (cf. Appleby on dual diagnosis risks), engagement and motivation in working towards abstinence in a holistic framework. This is even more important in areas where specialist alcohol treatment is via a third sector agency or other body and cross-referral and cross-agency working is required. Cross-reference to forthcoming NICE guidance on dual diagnosis may help here.	Thank for this comment. We have been careful to properly address the issue of risk management. We have taken care to refer to relevant NICE guidance. The new NICE guidance on dual diagnosis is concerned only with psychosis and so has little relevance to the large majority of people presenting to specialist alcohol services.
622	SH	Specialist Clinical Addiction Network (SCAN)	39. 17	NICE	App D	43	This is a further caution against using cut offs. The Audit was designed for use in primary care and the use of cut scores to send people down different treatment routes probably works reasonably well in this setting. The Audit has been used in other settings, for example, general hospitals, and the evidence base to support the same care pathways is much weaker.	Thank you. It is unclear why AUDIT is applicable in one medical setting and not another as it is measuring the same elements of need which determine the care pathways. We agree it has not been studied as widely in general hospitals, but this is lack of evidence rather than evidence that it is not appropriate.
623	SH	Specialist Clinical Addiction Network (SCAN)	39. 18	NICE	App E	44	Similar comment to section D above but with reference to SADQ. The SADQ was designed to assess whether people are suitable for controlled drinking – it does reflect current drinking but is not a substitute for a proper risk assessment. Guidelines need to take account of the available evidence, nonetheless, in the real world there are very limited facilities for inpatient or indeed day patient detoxification – most clinicians have experimented with home or other forms of community detoxification. So, even severe withdrawal, including a history of seizures and delirium and co morbidity	Thank you for your comment. The SADQ was also developed as a clinical tool to assess the need for withdrawal management and has evidence of predictive validity in withdrawal. But we agree it is not a substitute for risk assessment which is why the guideline (e.g. 1.3.2) describes the full range of issues that should be considered.

							may be handled at home or in the community depending on the facilities practically available.	
624	SH	Specialist Clinical Addiction Network (SCAN)	39.19	Full	5.9.3	120	Stepped care None of the studies reviewed directly addressed stepped care, which would be interesting and useful.	Thank you for your comment. The studies reviewed were, to our knowledge, the only studies which involved components of a stepped care approach and focused on a population with harmful alcohol use or alcohol dependence.
625	SH	St Mungo Housing Association Ltd	22.01	full	2.4.2	21	While the point about social learning theory is not disputed, it is not particularly helpful in developing understanding regarding the high prevalence of alcohol dependence among socially excluded client groups, particularly those who have suffered trauma, especially childhood abuse. (as referred to in 2.4.5 regarding comorbidity with anxiety and depression) Among client groups such as homeless, offending or secondary mental health clients, approaches based on social learning theory p may be less successful unless they are informed by a wider understanding of complex needs	Thank you for your comment. This is not inconsistent with paragraph 2.4.2 which is about causal factors rather than treatment approaches.
626	SH	St Mungo Housing Association Ltd	22.02	full	2.4.3	21	Allied to the above point, it is our experience that personality disorder is too readily diagnosed at the point where entanglement of behaviours related to alcohol and expressions of personality has already occurred. Typically, in our client group, the client may well have experienced trauma and not received adequate care or attention, and the role of alcohol as a self-medication is well-recognised. The progression of problematic behaviour due to the long term effects of alcohol mixed with the emotional disturbances due to the original traumatic experience is also typical. Nevertheless, the diagnosis of personality disorder is widely applied in such circumstances. It is our experience that if the client is assisted to recover from alcohol dependence and supported regarding underlying trauma there is the strong likelihood that indications of personality disorder will also abate.	Thank you for your comment. Again we agree with this point which is covered in paragraph 2.4.3.
627	SH	St Mungo Housing Association Ltd	22.03	full	2.4.5	22	Among the client groups referred to in comments 1 and 2 above it is not unusual to find that more than 80 or 90% of the clients have had such experiences. In some women's services this prevalence is even higher, reaching saturation.	Thank you for your comment. However, we have not been able to find any evidence to support such an approach.

							It would be helpful to indicate and cross reference distinct approaches and recommendations for such groups, especially women, as our experience indicates that unless adjustments in services are made for these groups, outcomes are poorer than average. Some of these issues have been addressed later in the guideline, and a cross reference at this point would be useful.	
628	SH	St Mungo Housing Association Ltd	22.04	full	2.7	25	regarding brief interventions it would be useful in the passage from lines 6 to 12 to refer to the following research done on motivational techniques in brief interventions: Counselor skill influences outcomes of brief motivational interventions. Gaume J., Gmel G., Faouzi M. et al. Journal of Substance Abuse Treatment: 2009, 37, p. 151–159. It is suggested that brief interventions performed with the necessary skill can have a strong impact even in cases where there is heavy drinking	Thank you for your comment. This paper was identified in our search but cannot be included in the guideline as it does not meet inclusion criteria. The participants are hazardous drinkers (9.6 – 18.1 drinks per week across treatment groups) and thus outside of the scope of this guideline which is focused on harmful or dependent drinkers.
629	SH	St Mungo Housing Association Ltd	22.05	full	2.8	26	In the passage from lines 14 to 26 we think it would be helpful to make reference to the particular needs of clients in supported accommodation such as hostels, especially to encourage good practice for multi-agency case coordination and case management, by encouraging liaison between staff responsible for detoxification services with keyworkers in the community. It is particularly helpful if medical practitioners support advocacy regarding clients' accommodation needs after detoxification, which could differ radically from their needs prior to detoxification.	Thank you but this is just an introductory chapter and the issues you raise are dealt with later on in the guideline.
630	SH	St Mungo Housing Association Ltd	22.06	full	2.9	28	the passage from lines 7-18 might be a good place to add that a prompt referral, assessment and engagement process is helpful to eventual outcomes. It is our experience that assessment on the same day or at least within 1 week of referral shows markedly better results than for clients who have to wait for more than a week and attendance after that falls off rapidly. Similarly clients who access interventions within days of their assessment also appear to obtain better outcomes than those who have to wait for weeks or months. This process is one of the most crucial in our view and can be supported by client involvement and peer support, and requires good monitoring and feedback systems	Thank you for your comment. However, the effectiveness of prompt referral and assessment and engagement is dealt with later in the guideline. This chapter provides a general introduction to set the scene for the evidence review.

631	SH	St Mungo Housing Association Ltd	22.07	full	4.4.5	68	We think that one must be cautious about the weight given to the concept that an individual must be fully seized of the idea to stop drinking, as a necessary precursor to provide treatment or for treatment to be successful. There appears to be a social myth that nothing can work unless the individual first of all decides to stop and change. Some of this may be attributed to the success of the AA programme, and their first step, with associated ideas that one must "hit rock bottom" and do it for oneself. Without in any way detracting from how AA's identify and deal with their problem, the danger is that agencies, especially those with responsibility to fund treatment, begin to take this personal decision as a criterion for admission or funding. However, we believe that the need for treatment should be the determining factor, and skilful motivational approaches are indicated and should be available where the harm is evident but the individual is not yet motivated enough to make this decision.	Thank you. We agree with your point which is reflected in the recommendations of this guideline. This section refers to what service users say about their experiences of help seeking and recovery. This section covers a range of experience and is not weighted towards personal motivation to stop. External factors are also described, such as relationships, employment and education.
632	SH	St Mungo Housing Association Ltd	22.08	full	4.4.9	76	The personal stories, particularly those regarding carers, highlights a problem regarding the use of terminology which this standard might helpfully try to clarify. While individuals may use the term "addict" or "alcoholic" to describe their own or a family member's problematic alcohol, we have often found it helpful to standardise on less emotive and more objective terms such as "alcohol use" which could be "problematic use" or result in "alcohol dependency"	Thank you for your comment. The language has been standardised in the guideline to reflect your suggestions. However, the terminology within the quotations inputted into the review of the qualitative literature was not changed as these were direct quotes from primary qualitative studies.
633	SH	St Mungo Housing Association Ltd	22.09	full	4.4.10	79	One of the biggest problems for staff is that alcohol treatment and treatment for other drugs provide different levels of service in which, for comparable levels of severity, alcohol treatment still takes a lower profile, making it less of a priority for assessment, referral to treatment and funding from social services for residential treatment than for problematic use of other drugs. It is accepted that there is a social stigma that inhibits clients from acting on their motivation to change once problems become manifest regarding their alcohol use. However there also seems to be a powerful counter-current in which the wide acceptance socially of harmful levels of drinking inhibits the clients from realising the extent of their problem and the pressing need	Thank you for your comment. We agree and NICE is currently developing specific commissioning guidance for alcohol which will deal with the matter you raise.

							to act on this realization, which impairs motivation. This is particularly noticeable in drug treatment programmes which do not address alcohol too, and this causes these programmes to be less effective than they could be if alcohol were treated in parallel and its inappropriate use challenged, rather than excluding it from the scope of treatment merely because it is a “drug” programme not a “drug and alcohol” programme In the recommendations we would suggest that an addition is made to provide commissioning guidelines to ensure that in drug services there is an appropriate element to address alcohol use (x ref 4.6.2 p91)	
634	SH	St Mungo Housing Association Ltd	22.10	full	4.5.3	81-89	This section regarding the impact on families especially children is very timely given the recent publication of news regarding how many children call in to helplines to report that their parents are addicted and they are suffering consequences. We think it would be a useful addition to this section to insert references to Childline, NSPCC and Drinkaware web links	Thank you for your comment. This section (now in Appendix 14) dealt exclusively with narratives from the NACOA site and while Childline, NSPCC and Drinkaware may be very useful, they were not assessed for this review. However, there will be links to voluntary organisations for families and carers in the Understanding NICE guidance booklet.
635	SH	St Mungo Housing Association Ltd	22.11	full	4.6.2	91-	[91 onwards…] as per point 9 above we suggest that guidelines for drug services ensure that adequate attention is given to address alcohol use, instead of excluding it from scope of service	Thank you for your comment but we are limited by our existing scope. We will consider this issue when we update the Drugs Guidelines.
636	SH	St Mungo Housing Association Ltd	22.12	full	4.6.2	91	[Lines 41-46] The point regarding supporting the client to prepare for treatment is important and we suggest it needs to be expanded to indicate the types of support that would help clients to prepare for treatment, suggesting a range of services including reduction, as well as social and coping skills. It is our experience that some clients, especially those whose needs are more complex, need weeks or even months of preparation before they are ready to engage in the more structured work that is typical of residential rehabilitation settings. A range of treatment models may best suit such clients, whose support needs may continue	Thank you for your comment. However, it is our view that the evidence is not strong enough to expand on the statement as you have suggested.

							for much longer than typically provided in current funding frameworks	
637	SH	St Mungo Housing Association Ltd	22. 13	full	4.6.7.1	93	We think that the use of reduction techniques should be added to the list of helpful suggestions, including encouraging self-monitoring, keeping track of the amounts used as well as the circumstances, the individuals' reactions to day to day events and the coping strategies they have tried to use. In our experience providing breath tests can be a useful adjunct to this work as it allows the practitioner to quantify the problem and explain likely levels of harm as well as adjusting a reduction programme to the needs of the individual. A brief explanation of the relevance to alcohol problems of health indicators such as haemoglobin levels and liver function tests may also be appropriate at this point	Thank you for your comment but we could find no specific evidence relevant to the matters you raise.
638	SH	St Mungo Housing Association Ltd	22. 14	full	4.6.7.2	93	The heading of this section we think should be different from the heading for 4.6.7.1 and summarise the access needs this section is intended to address	Thank you for your comment but we feel that the heading is suitable as it includes proving information.
639	SH	St Mungo Housing Association Ltd	22. 15	full	5.3.4	100	in lines 14-19 the role of treatment within CJS is explained. This could usefully be expanded to include a brief explanation of the Alcohol Treatment Requirement (ATR) order and services provided under these orders, which are subject to a variety of commissioning arrangements by DAATs and JSP's from a range of providers including health agencies, community drug and alcohol teams, probation services and third sector community providers, as well as some residential services. Many of the issues identified in this section, particularly regarding case management and coordination apply especially to ATR. Unless services within ATR (and possibly also Drug Rehabilitation Requirement services too) are brought within the framework suggested by these guidelines then the potential remains for disparity between the CJS and health systems and it will be more difficult to achieve the case management approach advocated in this section	Thank you but detailed discussion and recommendations for this aspect of the criminal justice system are outside the scope of the guideline.
640	SH	St Mungo Housing Association Ltd	22. 16	full	5.3.6	100 -101	We suggest that the issue regarding which agency provides the care manager and how the other involved agencies liaise with the care manager needs to be identified and addressed in this section so that a multi agency care plan can be agreed and implemented. The case recording and	Thank you for your comment but the precise configuration and composition of services are outside the scope of this guideline.

							monitoring function and how this information is shared should also be identified and addressed	
641	SH	St Mungo Housing Association Ltd	22.17	full	5.3.8	102	While we do not question the value of the stepped care model, it is our experience that sometimes opportunities for vocational work and social opportunity provide the necessary milieu for the client to develop motivation to address alcohol problems as well as the skills to participate in more intensive therapeutic approaches. The meaningful use of time can also mediate the effects of PTSD which may be felt more harshly as clients reduce or achieve abstinence. We would therefore like to see the sequence become more flexible and the possibility of occupational approaches introduced in the first stages.	Thank you for your comment. We agree that some degree of judgement and flexibility is required in the development of a stepped care system. The assessment system we have built into the stepped care system set out in the guideline we believe offers the opportunity for appropriate clinical flexibility.
642	SH	St Mungo Housing Association Ltd	22.18	full	5.8	113 -	[113 onwards…] One of the issues that the preceding studies touched upon is that it is difficult to separate the effects of alcohol treatment from the effects of the wider social systems in which the results of treatment have their effect. For example, treatment could have resulted in very successful rehabilitation, followed by career development. Then maybe the client hits a difficult patch, there may be health problems or redundancy from work, the client struggles to make the rent, moves to a cheaper place, old PTSD issues arise, depression and anxiety set in, the landlord acts badly, the basement flat floods, the housing officer does not respond appropriately and the client's hard won resilience collapses with a descent into mental ill health or substance use. All too often these results could have been avoided by taking into account the client vulnerability and ensuring that a higher level of service appropriate to the needs of the client is introduced early to avert the kind of collapse in the example. The stepped care model is respected and its attractions are obvious, but there needs to be some skill exercised in its application, particularly when dealing with clients with a complex history, to invoke a higher level of service where indicated. It is our experience that such clients are rarely afforded this higher level until a lot of damage has already been suffered, some of which could have been avoided.	Thank you for your comment. We agree that some degree of judgement and flexibility is required in the development of a stepped care system. The assessment system we have built into the stepped care system set out in the guideline we believe offers the opportunity for appropriate clinical flexibility.

643	SH	St Mungo Housing Association Ltd	22.19	full	5.8.6	118-119	for the reasons explained in the previous point, we suggest that the summary in this section be qualified to clarify that where clients already have a history of treatment and especially if there are complex needs, then a more sophisticated approach would be indicated, rather than starting at the lowest step automatically. This would still be cost effective, and might also be treatment effective. This factor could also explain why the interventions are not particularly distinguishable (in QALY results) from the control group. It is our experience that the social cost of continued alcohol problems is concentrated on the fewer more complex cases. This would also tend towards support and establish an evidence base for personalisation.	Thank you for your comment. We have amended this section to clarify that the GDG felt that the stepped care model described in the economic literature was not relevant to the study population covered in the guideline. This is also reflected in the 'Evidence to Recommendations' section, where we state that "none of the studies reviewed directly addressed stepped care either as defined in the guideline or for the populations covered by this guideline. The GDG has therefore no recommendations to make which might suggest changes to the current system for stepped care that structure the provision of alcohol misuse services".
644	SH	St Mungo Housing Association Ltd	22.20	full	5.10.1.1	120	Surely the recommendation should be in terms of work by qualified specialists rather than specialised agencies. Many organisations like ourselves try to work within a multi-disciplinary context, and we employ qualified alcohol or substance use specialists who would be eminently capable of conducting care coordination and case management of cases where alcohol dependency is one of the presenting problems. Otherwise, this point runs into a similar problem already discussed in the guideline in section 5.3.3 regarding Models of Care, in which the tiers of the service are mistaken for the attributes of the agency. As the guideline so astutely observes in lines 18-20 of section 5.3.2 on page 97, the interpretation of tiers to describe agencies rather than interventions has had unintended consequences. It would be foreseeable that the recommendation in 5.10.1.1 would have similarly unintended consequences unless it were clarified. So we suggest that this point should read "delivered by qualified specialised staff" rather than "specialised alcohol services" . Alternatively one could clarify that specialised alcohol services could include those delivered by a specialised person working within a non-specialised organisation.	Thank you for your comments. We agree and this has been changed to "delivered by appropriately trained and competent staff working within specialised alcohol services."

645	SH	St Mungo Housing Association Ltd	22.21	full	5.10.1.3	120	following the point we made in 16 above, another bullet point should be added to describe multi-agency liaison and agreement of the care manager and care plan	Thank you for your suggestion. We have now changed bullet 3 to read “a seamless multiagency and integrated care pathway.”
646	SH	St Mungo Housing Association Ltd	22.22	full	5.11	121	following point 18 above, we think that clients with previous treatment attempts compared to those newly presenting might show a significant effect so perhaps the research design should take this factor into account	Thank you for your comment. We agree assertive community treatment may be more appropriate for people who have had previous treatment attempts but there is not evidence to suggest which groups are more likely to benefit from assertive approaches.
647	SH	St Mungo Housing Association Ltd	22.23	full	5.17.1	127	The AUDIT screening tool is recommended in the WHO reference by Babor et al as suitable within a range of settings including criminal justice. However, the AUDIT questions do not include a basic question regarding whether the individual’s drinking is related to problems regarding crime. This must be a serious flaw in aligning the health and criminal justice assessments and interventions along similar lines of good practice. This is not just an academic problem but cuts across the model of service described later on in the diagram on page 148. When a court imposes an Alcohol Treatment Requirement the identification of alcohol use as part of an offence or an offending pattern is an essential aspect. For the purposes of this treatment, which is supposed to conform to tier 3 in Models of care, the need for treatment is established if the service assessment shows that alcohol played a part in the offender’s commission of an offence or a pattern of offending at a level of seriousness consistent with need for a community order, and the client accepts the treatment order; provided that suitable services are available in the community that satisfy the requirements of the order, then it should be given	Thank you for your comment. The AUDIT is designed to identify alcohol use disorders rather than offending. While alcohol misuse and offending sometimes occur together, there is a complex relationship between them which would be difficult to tease out in a simple screening questionnaire. Also there is evidence that offending is not a helpful screening question for alcohol use disorders. Hence the GDG has recommended AUDIT as a screening tool for alcohol use disorders which has evidence of validity across a range of settings including criminal justice settings. Decisions on alcohol treatment requirements should continue to be made on the basis of normal CJS assessments, but the AUDIT score may be a useful additional piece of information to include in such assessments. Making judgements, which considers the interaction between alcohol use and the causal development of co-morbidities and considers prognostic markers is a specialist competence that cannot be replicated in a tool. Those wishing to provide opinions of this nature should be

								suitably trained and competent.
648	SH	St Mungo Housing Association Ltd	22. 24	full	5.21	148	following on from point 23 above, the ATR intervention would spread across potentially all the audit scores though in practice only those scores in the categories 8-15 (rarely), 16-19 and >20 associated with an offence or pattern of offending would result in candidacy for an ATR	Thank you for your comment. ATR interventions are outside the scope of this guideline.
649	SH	St Mungo Housing Association Ltd	22. 25	full	5.23	173	line 27 correct “seen”	Thank you, this has been changed.
650	SH	St Mungo Housing Association Ltd	22. 26	full	5.25.1	175	community settings: we encounter a frequent obstacle when a client becomes motivated to achieve abstinence (often after a period of reduction) while living in the hostels where we provide services: because the client is identified as “drug seeking” GPs and CDATS are sometimes reluctant to provide the necessary prescriptions for medication, even if professional assessment concludes that they would be a good candidate and they enjoy professional support to help them manage medication. All too often this is linked to another issue that prevents good case coordination and care management: whether or not there is a specialist assessment on file that might conform to all the protocols suggested in the guidelines, if medical support is needed, then this assessment process is often repeated all over again. We would welcome suggestions in the guidelines for avoiding these two pitfalls, encouraging common assessment protocols.	Thank you for your comment. We agree and feel that the guidelines place the assessment of the need for withdrawal and prescribing in a proper context. We feel that this should improve the quality of withdrawal management across settings.
651	SH	St Mungo Housing Association Ltd	22. 27	full	5.23	173 et seq	as for 28 re section 5.25	Thank you for your comment. Due to the range of settings in which withdrawal is managed we have not been able to deal with all settings in great detail but rather set out general principles for good practice. Furthermore, we did not feel there was sufficient evidence to support preference of one setting over another unless otherwise stated in the guidelines.
652	SH	St Mungo Housing Association Ltd	22. 28	full	5.25	175	In both the introduction and in this section to consider the appropriate settings for assisted withdrawal, we believe it would be helpful to consider supported accommodation in more detail, especially to include the types of accommodation available within Supporting People	Thank you for your comment. Due to the range of settings in which withdrawal is managed we have not been able to deal with all settings in great detail but rather set out general principles for good

							pathways for vulnerable adults many of whom are heavily dependent on alcohol, have other comorbid conditions and receive a range of services including key work and care planning to assist them to address their problems. Some of this accommodation provision includes specialised staff support which is more specific to clients who are alcohol dependent. In our view these situations would be well suited as settings to provide reduction and then detoxification and are often under-utilised for this purpose, primarily due to factors regarding social exclusion agenda. Hostels are only mentioned in one person's narrative account, and are not mentioned in the rest of the guideline, yet we find that about 70% of these clients have alcohol problems and a high proportion of these also have other mental health problems. This is a huge concentration of potential candidates for withdrawal support, which would make a substantial contribution to improvements to their health and wellbeing and also reduce the potential cost to wider society of their continuing with dependent drinking and the problems associated with it. This would also support the conclusions of section 5.28 that community settings can be as effective as residential settings	practice. Furthermore, we did not feel there was sufficient evidence to support preference of one setting over another unless otherwise stated in the guidelines.
653	SH	St Mungo Housing Association Ltd	22. 29	full	5.25.5	181	Our services tend to support the most heavily dependent clients with complex needs, often with physical health complications, and it is often difficult to gain places for in patient detoxification. The obstacles presented by the present system deter clients from taking up in patient services, or result in their ejection from services. This may be one of the causes of the observation that some inpatient detoxifications are provided for those with lower severity than strictly necessary to qualify for inpatient detoxification.	Thank you. We agree and have made recommendations on the criteria for inpatient withdrawal which should hopefully improve access to this setting.
654	SH	St Mungo Housing Association Ltd	22. 30	full	5.28.11	212	We do not think it is adequate to recommend that homeless people with alcohol problems are given a maximum of 3 months residential rehabilitation. There are reputable rehabilitation centres who offer 6 month programmes for people with alcohol problems and complex needs, especially with traumatic backgrounds, whose services are used by a variety of social care funding panels. If this is applicable in general, then it must be particularly applicable	Thank you for your comment. The GDG could not find evidence to support 6 month residential rehabilitation as being more effective than 3 months.

							to the homeless client group, where social skills have been eroded and problems have consolidated. We also suggest that in this section the scope of aftercare for this particular client group needs more thought about how their ongoing needs should be addressed	
655	SH	St Mungo Housing Association Ltd	22. 31	full	general	general	We recommend that some thought is given in the recommendations and in the overall structure to reduction as a pre-cursor to successful withdrawal and rehabilitation. We would recommend that the guidelines should establish the case for preliminary reduction to support later interventions to be more successful. Our own experiences include establishing an alcohol reduction unit (albeit on a small and intensive scale within a more general hostel) is that reduction has been the pre-cursor for greater success of withdrawal treatment support and subsequent engagement either in residential rehabilitation or in ongoing recovery in the community. In both cases outcomes have been distinctively improved by this structured reduction intervention, which consisted of low threshold therapeutic group work, key work, and structured social groups. In our view, these experiences show the value of reduction approaches as part of a wider strategy to accomplish longer term treatment and sustained recovery	Thank you for your comment. We were unable to find any relevant high quality research evidence on the impact of alcohol reduction as a precursor to successful withdrawal although we are aware that this is practiced in some services. The GDG was concerned that in the absence of evidence of effectiveness of alcohol reduction, there was a risk that this may be interpreted by less experienced practitioners as a recommendation to encourage patients to detoxify without medication support. This obviously carries serious risks as described in the guideline. In view of the potential risks to patients and the proven effectiveness and safety of current standard practice, it may not be ethically appropriate to conduct research comparing untreated withdrawal with current standard practice.
656	SH	St Mungo Housing Association Ltd	22. 32	full	general	general	we welcome the guidelines as a comprehensive and useful source of information which we think will improve professional knowledge and understanding in this field	Thank you for your comment.
657	SH	The Children's Society	14. 01	All	General	General	We welcome the references in this guidance to the impact of a person's harmful drinking on their family and in particular on children. We would like to acknowledge this as a significant contribution towards improved outcomes for children affected by parental alcohol misuse.	Thank you for your comment.
658	SH	The Children's Society	14. 02	NICE	Person Centred Care	6	We recommend that paragraph 6 with the sentence beginning 'Families and carers should…' would benefit from the addition 'Families, including dependent children, and carers (including young carers) should also be given the information etc…'. This is to counterbalance the tendency	Thank you for your comment, but this is standard NICE text.

							within adult treatment services to overlook children and young people who are affected by their parent's alcohol misuse and the impact this has on their lives.	
659	SH	The Children's Society	14.03	NICE	1.1.2.5	11	We consider it essential that a bullet point is added here that states that staff in contact with parents who misuse should also refer the child to an appropriate support service. They could also be encouraged to ensure that the child has someone to talk to.	Thank you for your comment. We agree that the interests of the child should be paramount. With this in mind we believe that where only one parent has an alcohol problem, the child's well being may be properly taken care of within the family setting and outside referral may be neither required nor helpful in all cases. If both parents have an alcohol problem then there is a much stronger case for an intervention but this might take a number of forms of which referral of the child to an appropriate support service may be one but not the only possible intervention. This should be a matter for local services to determine.
660	SH	The Children's Society	14.04	Full	4.3	58	[Personal accounts – carers] An additional account from a young carer that demonstrates the impact that caring for a alcohol dependent parent has on a young person's life would enhance this section further.	Thank you. We agree this would be an advantage however we did not receive an account from a young carer.
661	SH	The Children's Society	14.05	Full	4.5	81	[Qualitative analysis] We welcome this excellent summary, however we regret that the statements come from adults' accounts as they look back at their childhood and there are none from children and young people themselves. In our experience, quotes directly from children and young people are extremely powerful because they are often expressed differently from adult's quotes and reflect a different perspective. We are able to provide some quotes from children and young people if required.	Thank you for your comment. We have mentioned that the retrospective nature of some of the stories could be a limitation; however some accounts are also written in the present tense. We were restricted to the accounts available from NACOA. Thank you for your offer of quotes, however these are not contained within the qualitative analysis so we could not use them in this context.
662	SH	Turning Point	30.01	All	General	General	Turning Point broadly supports these guidelines and we are satisfied that this document is well informed by a deep breadth of academic research that fully accounts for the wide ranging effects and reasons for alcohol dependence and harmful use.	Thank you for your comment.
663	SH	Turning Point	30.	All	General	General	In particular we support the document's notion that	Thank you for your comment.

			02				treatment should be accessible and suitable treatment should be provided to everyone who needs it through investment in more and better quality services. We would add that at the same time, there should be targets to reduce waiting times and improve the efficiency of services by considering how to integrate them. One implication of improving the right to immediate and accessible treatment is that both acute trusts and rehab organisations will become overburdened with demand and they must therefore in turn be enabled with better capacity. The guidance delivers a clear message that Primary Care should do more of the identification and brief interventions, and that organisations such as Turning Point should be better resourced to meet the demand that more identification would create. Alcohol accounts for a vast amount of financial cost both directly to health resources and indirectly in terms of days lost from work, accidents, crime and welfare, and it is very probable that a greater investment in treatment would pay for itself. Currently, and at the last count: The estimated annual spend on specialist alcohol treatment is £217 million (ANARP, 2004 national alcohol needs assessment for England) But according to the 2003 National Alcohol Harm Reduction (NAHR) Strategy's strategy unit interim analysis estimated that alcohol misuse was costing about £20 billion a year (Alcohol Concern estimates that this figure is now closer to £25 billion). This is made up of alcohol-related health disorders and disease, crime and anti-social behaviour, loss of productivity in the workplace, and problems for those who misuse alcohol and their families, including domestic violence. The NAHR's Strategy said that the annual cost includes:	

							• 1.2 million violent incidents. • Increased anti-social behaviour and fear of crime. • £95 million on specialist alcohol treatment. • Over 30,000 hospital admissions for alcohol dependence syndrome. • Up to 22,000 premature deaths annually. • At peak times, up to 70 per cent of all admissions to A&E departments. • Up to 1,000 suicides. • Up to 17 million working days lost. • Between 780,000 and 1.3 million children affected by parental alcohol problems. • Increased divorce. • The combined health harms of alcohol misuse cost the NHS £1.7 billion per annum. • The harm caused to the economy by lost productivity and profitability is estimated to cost £6.4bn per annum. • Half of those attending drug and alcohol services have mental health problems. Of course the implication of investment in alcohol interventions is that there will be a significant return on investment. Nevertheless, Turning Point is concerned that the bulk of the savings would lag behind the up-front costs, possibly by a decade or more; We recognise that alcohol harms are much more insidious and chronic than those from heroin, and especially in the current financial climate, we fear that there is a reluctance to invest so much for so long before the dividends are reaped. Any investment must therefore take account of the long term benefits and indeed the cost benefits that can be reaped, particularly in welfare, health, and the criminal justice systems in the long term.	
664	SH	Turning Point	30.	All	General	General	Turning Point supports the guidance's notion that treatment	Thank you for your comment.

			03				should encompass not only medical interventions but also take a person-centred approach to resolve other complex needs surrounding an individual's alcohol misuse. This means that the causes of alcohol misuse should be tackled along with any related mental health and drugs problems. Providing support to ensure someone does not relapse, once they have stopped using alcohol treatment, should include wide-ranging aftercare support around housing, education and employment that also helps people back into productive lives. One way to overcome increased demand for rehabilitation and to ensure that treatment is person-centred is through better commissioning of integrated services. For example in Somerset, Turning Point has been commissioned by the Drug Alcohol Action Team to provide a county-wide integrated service that treats both drug and alcohol problems. The efficiencies that this service has created mean that during the first year of opening, more people were referred to the service with a Primary Alcohol Problem than a Primary Drug Problem. Because it is an integrated service, it can support and treat people with a primary alcohol problem <u>as well as</u> people with a primary drug problem in an equitable way solely through the efficiencies of an integrated model – more capacity, less duplication and more consistency. Here are further details about this model: **Turning Point Somerset** **<u>Open Access Integrated drug and alcohol service across Somerset</u>** **Locations:** Somerset-wide (Including offices in Glastonbury, Bridgwater, Taunton, Yeovil and Wells) **What product is provided?**	

							Turning Point has a contract with Somerset Drug and Alcohol Action Team (DAAT) to provide an Open Access Integrated Community-based Drug and Alcohol Treatment Service across Somerset. The DAAT's Service Specification outlines the aims of the service as: ▪ The aim of the service is to enable all individuals who present to the service with drug and alcohol problems to overcome them and live healthy, crime free lives and realise their potential as individuals and as citizens of the community. ▪ In the main this will be achieved by service users minimising different forms of harm associated with their use and /or becoming free from their dependence to drug and alcohol use. ▪ A key objective of the service is to support service users to make positive and constructive changes in their lives. **These are the main aims and objectives of the service. In addition, Turning Point Somerset has the following mission statement:** ***Turning Point Somerset is an Open Access Integrated Community-based Drug and Alcohol Treatment Service for Somerset offering high quality clinical and non-clinical treatment and support to people with drug and/or alcohol problems. The service offers support to carers and family members of people using drugs and or alcohol. The service is available to adult (over 18) Somerset residents who require assistance in addressing the (illicit) drug or alcohol problem. The service also offers support to adult Somerset residents who are carers or family members of people misusing substances.*** ***The service aims to offer accessible, service user focussed services enabling people to make positive changes in their lives. The service aims to work with people in all stages of 'recovery' from problematic substance misuse, offering harm reduction services and abstinence-based support. The service aims to***	

							provide a choice of services for service users across Somerset in specialist centres and also offers support for people in community settings, such as GP practices. The service aims to offer effective referral routes to partner agencies and services and offer seamless throughcare and joint working with Primary Care, specialist services, such as Housing, Police, Probation, residential support. ***Turning Point Somerset embodies the principles of Turning Point and translates organisational values with local need. Services provided by Turning Point Somerset will be evidence-based, aligned to organisational and national policies, procedures and best practice and frequently audited to ensure a high standard of care is provided.*** Turning Point Somerset provides treatment and support through 4 specialist centres across Somerset, Wells covering the district of Mendip, Yeovil covering South Somerset district, Taunton covering Taunton Deane and West Somerset Districts and Bridgwater covering the Sedgemoor district. Turning Point Glastonbury serves as a base for administration and has limited service user services. **Who are the service users?** Adult residents of Somerset reporting problematic substance (drug and/or alcohol use) and/or their family, friends or carers affected by this substance use. **What are the benefits / outcomes of the product?** Integrating all community drug and alcohol services, including the Drug Intervention Programme & Drug Rehabilitation Requirements generates significant efficiencies to increase capacity by employing more frontline staff, improves accessibility for service users and offers greater choice. The service also improves staff performance management, gives commissioners greater control over the contract and has greater adaptability to change and move resources to meet the changing needs of the local area and	

							service user needs **Who are the stakeholders?** DAAT (PCT, County Council, District Council, Police, Probation), Local hospitals & specialist health services, Social Services, Mental Health Services, Service user groups **What model is used for the product?** An integrated drug and alcohol – integrated (MoC) Tiers – integrated staffing model. See lessons learnt paper about the implementation of this for future services. **Cost Benefits** Turning Point is currently undertaking cost benefit analysis on this Integrated model with Oxford Economic (advisors to HMT). The full results of this analysis will be available as of September 2010, though provisional analysis demonstrates that: • Throughout the year more people were referred to the service with a Primary Alcohol Problem than a Primary Drug Problem. • An integrated service supports and treats people with a primary alcohol problem as well as people with a primary drug problem in an equitable way solely through the efficiencies of an integrated model – more capacity, less duplication and more consistency. • The service has established many new services, such as BBV vaccination and testing, Community Detoxification, a county-wide structured group work programme, expansion of Non Medical Prescribing and many more – for the same amount of funding. • A truly integrated service provides; a safer service, a higher quality service, more choice for service users (particularly those that are abstinent) and for the same price if not less than fractured service provision with multiple providers. It also gives	

							commissioners more flexibility to respond to the changing needs of service users and the economic climate. • As a result of service efficiencies, the integrated service maintains a priority on Tier 2 and manages Tier 2 to Tier 3 more effectively to avoid drop out and improves retention. • In the first year of opening, the service achieved a 58 per cent increase in prescribing volume with the same funding in Specialist/Core Prescribing. • The service realised a balanced budget within one year of opening despite significant start up, HR, training and development costs. **Other recent outcomes** • The National Treatment Agency reports that the service has a 'low' waiting time of under 3 weeks for new clients. • Over 80% of clients are entering effective treatment. This means that they are staying with the service for over 12 weeks, and engaging in addressing their addiction and how they can reintegrate back into the local community through work and housing. • 72% of clients do not have a housing problem. Engaging with the service helps clients develop settled housing • Over 60% of clients engaging with this service are between the ages of 30 to 44. i.e. this is an age group not traditionally associated with antisocial behaviour.	
665	SH	Turning Point	30.04	All	General	General	Nevertheless, as commissioning requirements change, Turning Point remains concerned that the responsibility for "Who Pays" for alcohol interventions and rehabilitations is becoming diluted. With cuts in spending on the horizon for Local Authorities, Primary Care Trusts and other commissioning	Thank you for your comment.

							organisations, the question of who is prepared to pay for the treatment is becoming increasingly pertinent. Turning Point would advocate a Government-regulated 'ring-fenced' amount that has to be allocated by the service commissioning body. Under the forthcoming Drug Strategy (consultation published 20th August), the commissioning of drugs services by the National Treatment Agency is likely to now include provision for alcohol treatment too. As the principal body responsible for drugs (and under the new Strategy, probably alcohol) treatment, the National Treatment Agency will be merging into the Public Health Service by April 2012. As such ring-fencing for a drugs/ alcohol budget should feature as part of the currently ring-fenced NTA budget, or as a standalone and ring-fenced budget within the proposed overall (and in itself ring-fenced) budget for the Public Health Service.	
666	SH	Turning Point	30.05	All	General	General	In undertaking alcohol assessments and rehabilitation for adults, Turning Point also advocates that a broader assessment to do with family needs and parental ability should take place to ensure that alcohol problems do not become intergenerational as children deal with the consequences of having an alcoholic parent. One in eleven children live with parents who misuse alcohol (Alcohol Harm Reduction Strategy for England), and this can have profound consequences in a child's development, not only in terms of intergenerational alcohol misuse, but also as the quality of children's lives are profoundly affected (Bottling it Up, Turning Point, 2006, which examined the impact of parental alcohol misuse). The findings from Bottling it UP were recently (April 2010) given new pertinence by ChildLine's statement about the large number of children contacting them about their parents' drug and alcohol problems.	Thank you for your comment.

							In order to revitalise families and ensure that problems are not transferred from parent to child, services are required that prioritise parents with alcohol problems into treatment, including practical help in establishing routines around running a home, and for their children including counselling to help them cope emotionally. Above all, service commissioners should aspire to commission models that bring both parents and children together, through family therapy and activities such as family outings. From Turning Point's Bottling it Up report we know that where services do not account for parental and family circumstances, the effects of alcohol misuse on children can include: • Increased anxiety, anger and depression • Role of carer in the family; for siblings, parents, family finances, taking care of the home etc • Concern for parents safety, welfare and health • Altered perceptions of parental role and future views of parenting • Altered perception of alcohol; future use as a coping mechanism, or for 'escape' • Higher risk of anti-social behaviour and offending • Missing school with failure to achieve academic potential impacting upon employment prospects etc. • Increase likelihood of moving out of the family home at an early age to 'escape' from the problem therefore increasing isolation and possibility of homelessness. Services should also be aware that where parents are undertaking treatment, the effects on families can include: • Parents can struggle to provide adequate care and support for children • Children may be taken into care or cared for by relatives • May involve significant periods on absence from	

							children whilst drinking or whilst attending treatment • Focus is on alcohol at the expense of parenting In order to counteract such negative outcomes, Turning Point advocates: • Improved information directed at parents and children on the effects of problem drinking on families and where to go for support • Screening and early identification of families who need support • Alcohol services to provide support for parents and ensure children are taken into account during any intervention • Specialist services should be available in all areas • All professionals working with adult alcohol misusers should be trained in supporting parents • Adult services should ensure they assess the impact of alcohol on client's children	
667	SH	Turning Point	30.06	All	General	General	In terms of criminal justice interventions, people convicted of a crime related to drug use go through tailored sentences to reduce their drug taking and prevent reoffending, but due to a lack of funding and magistrates' awareness of treatment options, help that can be provided by Alcohol Treatment Requirements (ATRs) is not usually available to people who misuse alcohol. For those who have committed an offence, there should be an expansion of funding and services within the criminal justice system so that people get treatment as part of their sentence. In the current financial climate, while Turning Point recognises that increased funding is unlikely, one inexpensive solution is to better enable and educate magistrates to use community sentences instead of short periods of custody for lower level offenders. In order to deliver such sentences, magistrates need to be confident that community orders are a just and effective disposal	Thank you for your comment.

							option. Turning Point's experience is that magistrates' use of community orders varies significantly across the country and that magistrates do not make full use of the range of disposals available to them. In some areas of the country we have delivered training to magistrates on using community orders. In these training sessions, magistrates learn about the nature of substance misuse and different approaches to treatment, and explain the potential benefits to drug-misusing offenders of a community order. Where this training has taken place, there has been an increased use of Drug Rehabilitation Requirements (DRRs), which we support as a sensible alternative to prison. With appropriate, and relatively inexpensive resource and guidance such training could also be provided for ATRs by existing service providers. In terms of the reduced crime that such specialised sentences are proven to deliver, the savings made in the criminal justice system should pay for the increased use of such sentencing options.	
668	SH	Turning Point	30. 07	All	General	General	Turning Point very much advocates the guidance's guiding principal to identify dependent drinkers early. In 2003 the Strategy Unit Alcohol Harm Reduction Project – Interim Analytical Report, 2003, showed that alcohol was implicated in around 35% of Accident and Emergency Department (A&E) attendances and ambulance costs – at a cost of some £0.5 billion per year. As such, alcohol specialists should be placed in all A & E departments who can identify dependent drinkers and get them into treatment quickly. Without this support, those people are likely to turn up to A & E again and again without having their needs addressed, also adding to NHS costs. A toolkit already exists which can calculate the significant cost benefits of undertaking this type of intervention.	Thank you for your comment.

							Furthermore, and in tandem with the A&E interventions, Turning Point is also piloting a 'GP Click' service, which ensures good communication between healthcare professionals and patients and helps support the evidence-based of written information tailored to the patient's needs. This service also adheres to the Models of Care of Alcohol Misuse guidance that: "Individuals should be assessed and appropriately care coordinated within specialist substance service or non specialist service." The GP Click service also encompasses and meets the standards of current NICE Guidelines. The click is a swift self scoring tool that encourages GP's to screen patients within the 10 minute allotted time. Further information is available through Glenda Lee, Service Manager at Turning Point (Glenda.lee@turning-point.co.uk). Finally, and in terms of early interventions, Turning Point has also piloted an effective partnership with Tyne and Wear Fire Department to identify hazardous drinkers before their misuse potentially leads to hazardous and expensive house fires. Through its day to day work, the fire service is in regular contact with alcohol misusers and as such is able to make referrals to the Turning Point service. For example, one client referred to the service had had ten house fires, not only putting themselves at risk but the surrounding community. The service set up multi agency meetings, provided intense one to one support, and brought together all relevant services to provide a holistic treatment plan for this client. Another client who rarely left the house is now attending a community centre, reduced his alcohol intake and improved his quality of life. Inevitably, as these clients reduce their alcohol intake, so do the fires diminish. According to the Tyne and Wear Fire Department, the service's interventions have resulted in potential savings of	

							£23.23million (based on Fire Fatalities-Economic Costs of Fire 2004 –Communities and Local Government) of value for the Gateshead community. Turning Point advocates the duplication of such services throughout the country in order to ensure early identification and treatment of alcohol misusers and to reduce the risk of house fires.	
669	SH	UKCPA[6]	16.01	All	General	General	UKCPA would like to confirm that it has no comments to make on the above consultation.	Thank you.
670	SH	YWCA England & Wales	9.01	Full	General	General	YWCA England & Wales welcomes these guidelines and the opportunity to respond to this consultation. We are concerned about alcohol misuse amongst girls and women, and in particular recent research which has shown an increase in alcohol consumption amongst very young women. YWCA delivers services that help girls and women build resilience to developing a harmful relationship with alcohol, as well as helping them to address the root causes of their drinking. We provide safe, non-judgemental, women-only interventions and structured support to overcome their alcohol misuse. Our work supports girls and women to build their self-esteem, confidence and life skills so they do not feel the need to drink heavily. We believe there should be much greater focus on the reasons for girls and women's drinking in the first place and efforts should be made to find sustainable ways to support them.	Thank you for your comments.
671	SH	YWCA England & Wales	9.02	Full	4.4.6	70	**YWCA welcomes the full version's attention to gender, but we are concerned that the shorter (NICE) version does not replicate or reflect the findings of the longer version.** There are gender differences in alcohol consumption as well as access to and use of services, and these require that different mechanisms are used to support women. Whilst section 4.4.6 (Access & engagement) recognises this in the full version, the shorter version does not. It is essential that both guideline documents, and particularly the	Thank you for your comment. We have made reference to the issue in the introduction to the NICE guideline but we were unable to find good quality evidence to support the use of the "different mechanisms" you refer to.

[6] United Kingdom Clinical Pharmacy Association

							‘key priorities for implementation’ in the short version, reflect the different requirements that women have of services to ensure that NICE is promoting equality of opportunity and outcome. This is a requirement of the Gender Equality Duty (2007), which places an expectation on service providers, including public sector health and social care, to offer services that promote gender equality and combat sex discrimination.	
672	SH	YWCA England & Wales	9.03	Full	4.4.6	70	[Lines 25-28] From internal research YWCA has conducted, we know that girls and women have particular experiences, needs, and requirements of health services. As the research in the full document makes clear, when women do seek treatment for a problem, it is crucial that they feel comfortable and are treated in a holistic way – being supported to address their alcohol use as well as any other problem they may be experiencing. We know that many of the girls and women who access our safe, women-only services would not use generic, mainstream services and so, were it not for YWCA, they may not otherwise access any kind of support service – for whatever problem it is that they are facing. Where these specialist services are not available, mainstream services should be able to signpost to further specialist provision for women. This is particularly true for women where abuse or isolation has been a leading factor in developing a drinking problem. Research has shown that ‘women’s centres have a clear and important role in engaging women and fostering well-being, particularly women who are marginalised.’[7]	Thank you. We agree that services need to be sensitive to the experience and needs of women but we were unable to identify good quality evidence for the role of woman’s centres operating in the manner that you suggest.
673	SH	YWCA England & Wales	9.04	Full	4.4.6	70	[Lines 30-39] Counselling, as the full version suggests, can be critical to enabling a woman address the causes of her drinking, and can also affect a women’s retention in treatment. ‘Talking therapies’ are not as easily available to girls and women as they would like them to be and the guidelines should stress their value. YWCA’s own research[8] found that girls and	Thank you for your comment – as you can see from Chapter 6, we considered and made recommendations on a range of psychological interventions but for harmful and dependent drinking we found little evidence to support a specific recommendation for counselling.

[7] National Mental Health Development Unit (2010) Working towards Women’s Well-being: Unfinished business, p5. http://www.nmhdu.org.uk/silo/files/working-towards-womens-wellbeing-unfinished-business.pdf
[8] YWCA (2010) Young women and alcohol. Accessed at: http://ywca.org.uk/resources/reports/young_women_and_alcohol

							young women want support to address the root causes behind their drinking, as many of them use alcohol as a coping mechanism to self-medicate in an attempt to escape their problems. The full version findings that a 'therapist's ability to treat their patients with dignity, respect and genuine concern' are also in line with our findings. Our health research has found that girls and women want health professionals to be respectful, non-judgemental, to not patronise them and to be given their full time and attention. They also want to know that they can receive ongoing care, and not to feel as though they are only receiving temporary help or support. Appropriate care should involve girls and women in decisions, to ensure that they feel fully empowered and in control of their care and treatment, and that decisions are not being made about them without them.	
674	SH	YWCA England & Wales	9.05	Full	4.4.6	70	[Lines 41-44] We also welcome the recognition of the importance of childcare in supporting girls and women with alcohol problems. We provide childcare in as many of our centres as possible, as we know that this is a crucial way of supporting mothers to engage in a service, whatever that might be. It is important that this is provided on site, by someone they trust, and is free.	Thank you for your comment. However, your comments on service provision are outside the scope of the guideline but we will draw them to the attention of the NICE group who will be publishing commissioning guidance on alcohol.
675	SH	YWCA England & Wales	9.06	Full	4.4.6	70	[Lines 44-47] Flexibility is also critical for girls and women to be able to access services in a way that suits them and with which they can remain engaged. This is particularly important for those who have childcare responsibilities, or whose lifestyles may be chaotic. Girls and women tell us that for them, flexibility means flexible appointment times, including out-of-hours, and being able to access walk-in services. It can also mean having on-going care from the same medical professional, as and when they may need it.	Thank you for your comment. We agree that flexibility is an important characteristic to enable services to meet the needs of service users. However, we believe it is for local services to determine the manor in which this is implemented.
676	SH	YWCA England & Wales	9.07	Full	4.4.6	70 -71	[Lines 49-50 & 1-8] YWCA is also concerned about the social stigma that is attached to women's drinking. Many girls and women, and particularly young mothers, report to the YWCA that they feel judged, uncomfortable and embarrassed when they	Thank you for your comment. We agree with this which is why the area of stigma is raised in recommendation 4.4.1.1 ('When working with people who misuse alcohol……take into account that stigma

							access health services, and this affects their experience and use of them. It is important that alcohol treatment services do not make them feel this way, and that staff and the physical environment make them feel welcome and understood.	and discrimination is often associated with alcohol misuse and that minimising the problem may be part of the service user's presentation…').
677	SH	YWCA England & Wales	9.08	All	General	General	In summary, YWCA welcomes the full version's attention to gender, but we believe that in order to 'better promote equality of opportunity relating to gender', as the consultation questions ask, then this should also be made explicit in the short (NICE) version.	Thank you for your comment. We have now made it clear in the NICE version that alcohol related problems affect both men and women.

These stakeholder organisations were approached but did not respond:

15 Healthcare
Addiction Recovery Foundation
Adfam
Age Concern England
Alcohol Concern
Alkermes Inc
All About Nocturnal Enuresis Team
Archimedes Pharma Ltd
Association of British Insurers (ABI)
Association of Dance Movement Therapy UK
Association of Nurses in Substance Abuse
Association of Psychoanalytic Psychotherapy in the NHS
Association of the British Pharmaceuticals Industry (ABPI)
BALANCE North East
Barnsley Hospital NHS Foundation Trust
Barnsley PCT
Berkshire Healthcare NHS Foundation Trust
Birmingham and Solihull Mental Health Foundation Trust
Birmingham City Council
Bolton Council
Bolton PCT
BRENT Teaching PCT
British Association for Behavioural & Cognitive Psychotherapies (BABCP)
British Association of Psychodrama and Sociodrama (BPA)
British Dietetic Association
British National Formulary (BNF)

British Psychodrama Association
British Psychological Society, The
Brook London
Buckinghamshire PCT
BUPA
Calderdale PCT
Care Quality Commission (CQC)
Centre for Mental Health Research
CHiNWAG
CIS'ters
Citizens Commission on Human Rights
College of Emergency Medicine
College of Occupational Therapists
Commission for Social Care Inspection
Compass-Services to Tackle Problem Drug Use
Connecting for Health
CRI
Daiichi Sankyo UK
Department for Communities and Local Government
Department of Health Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (ARHAI)
Department of Health, Social Services & Public Safety, Northern Ireland (DHSSPSNI)
Doncaster Alcohol Services
DrugScope
Eastern Health & Social Services Board
European Association for the Treatment of Addiction
Faculty of Public Health
Family Planning Association
Gateshead Drug & Alcohol Team
Gateshead PCT
Genus Pharmaceuticals
Government Office Yorkshire and the Humber
Greater Manchester West Mental Health NHS Foundation Trust
Greenwich Council - Drug and Alcohol Action Team
HAGAM
Hampshire Partnership NHS Foundation Trust
Harmless
Havering PCT
Hayward Medical Communications
Hertfordshire Partnership NHS Trust

Humber Mental Health Teaching NHS Trust
Inclusive Health
Institute of Alcohol Studies
Institute of Psychiatry
Intapsych Ltd
Kettering General Hospital NHS Foundation Trust
Kingston Hospital NHS Trust
Lambeth Community Health
Lancashire Care NHS Foundation Trust
Leeds Irish Health and Homes
Leeds Partnerships NHS Foundation Trust
Leeds PCT
Lifeline
Lighthouse Project
Liverpool Community Health
Liverpool LINk (Local Involvement Network)
Liverpool PCT
Luton & Dunstable Hospital NHS Foundation Trust
Manchester Community Health
MBB Connections Healthcare
Medicines and Healthcare Products Regulatory Agency (MHRA)
Mental Health Act Commission
Mental Health and Substance Use: dual diagnosis
Mental Health Foundation
Mental Health Nurses Association
Mental Health Providers Forum
Merck Serono
Mersey Care NHS Trust
Microgenics GmbH
Milton Keynes PCT
Ministry of Defence (MoD)
MRSA Action UK
National Association for Children of Alcoholics
National Institute for Mental Health in England
National Offender Management Service
National Patient Safety Agency (NPSA)
National Pharmacy Association
National Public Health Service for Wales
NeuroDiversity International(NDI)/NeuroDiversity Self-Advocacy Network(NESAN)

Newcastle and North Tyneside Community Health
Newcastle Upon Tyne Hospitals NHS Foundation Trust
NHS Bedfordshire
NHS Calderdale - substance misuse commissioning programme
NHS Clinical Knowledge Summaries Service (SCHIN)
NHS Kirklees
NHS Knowsley
NHS North of Tyne
NHS Plus
NHS Quality Improvement Scotland
NHS Sefton
NHS Sheffield
North East London Mental Health Trust
North Essex Partnership NHS Foundation Trust
North Staffordshire Combined Healthcare NHS Trust
North Yorkshire and York PCT
Northern Ireland Chest Heart & Stroke
Northumberland Tyne & Wear Trust
Northumbria Police
Northumbria University
Offender Health - Department of Health
Oklahoma State University
Oxfordshire & Buckinghamshire Mental Health Partnership NHS Trust
Patients Council
PERIGON Healthcare Ltd
Phoenix Futures
Poole and Bournemouth PCT
Queen Mary's Hospital NHS Trust (Sidcup)
Retreat, The
Royal College of General Practitioners
Royal College of Pathologists
Royal Cornwall Hospitals Trust
Royal Society of Medicine
Safe Communities East Riding
Safer Middlesbrough Partnership
Salford Royal Hospitals Foundation NHS Trust
Sandwell PCT
SANE
Scottish Intercollegiate Guidelines Network (SIGN)

Sedgefield PCT
Sheffield Care Mental Health Trust
Sheffield Health and Social Care Foundation Trust
Sheffield PCT
Sheffield Teaching Hospitals NHS Foundation Trust
Social Care Institute for Excellence (SCIE)
Social Exclusion Task Force
Society for Acute Medicine
South Essex Partnership NHS Foundation Trust
South of Tyne & Wear PCT
South West Autistic Rights Movement
South West Yorkshire Partnership NHS Foundation Trust
St Helens Hospital
Staffordshire County Council
Substance Misuse Management in General Practice (SMMPG)
Sussex Partnership NHS Foundation Trust
Tees Esk & Wear Valleys NHS Trust
Teva UK Limited
The Albert Centre
The British Psychological Society
The Princess Royal Trust for Carers
The Survivors Trust
Tuke Centre, The
UK Advocates Ltd
UK National Screening Committee
UKPHA Alcohol & Violence Special Interest Group
United Kingdom Council of Psychotherapists
United Lincolnshire Hospitals NHS Trust
University Hospital Birmingham NHS Foundation Trust
University of Nottingham
Welsh Assembly Government
Welsh Scientific Advisory Committee (WSAC)
Wessex Alcohol Research Collaborative
West Hertfordshire PCT & East and North Hertfordshire PCT
West London Mental Health NHS Trust
Western Cheshire PCT
Western Health and Social Care Trust
York NHS Foundation Trust