National Institute for Health and Clinical Excellence

ALCOHOL DEPENDENCE
Scope Consultation Table
9 December 2008 – 20 January 2009

SH = Registered Stakeholders. These comments and responses will be posted on the NICE website after guideline development begins.
GRP = Guidelines Review Panel member. These are added to this table for convenience but will not be posted on the web.
EX = Expert reviewers who have been asked specifically to comment on the scope

#'	Type	Stakeholder	NICE	Section	Comments	Response
1	SH	Adfam	1	General	It is important that the scope includes the role and contribution that families and social networks play in alcohol dependence. Many family members receive no support to cope with their situation, and when they do it is often provided by the voluntary sector. There is a growing body of evidence on the benefits of involving family and social networks in alcohol treatment and recovery. The scope needs to be clear about dual diagnosis; many people with alcohol dependence also have mental health problems and may also be drug users Membership on the group from a family member would be beneficial.	Thank you for your comments. We understand the importance of families and carers in the treatment and support of people with alcohol problems, and this is covered in section 4.3.1 p. We are aware that there are common mental health problems associated with alcohol dependence and this is covered in section 4.3.1 m. We have recruited both service users and carers to sit on the guideline development group.
10	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	1	General	The Association for Family Therapy and Systemic Practice in the UK (AFT) welcomes the approach of looking at systemic interventions at all levels that include working with partners and families (and other members of the support networks), particularly because of the widely acknowledged impact of alcohol misuse on close relationships, as well as the influence of factors like stress in relationships on alcohol misuse.	Thank you for your comments.
11	SH	Association for Family Therapy and Systemic	2	General	AFT is the leading body representing those working with families in the public and independent sector of the UK (please visit the	Thank you for your comments. We will be including family interventions that are available on the NHS, or funded by the NHS

		Practice in the UK (AFT)			website (www.aft.org.uk) for further information). The broad group of therapies under the banner of 'systemic family therapy' work not only with families, but also with individual children and adults, couples, multifamily groups, and the wider communities of the clients. They work in ways that not only support change with individuals but also in their relationships in the family and beyond, so individuals and/or those important to them are supported in making and maintaining changes that improve their lives and well-being. AFT's multidisciplinary membership includes family and systemic psychotherapists and psychotherapists, social workers, adult and child psychologists, child and adult psychiatrists, occupational therapists, community psychiatric nurses and others working in health and social care, as well as those who train and manage these professions. AFT emphasises the need for health policy and resources to acknowledge the importance of people's relationships in facilitating and supporting change. People's significant relationships in their families, communities and beyond, will influence their attitudes and behaviour and can be crucial in supporting and sustaining individual, and family well-being. For the research and evidence base for systemic family therapy, see http://www.aft.org.uk/training/research.asp. For an overview of current practice of family therapy and systemic practice in alcohol misuse and other services in the UK, see http://www.aft.org.uk/media/documents/V4CurrentPracticeFuturePossibilitiesDec07.doc	or local authorities, for which there is evidence of clinical and cost effectiveness.

12	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	9	General	Evidence for the effectiveness of systemic family therapy with alcohol misuse includes: Familial Responses to Alcohol Problems by Judith L. Fischer, Miriam Mulsow and Alan W. Korinek (eds) Journal of Family Therapy Volume 30, Issue 3, Date: August 2008, Pages: 328-330 Integrating couples and family therapy into a community alcohol service: a pantheoretical approach. Journal of Family Therapy Volume 23, Issue 1, Date: February 2001, Pages: 85-101 Arlene Vetere, Mavis Henley Family–oriented treatment for people with alcohol problems in Ireland: a comparison of the effectiveness of residential and community–based programmes Journal of Family Therapy Volume 25, Issue 1, Date: February 2003, Pages: 15-40 Mairead Doyle, Alan Carr, Stephen Rowen, Paudie Galvin, Sheila Lyons, Gerry Coon Asen, E. (2002): outcome research in family therapy. Advances in Psychiatric Treatment. 8. 230-238.	Thank you for this information, these references have been noted.
13	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	10	General	Training in systemic family interventions is important for staff at all levels to assess, support and treat children and adults affected by alcohol misuse and its associated problems. A systemic approach will be useful for staff working with brief or long term treatments especially for those who offer family interventions. See Stratton, P. (2005): Report on the evidence base of systemic family therapy, www.aft.org.uk.	Thank you for your comments. We will be including family interventions that are available on the NHS, or funded by the NHS or local authorities, for which there is evidence of clinical and cost effectiveness.
16	SH	Berkshire Healthcare NHS	1	General	What evidence is there for what is needed for the prevention of and intervention in alcohol misuse	Thank you for you comment. Prevention of alcohol use disorders is the remit of the

		Foundation Trust			in the 10-18 age group?	Public Health PDG. The evidence for need and effectiveness of interventions for this age group will be considered in this guideline during development.
17	SH	Berkshire Healthcare NHS Foundation Trust	2	General	The numbers of young people presenting with alcohol 'dependence' is not likely to be large (they may also be 'invisible') and possibly Part 1 and Part 2 could have been made more relevant to this age group. That said, it is important to know that young people with alcohol issues are being screened and assessed, and if young people do present with 'dependence' that there is a clear pathway to access appropriate help.	Thank you for your comment, we agree. This will be drawn to the attention of the other guideline development groups, who are dealing with part 1 and part 2.
18	SH	Berkshire Healthcare NHS Foundation Trust	3	General	Where alcohol use, misuse or dependence are found in children and young people under the age of 18 (16?) years, consideration should be given to whether or not issues of child protection need to be pursued.	Thank you for your comment. Though we will be addressing the needs of children and young people between 10 and 18 years, the remit of this scope does not include the specific care of dependants. However, there is NICE guidance which has addressed interventions to reduce substance misuse among vulnerable and disadvantaged children and young people (2007) which may of interest.
19	SH	BPS Faculty of Addictions	2	4.3.1 i), j),k),m)	The inclusion of psychological & psychosocial interventions and the treatment of common mental health problems are welcomed.	Thank you for your comment.
20	SH	BPS Faculty of Addictions	3	4.3.1. p)	The acknowledgement of the role of families and carers in the process is welcomed.	Thank you for your comment.
21	SH	BPS Faculty of Addictions	1	General	The guidelines are narrow and only focus on alcohol which allows for a clearer more precise focus, but does not address the issues and complexities of co-morbid conditions and the concurrent use of other drugs and substances. They are therefore helpful in providing guidance in treating people with exclusive alcohol problems, but not those with multiple substance and/or dual (multiple) diagnosis problems.	Thank you for your comment. In the interest of coherence we need to set boundaries around the scope, which means we cannot look at the many complexities of co-morbid conditions. However, we are looking at the management of common mental health problems in section 4.3.1 m, and we have explicitly added co-morbid drug misuse to this section.
22	SH	British Psychological Society	2	3 b)	Other severe mental health problems such as psychosis and bi-polar affective disorder are also associated with problematic alcohol use and	Thank you for your comment. It is beyond our scope to address severe mental illness with alcohol dependency; however the NCC-MH is

					present treatment challenges.	currently starting up a new guideline on dual diagnosis which will address this.
23	SH	British Psychological Society	3	3 b)	Other guidance issued by NICE relating to common mental health problems have identified the effectiveness of psychological therapy for these problems (e.g. anxiety, depression, PTSD). This has been taken further forward by the Department of Health's Improving Access to Psychological Therapies agenda. Will this be addressed in relation to people with co-existing alcohol problems in these guidelines?	Thank you for your comment. We will be addressing the management of common co-existing mental health problems (see section 4.3.1m), such as those you suggest, if this differs from the management of common mental health problems alone. This will include the consideration of psychological interventions. Furthermore, throughout development, the GDG will be mindful of access and engagement issues.
24	SH	British Psychological Society	4	4.2 a)	People with alcohol problems are also received into the Prison system. Should the prison healthcare context also be included?	Thank you for your comment. We agree that it is important to consider prison settings in the identification and management of alcohol dependence, and have added the 'criminal Justice System' to section 4.2a. Also, for your interest, the NTA is about to publish guidelines on management of adolescent addictions, including alcohol, in custodial settings.
25	SH	British Psychological Society	5	4.3.1 i)	Other interventions derived from psychological theory include Social Network Behaviour Therapy (SNBT), Relapse Prevention and systemic based interventions such as couple and family work (as distinct from support for family and carers).	Thank you for your comments, these have been noted.
26	SH	British Psychological Society	6	4.3.1 i)	Contingency Management is not widely used (if at all) in alcohol treatment services in the UK.	Thank you for your comment. We understand that contingency management is not widely used; however the evidence for its effectiveness will be reviewed along with other psychological interventions.
27	SH	British Psychological Society	1	General	This development of clinical guidelines in the area of alcohol dependence and harmful use is welcomed. The psychological, physical and social harms associated with problematic alcohol use are believed to be significant, enhancing treatment effectiveness is an important goal.	Thank you for your comments.
28	SH	British Psychological Society	7	General	What will the guidelines take for measures of outcome for alcohol treatments? Are the proposed guidelines likely to comment on the	Thank you for your comment. The GDG will consider all relevant outcome measures during the course of development.

					validity of abstinence versus harm reduction interventions with alcohol, and are the guidelines going to comment on the role of controlled drinking programmes / interventions with dependant drinkers.	
29	SH	British Psychological Society	8	General	Risky single occasion drinking (RSOD) needs to be a focus of such guidelines, that is to say where men and women exceed the recommended daily limits (4 units for men; 3 for women).	Thank you for your comment. This is outside the scope of the guideline, which focuses on treatment seeking individuals, however the Public Health PDG guideline, which will consider non-treatment seeking individuals should cover this.
30	SH	British Psychological Society	8	General	There has been much focus on heavy drinking in the past (i.e. in excess of 6, 7 or 8 units in a single session) and associated alcohol dependency, but more pervasive is RSOD and thereby arguably is the bigger societal problem in need of greater attention. Interventions need to be multifaceted, focused on behavioural, cognitive and affective variables at the individual level, but addressing barriers to behavioural change that are extant in the socio-cultural context.	Thank you for your comment. This is outside the scope of the guideline, which focuses on treatment seeking individuals, however the Public Health PDG guideline, which will consider non-treatment seeking individuals should cover this.
31	SH	British Psychological Society	9	General	Social marketing health promotion should be informed by message framing effects (e.g. loss vs gain framed messages) and should maximise targeting of such messages. Such promotions could usefully focus on the formation of implementation intentions' (IIs), specifying, when, where and how behavioural change will ensue, since research has shown such IIs are more predictive of behavioural change than simple intention formation.	Thank you for your comment. These issues are outside of our scope, however the Public Health PDG are currently developing a guideline on the prevention of alcohol-use disorders, which will look at marketing issues.
32	SH	British Psychological Society	10	General	Some hold the view that it is not helpful for RSOD or heavy drinking to be represented as a medical `illness' (though there is evidence for and against dispositional explanations of excessive drinking), since such a representation can strip people of personal agency and the anticipation that behavioural change is possible. Strategies for	Thank you for your comment. This is outside the scope of the guideline, which focuses on treatment seeking individuals, however the Public Health PDG guideline, which will consider non-treatment seeking individuals should cover this.

					strengthening self-efficacy are important.	
33	SH	British Psychological Society	11	General	Education about the effects of drinking on mood and physical health is needed. That alcohol acts initially as a stimulant and then with increasing dosage as a central nervous system suppressant and mood depressant is not widely understood amongst the general public, nor is it understood well amongst the general public that pre-existing low mood states can be accentuated by immoderate alcohol use. The incidence of liver disease amongst the under 20's and 30's has been increasing, so it is evident that some young people do not comprehend the physical health effects of RSOD or heavy drinking. Education and social marketing can help to establish new social norms for drinking responsibly and unharmfully and thereby intervene at the sociocontextual level to reduce RSOD and heavy drinking.	Thank you for your comment. These issues are outside the scope of this guideline, however will be addressed by guidance on prevention of alcohol-use disorders produced by the Public Health group (part 1).
36	EX	Christine Godfrey		General	The scope is extremely wide – from 10 upwards and covering a wide spectrum of alcohol disorders. There is a wide evidence base and it is difficult to see how a thorough examination of all evidence can be undertaken with such a broad scope.	Thank you for your comment. We agree that this scope is wide and presents us with a challenge; however, we have to include what is stated in the remit.
37	SH	Department of Health	1	General	We note that the scope consultation document is for *"alcohol dependence and harmful alcohol use: scope consultation"* with the full guideline title of: *"Alcohol dependence and harmful alcohol use: diagnosis and management in young people and adults".* We do not wish to see restriction of the scope of the guidelines, and we have no objections to the inclusion of harmful drinkers. We feel however that the consideration of dependence *and* harmful alcohol use in the same clinical guideline may raise some issues, as there is a potential risk of neither dependent users nor harmful drinkers receiving adequate consideration.	Thank you for your comment. We are interested in harmful alcohol use as well as dependence since 30% of people currently seeking help in community based alcohol agencies are harmful drinkers not meeting the criteria for alcohol dependence (ANARP, 2005). The wisdom and effectiveness of this approach should be examined to guide rational treatment provision. Further, much of the evidence base includes harmful drinkers as well as dependent drinkers.
38	SH	Department of	2	General	**For dependent users;** whilst assessment for all	Thank you for your comment. A distinction

		Health			is appropriate, we consider that the greatest need is for guidelines on the management of dependence for the estimated 10 to 20% of dependent users who may benefit from specialist treatment at any one time. In our view therefore, it is important that the inclusion of harmful misusers with dependent users does not dilute the focus of the guidelines on treatment for dependency. **For harmful users;** we feel that the association of harmful users with dependency may imply that health and other harms only occur in the context of dependency, when many important health harms arise in the misusing population that is not dependent. Current evidence shows that brief advice and brief interventions are often effective alone for harmful users (just as they are for hazardous drinkers) and the association with dependency for this group of drinkers has the potential to over-medicalise the approach to harmful drinkers.	will be made between opportunistic screening and brief intervention provided in primary care settings for hazardous/harmful drinkers (covered by the Public Health PDG) and the specialist interventions provided for harmful drinkers seeking help (within the scope of this group). It will also be important for the various groups overall to have clear integrated care pathways for different drinkers (e.g. harmful drinkers not responding to brief intervention). This does not imply medicalisation of harmful drinking, particularly as specialist services for this group are most likely to be provided by non-medical staff (e.g. alcohol counsellors) either in primary care or in non-statutory counselling agencies.
39	SH	Department of Health	3	General	We see that the steering committee, which oversees all the guidelines involved, will be considering crossover issues. We hope to see these issues work themselves out as the development of the respective guidelines progresses, in order to ensure that a wide scope does not lose the clarity of focus.	Thank you for your comments. We agree and will endeavour to do this.
40	SH	Department of Health	4	General	**Clinical need for guidelines: Use of the term *alcohol use disorder*** The material, produced by the National Collaborating Centre for Mental Health (NCCMH) for the stakeholder meeting on 7 January 2009, stated under the heading *"Clinical need for guidelines"* that an estimated 38% of men and 16% of women aged between 16 and 64 have an alcohol use disorder, and that 6% of men and 2% of women have alcohol dependence.	Thank you for your comment. To clarify: 38% of men and 16% of women aged 16 - 64 yrs have an alcohol use disorder. 23% of adults of any age in England drink above the threshold for hazardous/harmful drinking on the World Health Organisation's Alcohol Use Disorders Identification Test, indicating that they are at increased risk for alcohol related harm. 6% of men and 2% of women have alcohol dependence. To distinguish between those who exceed

					In our view, the percentages for the disorder of alcohol dependence are well known, but if the term “alcohol use disorder” and the associated percentages are to be used, then a clear definition for this term is necessary. The percentages given appear to indicate that NICE intends for this term to encompass everyone whose alcohol consumption exceeds the Government guidelines. We feel however that hazardous drinking is not technically a medical disorder, and that this grouping would run counter to the WHO lexicon of terms, which provides the following definition: *“Hazardous drinking is a pattern of alcohol consumption that increases the risk of harmful consequences for the user or others. Hazardous drinking patterns are of public health significance despite the absence of any current disorder in the individual user”.* Additionally for harmful drinkers, we believe that the relevant disorder would often be their actual diagnosed alcohol-related disorder (such as pancreatitis, cancer, liver disease, depression, high blood pressure etc), and not an alcohol use disorder such as abuse or dependence.	government guidelines and those who have an alcohol use disorder, ‘harmful alcohol use’ and ‘alcohol dependence’ are classified as Alcohol Use Disorders in the WHO International Classification of Diseases; Mental Disorders 10th Revision. A distinction will be made between opportunistic screening and brief intervention provided in primary care settings for hazardous/harmful drinkers (covered by the Public Health PDG) and the specialist interventions provided for harmful drinkers seeking help (within the scope of this group).
41	SH	Department of Health	5	General	In our opinion, if the intention is to group together all misusing drinkers under the single heading of *alcohol misuse* for the purposes of your guidelines, then this particular use would need to be made clear at the outset in order to avoid potential misunderstanding. We would anticipate that the prevention group, focusing on brief interventions for hazardous use, might see benefits in not characterising hazardous drinking as an alcohol use *disorder*. We recognise that a range of terminology is used	Thank you for your comment. This guideline will include definitions of alcohol dependence and harmful alcohol use as described in section 4.3.1a. With regards to interventions for hazardous use, as mentioned previously, opportunistic screening and brief intervention provided in primary care settings for hazardous/harmful drinkers will be covered by the Public Health PDG, and the specialist interventions provided for harmful drinkers seeking help is within the scope of this group.

					in various reports, but we would support careful consideration of terms at the outset.	
42	EX	Duncan Raistrick		General	The scope for this kind of review is fairy straightforward and seems to be well covered in the scoping document. My only comment would be that undue prominence seems to be given to pharmacotherapies whereas I would see psychosocial interventions as the mainstay of treatment to be supported by pharmacotherapies in particular circumstances.	Thank you for your comment. We are looking specifically at psychological and psychosocial treatments in section 4.3.1j, and these in combination with pharmacological treatments in section 4.3.1k.
43	SH	European Association for the Treatment of Addiction	3	3 c)	The statistics given within the scope indicate that 38% of men and 16% of women aged between 16 and 64 have an alcohol use disorder, and that 6% of men and 2% of women have alcohol dependence. In comparison, according to the National Drug Strategy published by the Home Office in February 2008, there are an estimated 332,000 problem drug users in England. In comparison, according to the National Drug Strategy published by the Home Office in February 2008, there are an estimated 332,000 problem drug users in England. However, our members commented that the needs of people with alcohol misuse problems are still not being addressed. Currently, there is an overwhelming focus on tackling drugs and ensuring access to treatment, and not enough on alcohol issues. Access and provision of alcohol treatment needs to be equal to drug treatment. Consequently, EATA welcomes the proposed guidelines for helping to re-address this issue but recommends that they should help to put alcohol treatment as high on the agenda as those for drug treatment.	Thank you for you comments, these have been noted.
44	SH	European Association for the Treatment of Addiction	4	4.2 a) and 4.2 (b)	EATA members in the voluntary and independent sector provide services to those with alcohol dependence problems across the complete spectrum of care, including rehabilitative	Thank you for this comment. A number of people have already commented on this and it is unfortunate that the wording creates the impression that the guideline comments

					treatment, social care and other support services. A large proportion of the alcohol treatment services provided nationwide is through these types of organisations, after having been commissioned by local Drug and Alcohol Action Teams to provide these services within the local community. Point 4.2 (b) highlights that this "*is an NHS guideline. However it will comment on the interface with other services – such as social services and the voluntary sector – where relevant."* EATA believes that to describe the document as an "NHS guideline" is an underestimation. The document could also be a useful point of reference for service providers outside the NHS. As a result the scope (and the guidelines) need more than just comments on the interface with other services because the role the voluntary and independent sector plays regarding the treatment of people with alcohol dependency problems is extremely important. We recommend that more emphasis is given to the important role that the voluntary and independent sector plays within the treatment of people with alcohol dependency problems. Those employed within these services will be looking to the guidelines to direct them in how they identify, assess, treat and manage clients who present to them with alcohol dependency problems. Ensuring the maximum integration of the voluntary and independent sector in these guidelines is essential for improving the standards and availability of alcohol dependency treatment.	solely on the interface between NHS and other service providers. However we are clear, given that considerable NHS funded services are provided with outside NHS direct providers, by non-statutory and independent sector organisations that we will need to consider directly the interventions provided within those services, as well as the structural organisation relationship to the wider community of alcohol service providers. We have amended the scope to clarify this.
45	SH	European Association for the Treatment of	5	4.2 b)	At the NICE Alcohol Dependence Guidelines Stakeholder Meeting on 7 January 2009, it was noted that NICE was keen to encourage more	Thank your for your comment. In our drafting we did not make clear that we were fully committed to a non-statutory involvement

		Addiction			voluntary and independent sector organisations to come forward with their comments and to join the Guideline Development Group, particularly those with experience of alcohol dependency treatment provision. There were concerns that there had not been enough representation from this sector. EATA agrees that it is important that the treatment and aftercare sector is given the fullest opportunity to highlight their key issues and concerns within the group, and bring their practical experiences and evidence to the guidelines. EATA recommends that real effort is made to encourage the involvement of the sector in the development of these guidelines and that their views are fully listened to and incorporated into the document. EATA is happy to facilitate this because we are uniquely placed within the voluntary and independent sector; we represent the majority of voluntary and independent service providers across the treatment sector.	within the guideline development group, as they are a significant provider of NHS funded alcohol services. We are pleased to tell you that we've appointed two members to the guideline group who are currently employed in the non-statutory sector in the provision of alcohol services.
48	SH	European Association for the Treatment of Addiction	1	General	EATA welcomes the opportunity to comment on the scope for the third of three pieces of NICE guidance addressing alcohol-use disorders: in particular, Dependence. The European Association for the Treatment of Addiction (UK) is the main representative body for the voluntary and independent drug and alcohol treatment and aftercare sector, working to ensure that people affected by substance dependencies get the treatment they need. The Association contributes to the debate on policy that relate to drug and alcohol treatment. In this role, we respond to consultations and reports from government departments and agencies and other bodies. In this official submission, EATA is representing both the views of our members and the organisation as a whole.	Thank you for your comments.

49	SH	European Association for the Treatment of Addiction	2	General	EATA particularly welcomes this focus on establishing guidelines for alcohol dependence. But as well as improving the quality of services available for those with alcohol dependency problems, there must be concerted efforts to increase the quantity of services. The overwhelming message that EATA has received from its members on the alcohol treatment system, particularly with regards to recent policy developments, is frustration that there still exists a huge gap between the demand for alcohol treatment and the actual provision of services. The alcohol treatment field needs more resources to help those who require support now and for whom early interventions or education is too late. The chronic shortfall in alcohol services has been reported by many EATA members over the years and recent policy developments do not seem to have addressed this poor situation.	Thank you for your comments.
55	SH	Faculty of Public Health	1	General	The Faculty of Public Health (FPH) is the leading professional body for public health specialists in the UK. It aims to promote and protect the health of the population, and improve health services by maintaining professional and educational standards, advocating on key public health issues, and providing practical information and guidance to public health professionals.	Thank you for your comments.
56	SH	Faculty of Public Health	2	General	FPH welcomes the development of guidance by NICE on this extremely important public health issue, estimated to result in over 26,000 deaths per year and to cost the NHS £1.7bn annually.	Thank you for your comments.
57	SH	Faculty of Public Health	8	General	It would be helpful if the guideline could make specific recommendations about skill levels and staff training requirements for each recommended intervention, in the context of the Drugs and Alcohol National Occupational Standards (DANOS), especially as staff from a wide variety of backgrounds are usually involved in care pathways.	Thank you for your comment. This has been covered by NTA Models of Care for Alcohol Misusers. The guidelines are concerned with a review of the evidence base, however we will be looking at therapist skill factors that may have a bearing on outcome where possible.
64	SH	Institute of Alcohol Studies	1	3 a) Clinical	We consider this paragraph to be somewhat confused regarding the criteria for alcohol	Thank you for your comment. There are differences between the criteria for alcohol

				need for the guideline	dependence. The two sets of diagnostic criteria (DSM-IV and ICD-10) are much more similar than this paragraph implies. Both sets of criteria are based upon the concept of the alcohol dependence syndrome and differences are relatively subtle and need to be understood in the light of Edwards, G. and Gross, M.M.(1976) 'Alcohol Dependence: provisional description of a clinical syndrome', BMJ 1, 1058-61. Further confusion arises due to the inclusion of the IDC-10 definition of harmful use, but without also including the parallel DSM category for alcohol abuse. As these guidelines appear to be mainly concerned with dependence, it is unclear how relevant the diagnostic criteria of harmful use are to this Guidance. However, if they are relevant, then the DSM category for alcohol abuse should also be mentioned.	dependence and harmful use/abuse between the two classification systems and are mentioned here to assist a wider audience. Members of the GDG are involved in the revision process of these systems; however, we will focus primarily on ICD-10 as the prevailing system in use in the NHS.
70	SH	Institute of Psychiatry	1	Box	There is considerable overlap between part 2 and part 3 it is important that this is addressed and the information provided is consistent across the guidance	Thank you, we are aware of this and are in close collaboration with the other groups to ensure consistency is upheld and overlap does not occur.
71	SH	Lundbeck	7	3 a)	As highlighted at the scope consultation meeting, ICD11 and DSMV are in development. If these alter the definitions of drug dependence, this may impact on the scope and content of the guidelines. Please clarify how this will be addressed.	Thank you for your comment. The classification systems currently in place are ICD 10 and DSM4. Members of the GDG are involved in the revision process of these systems, but at present the criteria for ICD11 and DSM 5 have not been agreed. Therefore, we will have to work with the prevailing definitions
72	SH	Lundbeck	3	4.3.1 c) (d)	Tools for assessment of treatment response as well as tools for diagnosis and assessment of severity should be included. We recommend inclusion of the Timeline Follow-Back measurement tool. [L. C. Sobell et al (2003). Assessing drinking outcome in alcohol treatment efficacy studies: selecting a yardstick of success. *Alcoholism: Clinical and Experimental Research,*	Thank you for your comment. TLFB is a research tool. Its utility as a clinical tool will be examined as part of the guideline development process.

					27(10), 1661-1666.].	
73	SH	Lundbeck	4	4.3.1 e)	Care pathways should include the goal of 'reduction in alcohol consumption' as a specified outcome. For example, a goal based on WHO-definitions of drinking levels would be a measurable downward shift from the more harmful to the less harmful or 'safe' drinking.	Thank you for your comment, however goals and outcomes are not synonymous. We will examine appropriate goals for people seeking help for alcohol use disorders; evaluation of treatment outcome studies will examine reductions in drinking as well as abstinence as outcomes.
74	SH	Lundbeck	8	4.3.1 f)	Please clarify 'the range of care routinely made available by the NHS' in terms of the definition of 'routinely'.	Thank you for this comment. We agree that the phrasing as currently worded is rather uninformative, however this will be clarified within the clinical questions when developed.
75	SH	Lundbeck	5	4.3.1 g)	In conjunction with care pathways, pharmacological interventions should be well-defined, with clear treatment goals (for example, based on WHO-definitions of drinking levels, a measurable downward shift from the more harmful to the less harmful or 'safe' drinking). These clear treatment goals should include 'reduction in alcohol consumption'. This applies to *hazardous* and *harmful* levels of drinking, and is relevant to this guideline.	Thank you for your comment. As mentioned previously, we will examine appropriate goals for people seeking help for alcohol use disorders; evaluation of treatment outcome studies will examine reductions in drinking as well as abstinence as outcomes.
76	SH	Lundbeck	6	4.3.1 h)	We would like to highlight that the clinical trial programme for nalmefene will continue throughout the timeline for development of this guideline. Nalmefene is not likely to be fully licensed when the guideline is published in 2010. Lundbeck are more than happy to provide further information on the clinical trial programme and clinical indication to inform the GDG.	Thank you for your comment, this would be helpful.
77	SH	Lundbeck	1	general	We note that the Short Title is Alcohol Dependence and Harmful Alcohol Use. As acknowledged at the scope consultation meeting by the panel representatives from the Guideline Development Group (GDG), there is a wider spectrum of levels of alcohol misuse. If the guideline's aim is to reduce the harmful consequences of alcohol misuse, then it is relevant to include *hazardous* in the scope, as well as *harmful* and *dependent* drinking to avoid a potential gap in the care pathway. This point	Thank you for your comments. We are interested in harmful alcohol use as well as dependence since 30% of people currently seeking help in community based alcohol agencies are harmful drinkers not meeting the criteria for alcohol dependence (ANARP, 2005). A distinction will be made between opportunistic screening and brief intervention provided in primary care settings for hazardous/harmful drinkers (covered by the Public Health PDG) and the specialist

					was raised at the scope consultation meeting as a question on potential overlaps and gaps between the 3 guidelines and specifically where people with *hazardous* alcohol use would be included. The panel commented that the Public Health GDG would need to consider this *hazardous* population in terms of the full breadth of interventions available as well as being considered by the Alcohol Dependence and Harmful Alcohol Use GDG.	interventions provided for harmful drinkers seeking help (within the scope of this group). It will also be important for the various development groups overall to have clear integrated care pathways for different drinkers (e.g. harmful drinkers not responding to brief intervention).
78	SH	Lundbeck	2	general	The scope should explicitly include 'reduction in alcohol consumption' (in addition to 'abstinence') as a goal of treatment and a measurement of outcome. Although abstinence might be seen as an 'ideal' outcome, this may be unattainable, and indeed unrealistic in the majority of cases, especially where patient choice/clinical circumstances might dictate, and where 'reduction in consumption' itself can be linked to measurable gain in public health. [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. As mentioned already, goals and outcomes are not synonymous. We will examine appropriate goals for people seeking help for alcohol use disorders; evaluation of treatment outcome studies will examine reductions in drinking as well as abstinence as outcomes.
79	SH	Lundbeck	9	general	For information there are some typos in the scope document.	Thank you for your comment, these will be rectified.
80	SH	NHS Direct	1	General	NHS Direct welcomes the guideline and after consultation makes no comments on the draft scope.	Thank you for your comment.
110	SH	Northumbria University	2	4.3.1 i)	12-step programmes are not "employed" in the NHS but are often used by NHS professionals as a form of aftercare.	Thank your for your comments. 12 step programmes are often provided by the non-statutory sector but funded by NHS or local authorities, often in residential settings. This will therefore fall within the scope of the guidelines. There are also some examples of 12 step facilitation programmes within the

						NHS helping people to access 12 step services and mutual aid organisations. This section has now been amended.
111	SH	Northumbria University	3	4.3.1 j)	Referral to Alcoholics Anonymous is rightly mentioned here but it should be clearly recognised in the Scope that many individuals do not find AA appealing or try it but do not benefit from it. Other, non-12-step forms of mutual aid should be mentioned in the Scope and in the eventual guidance. In particular, attempts are currently underway to promote SMART Recovery in the UK and it is likely that this will prove popular and useful as a form of aftercare and as an alternative to formal treatment for many people with alcohol dependence.	Thank you for your comment. Alcoholics Anonymous and the 12-step programmes are examples used in the scope, though the guideline will also consider other forms of mutual aid during development.
112	SH	Northumbria University	1	General	It will be essential for the Scope and guidance to recognise that, among people who have successfully recovered from alcohol dependence, the great majority have done so without professional help. In view of this high rate of natural recovery, it is important to try to assist the process of natural recovery by making easily and widely available forms of individual self-help in various media (in printed form, by DVD etc. and, increasingly, via the Internet) and also by encouraging mutual aid groups in the alcohol field. This kind of activity is mentioned in the Scope but should be given more prominence.	Thank you for your comments. These issues will be dealt with by the Public Health development group, and also where appropriate in this guideline, such as the guided self-help and mutual aid groups (section 4.3.1j).
116	SH	PharMAG (Pharmacy misuse advisory group)	1	general	We strongly recommend that a pharmacist is included on the guidelines group.	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 146.
117	SH	PharMAG (Pharmacy misuse advisory group)	2	General	PharMAG welcomes these guidelines	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 147.
118	SH	PharMAG (Pharmacy misuse advisory group)	3	General	Community pharmacists are actively involved in providing public health information and as the health professional on the high street are in a valuable position to be able to identify people who have an alcohol problem and refer them on.	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 148.

					In addition community pharmacists often know the whole family and with that have potential access to information about hidden alcohol problems in the family.	
119	SH	PharMAG (Pharmacy misuse advisory group)	4	General	Pharmacists in the drug misuse field have shown themselves to be a valuable resource for example providing supervised consumption – without whom the current drug policy could not have demonstrated such success. The Audit commission highlighted that pharmacists were an under utilised resource. Pharmacists can provide alcohol patients eg undergoing detox or relapse prevention work, with similar levels of care, shared care and multidisciplinary working across the primary and secondary care sector as they so successfully do with patients on opiate substitute treatment.	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 149.
120	SH	PharMAG (Pharmacy misuse advisory group)	5	General	Pharmacists can have a direct role to play in monitoring detox eg by dispensing daily doses of chlordiazepoxide, (working in shared care with primary or secondary care prescribers and key workers in the same way as currently occurs with methadone or buprenorphine). Pharmacist can monitor withdrawal symptoms and blood pressure for example, on a daily basis.	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 150.
121	SH	PharMAG (Pharmacy misuse advisory group)	6	General	Pharmacists can have a direct role to play in relapse prevention eg dispensing disulfiram or naltrexone in daily instalments or even supervising consumption and supporting patients through the difficult initial phases	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 151.
122	SH	PharMAG (Pharmacy misuse advisory group)	7	General	Service users should be specifically asked about the role of pharmacists. Those service users who have had direct or indirect (eg through a partner) experience of supervised consumption of daily doses of methadone or buprenorphine have indicated to members of PharMAG that they believe that daily supervised doses of eg chlordiazepoxide or disulfiram where the patient attends a community pharmacy each day, would be preferable in some instances rather than attending a clinic or GP practice.	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 152.

123	SH	PharMAG (Pharmacy misuse advisory group)	8	General	Pharmacists working in secondary care specialist services, prisons and primary care provide a valuable role in writing Patient group directions for the administration of medicines such as chlordiazepoxide, it is important that a pharmacist is included on the NICE guidelines group.	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 153.
124	SH	PharMAG (Pharmacy misuse advisory group)	9	General	Pharmacists working in specialist drug and alcohol services have an important role to play for example, there are many pharmacist prescribers working in this field – and prescribing alcohol detox and relapse prevention regimens would be a logical extension of the role of prescribing methadone and buprenorphine.	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 154.
125	SH	PharMAG (Pharmacy misuse advisory group)	10	General	Pharmacists contribute to the necessary governance processes to ensure accuracy and compliance with clinical guidelines and ensure, for example that drug names are spelt correctly to ensure that errors do not occur in prescribing	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 155.
126	SH	PharMAG (Pharmacy misuse advisory group)	11	General	There is no reference to the importance of high dose vitamin B and C or oral vitamin B. It will be interesting to see if NICE can provide definitive evidence for the selection criteria for patients for prophylactic IV or IM administration of Vitamin B and C, it would seem rational to include all patients undergoing detoxification. In many emergency departments and acute admission units Vitamin B and C are routinely administered. There is also some confusion about doses and the kinetic limitations of oral thiamine absorption and it would be helpful if NICE could produce simple guidance as to what would be the most sensible oral vitamin B treatment regimen.	This comment appears to be a near duplicate of that made by the RPSGB. Please see response to comment number 156.
127	SH	Royal College of Nursing	1	General	With a membership of over 400,000 registered nurses, midwives, health visitors, nursing students, health care assistants and nurse cadets, the Royal College of Nursing (RCN) is the voice of nursing across the UK and the largest professional union of nursing staff in the world. RCN members work in a variety of hospital and community settings in the NHS and	Thank you for your comment.

					the independent sector. The RCN promotes patient and nursing interests on a wide range of issues by working closely with the Government, the UK parliaments and other national and European political institutions, trade unions, professional bodies and voluntary organisations. The RCN welcomes this consultation document. The draft scope is comprehensive and there are no additional comments to make on this document.	
130	SH	Royal College of Paediatrics and Child Health	6	4.2 a)	The input provided by community paediatricians and school nurses should not be overlooked.	Thank you for this comment. In response to this and comments from others we are seeking to appoint a specialist advisor from the paediatric community.
131	SH	Royal College of Paediatrics and Child Health	7	4.2.b)	Youth Offending Teams may have a health professional attached to the team and are likely to have experience of young people with harmful alcohol use of dependence	Thank you, your comments have been noted.
134	SH	Royal College of Paediatrics and Child Health	8	4.3.1 l)	The College believes that it is essential that specific attention is paid to the most appropriate setting for managing both acute and planned withdrawal from alcohol for young people. In my experience, it has been very difficult to arrange admission to a paediatric ward for detoxification, particularly for young people aged 16 -17, but also for those younger than this.	Thank you for raising this important point, this will be discussed and considered in the guideline development process.
135	SH	Royal College of Paediatrics and Child Health	1	General	A large and common clinical group presenting to paediatricians includes all those young people (10 to 18 years) who come into hospital suffering from the effects of alcohol ingestion. Nearly all are seen in Accident and Emergency. Some are admitted to the paediatric ward, and usually respond well to supportive care, which may include intravenous rehydration. An unknown proportion may have significant social or psychological problems. Only in a minority of services are these young people seen by a mental health professional as a routine. The College is unsure whether any of this would	Thank you for this comment. We agree that there are important differences between younger and older populations who present in services, and this will be considered in the course of guideline development. You will be pleased to know we have representation of A&E services on the GDG.

					qualify them for a diagnosis of “Harmful Alcohol Use”, or whether there is always enough information to make this diagnosis. The College would like an assurance that this important group will be included in the scope of the guideline.	
136	SH	Royal College of Paediatrics and Child Health	9	General	Having attended the Stakeholder meeting on 7th January, the College was very disappointed to learn that pregnant women are excluded from this guideline. The College strongly believes that NICE should specifically address the issues of the management of alcohol-dependent pregnant drinkers.	Thank you for your comment. Pregnant women are excluded from the scope of the guideline ensuring consistency across the other guidance addressing alcohol use disorders. The scope has been amended accordingly. The maternity care of women with alcohol problems is being addressed in the NICE ‘Pregnant women with complex social factors which is currently in development’. This is a potentially large and specialised area for address that will need specific expertise and GDG membership. In light of this we propose that you feed this suggestion to the NICE topic selection panel as worthy for consideration for a future guideline
137	SH	Royal College of Paediatrics and Child Health	10	General	The College is extremely concerned that the people being recruited to the GDG do not include a paediatrician, even though the guideline addresses alcohol dependence and harmful drinking in adults and young people over the age of 10 years. Young people in this age group can present to paediatric services as well as CAMHS.	Thank you for this comment. A number of people have drawn this to our attention and as a result we are seeking to appoint a specialist advisor from the paediatric community to the guideline development group.
138	SH	Royal College of Physicians	1	4.2b)	“Other services”, especially the voluntary sector currently provide much of the care for patients with alcohol related problems. The guidelines should not merely comment on the interface with other services but should actively recommend and encourage their use and indicate how patients (“clients, service users”, whatever is the preferred term) can access them with ease. The guidelines should also emphasise the needs and the rights of patients to switch easily between the NHS and other services as they see fit. It is important that “other services” are	Thank you for you comment, we agree that non-statutory involvement within the guideline development group is important given that considerable NHS funded services are provided with outside NHS direct providers, by non-statutory and independent sector organisations, as well as the structural organisation relationship to the wider community of alcohol service providers. Section 4.2b has been amended to clarify this. We are also pleased to say that we now have two members from this sector on the

					adequately represented on the GDG.	GDG.
141	SH	Royal College of Physicians	3	4.3.1 e)	The areas that will be covered by the guideline are necessarily many and varied and they appear in what appears to be random order. All these areas cannot have and should not have the same degree of emphasis. It seems sensible to have a stated aim for the guideline and developing appropriate (and seamless) pathways of care should be the core objective of the guideline. All the areas to be covered can be fitted into this core objective with greater or lesser importance based on evidence for efficacy.	Thank you for your comment. We agree that there needs to be appropriate and seamless pathways of care. Whether this should be the core objective of the guideline we are less certain. As you will be aware there are a number of other pieces of guidelines are currently in development from NICE (clinical management of acute withdrawal and public health guidance for prevention). We see our role in developing the pathways to ensure that there is a clear link between all three guidelines, but of course those other groups will themselves have views on the pathways and for this to be the core objective of our guideline does not seem appropriate.
142	SH	Royal College of Physicians	4	4.3.1 f)	The range of care routinely made available by the NHS is almost invariably inadequate (see section 4.2b). The guideline should state in clear and precise terms what constitutes an adequate range of care against which commissioners and providers can be benchmarked. This is also essential when it comes to addressing the current under- funding of services and may provide some incentive to identifying monies specifically for the management of alcohol as opposed to funding for alcohol **and** drug services.	Thank you for the comment. We have set out what we think is reasonable to cover within the time and resources available within the scope. As you will be aware the primary function of a clinical guideline is to make recommendations and to set standards for clinical practice. It will be for others, perhaps through the publication of NICE commissioning guidance, to more directly address the issues of commissioners and providers of services. The matter of funding again is clearly outside the remit of the guideline.
143	SH	Royal College of Physicians	5	4.3.1 m)	Mental health problems are almost the norm in patients with significant alcohol related problems. It matters not whether these mental health problems cause, result from or are merely associated with alcohol misuse and the caveat “if this differs from the management of common mental health problems alone” is both an unhelpful and impossible distinction to make	Thank you for your comments. This scope is not intended to replace other existing NICE guidance on e.g. management of depression, which is common in this population. However, the intention is to examine how management of e.g. depression would differ in people with alcohol dependence compared to those who are not alcohol dependent, for which there is an evidence base that will be reviewed. The same will apply to other co-morbid common mental disorders and drug misuse. Severe mental disorders comorbid with alcohol will

						be dealt with by the NCC-MH in an upcoming guideline on dual diagnosis.
144	SH	Royal College of Physicians	6	4.3.1 q) and 4.3.2 a)	These two points seem to contradict one another assuming the terms “alternative” and “complementary” are being used in the usual colloquial sense.	Thank you for your comment, we agree this is unclear so this sentence has been amended.
146	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	1	general	We strongly recommend that a pharmacist is included on the guidelines group.	Thank you for your comment. We have appointed a psychopharmacologist to the guideline development group who has expertise in this field.
147		Royal Pharmaceutical Society of Great Britain (RPSGB)	2	General	RPSGB welcomes these guidelines	Thank you for your comment.
148	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	3	General	Community pharmacists are actively involved in providing public health information and as the health professional on the high street are in a valuable position to be able to identify people who have an alcohol problem and refer them on. In addition community pharmacists often know the whole family and with that have potential access to information about hidden alcohol problems in the family. Research has shown that community pharmacists are in a good position to provide brief interventions for alcohol misuse – see http://www.rpsgb.org/pdfs/commpharmalcmisuseservices.pdf	Thank you for your comment, this has been noted.
149	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	4	General	Pharmacists in the drug misuse field have shown themselves to be a valuable resource for example providing supervised consumption – without whom the current drug policy could not have demonstrated such success. The Audit commission highlighted that pharmacists were an under utilised resource. Pharmacists can provide alcohol patients e.g. undergoing detox or relapse prevention work, with similar levels of care, shared care and multidisciplinary working across the primary and secondary care sector as they so successfully do with patients on opiate substitute	Thank you for your comment, this has been noted.

					treatment.	
150	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	5	General	Pharmacists can have a direct role to play in monitoring detox e.g. by dispensing daily doses of chlordiazepoxide, (working in shared care with primary or secondary care prescribers and key workers in the same way as currently occurs with methadone or buprenorphine). Pharmacist can monitor withdrawal symptoms and blood pressure for example, on a daily basis.	Thank you for your comment, this has been noted.
151	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	6	General	Pharmacists can have a direct role to play in relapse prevention e.g. dispensing disulfiram or naltrexone in daily instalments or even supervising consumption and supporting patients through the difficult initial phases	Thank you for your comment, this has been noted.
152	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	7	General	Service users should be specifically asked about the role of pharmacists. Those service users who have had direct or indirect (e.g. through a partner) experience of supervised consumption of daily doses of methadone or buprenorphine have indicated that they believe that daily supervised doses of e.g. chlordiazepoxide or disulfiram where the patient attends a community pharmacy each day, would be preferable in some instances rather than attending a clinic or GP practice.	Thank you for your comment, this has been noted.
153	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	8	General	Pharmacists working in secondary care specialist services, prisons and primary care provide a valuable role in writing Patient group directions for the administration of medicines such as chlordiazepoxide, it is important that a pharmacist is included on the NICE guidelines group.	Thank you for your comment, this has been noted.
154	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	9	General	Pharmacists working in specialist drug and alcohol services have an important role to play for example, there are many pharmacist prescribers working in this field – and prescribing alcohol detox and relapse prevention regimens would be a logical extension of the role of prescribing methadone and buprenorphine.	Thank you for your comment, this has been noted.
155	SH	Royal Pharmaceutical	10	General	Pharmacists contribute to the necessary governance processes to ensure accuracy and	Thank you for your comment, this has been noted.

		Society of Great Britain (RPSGB)			compliance with clinical guidelines and ensure, for example that drug names are spelt correctly to ensure that errors do not occur in prescribing	
156	SH	Royal Pharmaceutical Society of Great Britain (RPSGB)	11	General	There is no reference to the importance of high dose vitamin B and C or oral vitamin B. It will be interesting to see if NICE can provide definitive evidence for the selection criteria for patients for prophylactic IV or IM administration of Vitamin B and C, it would seem rational to include all patients undergoing detoxification. In many emergency departments and acute admission units Vitamin B and C are routinely administered. There is also some confusion about doses and the kinetic limitations of oral thiamine absorption and it would be helpful if NICE could produce simple guidance as to what would be the most sensible oral vitamin B treatment regimen.	Thank you for your comment. We agree that this is a relevant issue which will need to be drawn to the attention of our GDG and the GDG of Clinical Management.
161	SH	Sheffield PCT	1	General	No reference to aftercare	Thank you, this has now been inserted into section 4.3.1e.
162	SH	Sheffield PCT	2	General	Why has the age 10 years and over been chosen?	Thank you for this comment, as you may be aware there are two other pieces of NICE guidance on the management of acute alcohol withdrawal and public health guidance for alcohol in development. Both of these guidelines had already established a 10+ age range for their guidance. In light of this we also chose the same age range in order to facilitate integration of the various pieces of guidance.
163	SH	Tees Esk & Wear Valleys NHS Foundation Trust	2	3 a)	DSMIV and ICD10 are much more similar than the text recognises. Both sets of criteria are based upon the concept of the alcohol dependence syndrome - and differences (which could be commented on in some detail) are relatively subtle and need to be understood in the light of Edwards & Gross's BMJ paper (? 1978). The section is further confused because of mentioning IDC10's harmful use - but not the parallel DSM category (alcohol abuse). As these guidelines are on dependence - not harmful	This comment appears to be a near duplicate of that made by the Institute of Alcohol Studies.

					use/abuse - I don't see why either of these categories need to be mentioned here. However, elsewhere the guidelines appear to include harmful use, so they should include abuse (notwithstanding reservations about the actual terminology).	
169	SH	UKPHA Alcohol & Violence Special Interest Group	1	General	The UKPHA Alcohol & Violence Special Interest Group are pleased that the scoping covers the interface with social services and the third sector (4.2.b) and approaches such as the 12 step plan and Alcoholics Anonymous (4.3.1.j) and at a range of setting for care (4.2.a).	Thank you for your comment; we agree that looking at care and treatment in a range of settings is important.
170	SH	UKPHA Alcohol & Violence Special Interest Group	2	General	It would be very valuable for the scoping document to at least acknowledge secondary harm such as violence to others if only to say it is not within the scope of the guideline. 3a may be a further opportunity to add something after 'the ICD -10 defines harmful use' as a pattern of drinking that causes damage to the physical and mental health' e.g. of the individual. This guideline is not directly concerned with damage to others arising from some of the behavioural aspects of dependence. The issue of violence and other secondary harm could also be recognised at 4.3.1p (areas for inclusion) which covers involvement and support for the family and carers.	Thank you for your comment. We agree secondary harm is an important issue, however the remit of this scope does not include the specific care of dependants. As you mention we will be considering family therapy (section 4.3.1p) in relation to support needed by family and carers which is linked to this issue.
157	SH	Sheffield PCT	3	2 c	Consideration should be given to when “preferences” of patients are not compatible with clinical need.	Thank you for your comment. We will draw this to the attention of the GDG, as this is a central concern for NICE.
4	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	3	3 c	The guidelines cover adults of parenting age, which has implications for the risks on the children who live with parents who misuse alcohol, Some of the most vulnerable children covered by Think Family will be living with parents who misuse alcohol - see Reaching Out: Think Family (www.cabinet-office.gov.uk which gives figures of 1.3 million children who live with	Thank you for your comment. We agree secondary harm is an important issue, however the remit of this scope does not include the specific care of dependants. We will be considering family therapy (section 4.3.1p) in relation to support needed by family and carers which is linked to this issue.

					parents who misuse alcohol. It is estimated that 6.2% of adults in the UK have grown up in a family in which one or both parents drank excessively (Alcohol Concern, 2008, Alcohol and the family)	
14	SH	Berkshire Healthcare NHS Foundation Trust	4	3 c	They say “men and women” from 16 years and upwards, 16 and 17 year olds are within the remit of child and adolescent mental health services, though are not seen as needing paediatric services. There is a dichotomy of thinking in children’s services, though this is probably beyond the scope of NICE.	Thank you for noticing this. This has now been amended to read ‘males and females.
58	SH	Institute of Alcohol Studies	2	3 (b) Clinical need for the guidelin e	In terms of clinical and cost effectiveness, we think that consideration should here be given to the impact of co-morbidity on treatment compliance, risk of relapse and increased frequency of treatment episodes including hospital admissions.	Thank you for this comment. We do intend to take into account of a large number of contextual factors including those that you describe when evaluating our evidence, in order to determine clinical and cost effectiveness of the various interventions we review. Management of co-morbid problems is covered in section 4.3.1m.
67	SH	Institute of Psychiatry	2	3 a	Mention is made of harmful use (ICD10) but not alcohol abuse (DSM)	Thank you for your comment. There are differences between the criteria for alcohol dependence and harmful use/abuse between the two classification systems and are mentioned here to assist a wider audience. To distinguish between those who exceed government guidelines and those who have an alcohol use disorder, ‘harmful alcohol use’ and ‘alcohol dependence’ are classified as Alcohol Use Disorders in the WHO International Classification of Diseases; Mental Disorders 10th Revision. We will focus primarily on ICD-10 as the prevailing system in use in the NHS.
14 5	SH	Royal Cornwall Hospitals Trust	1	3 b	Self-harm and suicide attempts are common problems in service users with alcohol dependence or harmful alcohol use. Service users with these problems are seen by acute hospital, minor injury and mental health services.	Thank you for your comment. We agree these are very important issues, and have now added suicide and self-harm to section 3b.

					Suicide is also a major cause of mortality in service users with alcohol dependence / harmful use. May I suggest specific mention is made of this in the description of clinical problems associated with alcohol dependence / harmful use. I believe this would assist the guideline group to address the care of services users who are at risk of self-harm / suicide and perhaps to link this guidance with the NICE guidelines for the primary and secondary care of self-harm	
2	SH	Age Concern England	1	4.2 a	We suggest adding 'transition from services for adults of working age to older people's services' to the list of healthcare settings as some mental health services are still divided in this way.	Thank you for this comment, we have amended the bullet point to read as follows: 'Transition through the range of health care services from childhood to older adults.'
34	EX	Christine Godfrey		4.2 a and b	Care in the voluntary and private sector is frequently commissioned by the NHS/DATs. The unusual commissioning process for alcohol services and the potential problems in applying the same evidence standards should be noted in the guidance and the simple division between a and b does not reflect current practice see evidence from the ANARP study	Thank you for this comment. We are clear that for this guideline we need to be concerned with the provision of services, which may be funded by the NHS, but which are provided by other agencies. We agree that in this context of the draft scope, in particular 4.2b, it is potentially misleading. This is a simple translation from standard NICE templates and should have been spotted earlier. Thank you for noticing this, it has now been amended.
50	SH	Faculty of Public Health	3	4.1.1	We assume that the population of all those aged 10 and above will include pregnant women, who have unfortunately been excluded from the scope of the clinical management guideline.	Thank you for your comment. Pregnant women are excluded from the scope of the guideline ensuring consistency across the other guidance addressing alcohol use disorders. The scope has been amended accordingly. The maternity care of women with alcohol problems is being addressed in the NICE 'Pregnant women with complex social factors which is currently in development'. This is a potentially large and specialised area for address that will need specific expertise and GDG membership. In light of this we propose that you feed this suggestion to the NICE topic selection panel as worthy for consideration for a future guideline

51	SH	Faculty of Public Health	4	4.2	In view of the high prevalence of harmful and dependent alcohol use among those in the criminal justice system, it would be helpful if this setting could be specifically included, especially services in prisons.	Thank you for your comment. We have now amended this section to specifically include the Criminal Justice System.
59	SH	Institute of Alcohol Studies	3	4.2.(b) Healthc are setting	In terms of increasing detection of harmful drinking and dependence, we think the document should here include reference to the role of nursing and medical staff employed as occupational nurses and doctors and those working in the context of police custody and prisons. Identifying harmful drinking in the employment and criminal justice settings could enhance effectiveness.	Thank you for your comment. Early identification for non-treatment seeking individuals will be addressed by the Public Health group, whereas this guideline will address early identification in treatment seeking individuals. Section 4.3.1b has been amended to clarify this. Reference to staff roles you mention will be covered within the healthcare settings we have listed. We have also specifically added the Criminal Justice System in section 4.2b.
128	SH	Royal College of Paediatrics and Child Health	4	4.1.1	The College is pleased to see that this Scope does not exclude pregnant women, in contrast to the Clinical Management Scope, where pregnant women were specifically excluded	Thank you for your comment. Pregnant women are now excluded from the scope of the guideline ensuring consistency across the other guidance addressing alcohol use disorders. The scope has been amended accordingly. The maternity care of women with alcohol problems is being addressed in the NICE 'Pregnant women with complex social factors which is currently in development'. This is a potentially large and specialised area for address that will need specific expertise and GDG membership. In light of this we propose that you feed this suggestion to the NICE topic selection panel as worthy for consideration for a future guideline
158	SH	Sheffield PCT	5	4.2 b	What is the status of this guideline for those services that are not solely commissioned by the NHS – e.g. joint commissioned by NHS and another organisation?	Thank you for your comment. A number of individuals have raised questions about the recommendations concerning independent, non-statutory services commissioned by the NHS. We are clear that the recommendations that we are making should apply to those services commissioned by the NHS but not necessarily provided by them.

						In order to facilitate this we have appointed two guideline development group members who come from non NHS services but nevertheless are commissioned to provide services by the NHS. Section 4.2b has been amended.
164	SH	Tees Esk & Wear Valleys NHS Foundation Trust	1	4.1.1	Include explicitly over 65s and alcohol related organic brain disorder	Thank you for your comment; it is our intention to cover over 65s as well as organic brain disorder.
46	SH	European Association for the Treatment of Addiction	6	4.3	EATA is disappointed that this section on the scope for clinical management which outlines areas that will be covered by the guidelines appears to omit or give less importance to people with dual diagnosis issues. It is important to recognise that many people with alcohol problems also present with multiple needs such as mental health and/ or other drug problems. The document should include guidelines on this area or at least make reference to other guidelines that exist and recommend their use in tandem to ensure that all needs are being responded to Should it include guidelines or should it make reference to other guidelines that exist and should be used in tandem of these guidelines to ensure responding to all needs.	Thank you for your comment. In the interest of coherence we need to set boundaries around the scope, which means we cannot look at the many complexities of co-morbid conditions. However, we are looking at the management of common mental health problems in section 4.3.1 m. It is beyond our scope to address severe mental illness with alcohol dependency; however the NCC-MH is currently starting up a new guideline on dual diagnosis which will be referred to.
129	SH	Royal College of Paediatrics and Child Health	5	4.1.2	Although the majority of young people who experience harmful use or alcohol dependence are over the age of 10 years, many clinicians have occasionally seen a child younger than this who has become intoxicated, perhaps as a “one off” episode, who nevertheless has experienced actual physical harm as a result.	Thank you for your comment. This issue of one off drinking probably relates more to the early identification/prevention of non-treatment seeking individuals covered by the Public Health PDG guideline.
3	SH	Age Concern England	2	4.3.1 m	We suggest that both depression in later life and dementia are considered in this context as both are known co-morbidities with alcohol problems	Thank you for this comment. We would consider that reference to common mental health problems would cover depression in later life. The issue concerning dementia is somewhat more complex. We will be covering the neuropsychological consequences of alcohol abuse, and this will include alcohol induced dementia. We feel it would be better

						to deal with issues concerning dementia within this context rather than have a separate reference to it.
5	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	4	4.3.1 b & 5	There is an emphasis on working with parents of children in vulnerable families in the public health NICE guidelines (PH7, PH6, PH4) quoted in section 5 whereas the Clinical guidelines (CG62), omit reference to the need to address relationship difficulties, especially the impact of alcohol problems in parents on their children See Reaching out:Think Family (www.cabinet-office.gov.uk) for their definitions of 'at risk' families who have several vulnerabilities. See Learning lessons, taking action: Ofsted's evaluations of serious case reviews 1 April 2007 to 31March 2008. – for comments about the need to assess risks in parents who misuse drugs and alcohol.	Thank you for your comments. CG62 doesn't specifically address relationship difficulties in this context, however it is relevant here as it considers the minimisation of risk of exposure to alcohol.
6	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	5	4.3.1 i	It is important to include family and systemic psychotherapy (family therapy), given that the starting age for this guideline is 10 years, and there will be adults living with partners and children. Examples of family therapy services in alcohol and substance misuse services in the NHS include: **Meanwhile Family Therapy Service** in Brent is a pioneering service that was set up following research into the use of family therapy with substance misuse. The service covers an age range of alcohol misusers between 16 and 70 years. http://www.cnwl.nhs.uk/Substance_Brent_Family_Therapy_Service.htm SL&M Addictions Division/Southwark **(Blackfriars Road CDAT,** **151, Blackfriars Road, London SE1 8EL)** **provides systemic family therapy to parents**	Thank you for your comment. We agree and will review the evidence for effectiveness of family therapies in management of both adults and children.

					who misuse alcohol, whether or not Social care is involved, to adolescents with their parents/ family, and to couples where one or both partners misuse alcohol. **Time4Change** is a family Intervention project in Plymouth for those who have lost their tenancy or where there are antisocial behaviour problems, associated with drugs or alcohol, which includes family therapy to support the relationships affected by alcohol. **The Kent and Medway Alcohol Service Couple and Family Therapy Team**, winners of the Mental Health Including Dual Diagnosis/CCBT Ltd Award at the 2008 Nursing in Practice Awards. The Family Therapy Team's clinical "mission" is to engage with and assist complex as well as challenging couples and families with enduring alcohol-related problems.	
7	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	6	4.3.1 p	'Carers' need to be defined as partners, parents, or children, as these differences have implications for resources which offer conjoint marital therapy and family therapy, and interventions that link the different professionals and agencies involved. A strong feature of systemic family therapy is its flexibility, involving couples or across generations, people of different ages and support and treatment networks, as well as working in collaboration with other services.	Thank you for your comment. The term 'carers' here applies to all people who have regular close contact with the person, including advocates, friends or family members, although some family members may choose not to be carers. This will be specified to certain interventions where needed in the full guideline. In light of this, section 4.3.1p has been slightly amended.
15	SH	Berkshire Healthcare NHS Foundation Trust	5	4.3.1	If a child has an alcohol problem/usage then usually the parents also have a problem with alcohol and there is a need for a whole family approach to alcohol as opposed to just support for carers.	Thank you for your comment. This is covered in section 4.3.1p, which addresses the support of family and carers provide for the person with an alcohol problem, but also the supported need for the family and carers themselves.

52	SH	Faculty of Public Health	5	4.3.1 m	It would be helpful if this also included illegal drug misuse, as there are considerable risks, including accidental overdose and death, for dependent and harmful alcohol users who may also be intermittent 'casual' users of illicit drugs. All staff working with harmful and dependent alcohol users need to be aware of these risks and how to provide appropriate harm reduction messages.	Thank you for your comment. Section 4.3.1m has now been amended to specifically include co-morbid drug misuse.
53	SH	Faculty of Public Health	6	4.3.1 q	The recommendation to include the principal complementary and alternative interventions is particularly welcome.	Thank you for your comment.
60	SH	Institute of Alcohol Studies	4	4.3.1(d) & (e)	Explicit reference should here be made of the need to implement a stepped care approach including aspects relating to assessment of complex problems by multi-disciplinary teams and integrated care pathways to provide the patient with a range of interventions, including those provided outside the NHS.	Thank you for your comment. This will be addressed during development when looking at care pathways. It will also be important for the various groups overall to have clear integrated care pathways for different drinkers (e.g. harmful drinkers not responding to brief intervention).
61	SH	Institute of Alcohol Studies	5	4.3.1(i) Areas that will be covered by the guideline	We are not aware that 12 step programmes are provided directly by the NHS.	Thank you for your comment. 12 step programmes are often provided by the non-statutory sector but funded by NHS or local authorities, often in residential settings. This will therefore fall within the scope of the guidelines. There are also some examples of 12 step facilitation programmes within the NHS helping people to access 12 step services and mutual aid organisations.
62	SH	Institute of Alcohol Studies	6	4.3.1(j) Areas that will be covered by the guideline	We think that this paragraph requires some clarification. 12 step programmes have been mentioned in the previous paragraph and we think it is necessary to clarify whether the distinction is between a 12 step programme per se and merely referral to one, or between a medically based in-patient/out-patient programme and attendance at self-help meetings? Perhaps an alternative description to 'low intensity psychological intervention' could be used for AA.	Thank you for your comment. The scope of the guidance includes psychosocial interventions typically provided or funded by the NHS or local authorities. This would include some NHS programmes that provide specific "12 step facilitation" as a professionally delivered intervention to encourage engagement with AA, and 12 step programmes typically provided by the non-statutory sector, often in residential settings. The support provided by AA itself will be outside the scope of this guideline.

63	SH	Institute of Alcohol Studies	7	4.3.1(n) Areas that will be covered by the guideline	We do not understand why alcohol withdrawal fits are mentioned in this paragraph. Management of alcohol withdrawal is covered in 4.3.1l and so this much more logically belongs there, as is also the case with delirium tremens.	Thank you for your comment. Withdrawal fits are a neuropsychiatric complication of alcohol withdrawal although their prevention and management will be part of overall guidance on managing alcohol withdrawal. The same distinction applies to delirium tremens. However, we have removed both withdrawal fits and delirium tremens from section 4.3.1n for clarity.
65	SH	Institute of Alcohol Studies	8	4.3.1(o) Areas that will be covered by the guideline	We feel that this paragraph should also refer to the fact that religious and spiritual programmes (including but not exclusively 12 step programmes) are very important. Although they may be outwith the guidelines (in view of 4.3.1(f)) we do think that mention should be made of them here. With reference to learning disability, we feel that reference should here be made to age and disability, environmental problems and the axes of 'global assessment of functioning'.	Thank you for your comment. 12-step programmes are given as an example in the scope. We agree that looking at care and treatment in a range of settings is important, and the guideline will consider other forms of mutual aid during development. This is outside the scope of this guideline.
66	SH	Institute of Alcohol Studies	9	4.3.1(p) Areas that will be covered by the guideline	We feel that the document does not adequately cover the necessity to assess risks to dependant children, nor does it contain reference to assessing and providing interventions for families 'in their own right' ie, not just in the context of conjoint marital therapy or family therapy.	Thank you for your comment. We agree secondary harm is an important issue, however the remit of this scope does not include the specific care of dependants. However, as you mention we will be considering family therapy (section 4.3.1p) in relation to support needed by family and carers which is linked to this issue.
68	SH	Institute of Psychiatry	3	4.3.1 h	I understand that currently acamprosate and disulfiram are the only licensed pharmacological interventions to aid the maintenance of abstinence in the UK hence the list in section g contains more drugs that are not licensed (opioid antagonists, topimarate and baclofen). How will this be reconciled with the statement that "recommendations will normally fall within licensed indications"	Thank you for your comments. We will only consider recommending off-licence drugs if they are currently widely used in the NHS, or if there is clear evidence to support their use.
69	SH	Institute of Psychiatry	4	4.3.1 i	Does the NHS employ 12-step programmes or rather facilitate access to the self help group AA?	Thank you for your comment. 12 step programmes are often provided by the non-

					For example I am aware that some treatment services provide an introduction to AA, explore some of the steps or provide access to AA members but I am not aware of any that provide the full 12-Step programme.	statutory sector but funded by NHS or local authorities, often in residential settings. This will therefore fall within the scope of the guidelines. There are also some examples of 12 step facilitation programmes within the NHS helping people to access 12 step services and mutual aid organisations.
113	SH	PharMAG (Pharmacy misuse advisory group)	12	4.3.1 g	Disulfiram and topiramate are both spelt incorrectly	Thank you, this has been amended.
114	SH	PharMAG (Pharmacy misuse advisory group)	13	4.3.1 g	Ondansetron is spelt incorrectly	Thank you, this has been amended.
115	SH	PharMAG (Pharmacy misuse advisory group)	14	4.3.1 n	Wernicke is spelt incorrectly	Thank you, this has been amended.
132	SH	Royal College of Paediatrics and Child Health	2	4.3.1 c	Including the applicability of such methods in different settings e to detect alcohol problems manifesting in people other than the person with the alcohol problem.e.g. ante-natal services, paediatric services	Thank you for your comment; we agree secondary harm is an important issue; however the remit of this scope does not include the specific care of dependants. As to whether ante-natal services will be considered remains to be seen, as we are waiting for the NICE to respond on whether the other guideline on complicated pregnancy will be covering this. This guideline already has a very broad scope and we will need to consider this very carefully.
133	SH	Royal College of Paediatrics and Child Health	3	4.3.1 e	Including care pathways for people with such problems identified by services primarily oriented towards users other than those with the alcohol problem e.g. paediatrics, obstetrics	Thank you for this comment. We are slightly unclear as to what you are suggesting, but in response to other comments about the pathways we have been clear that we would wish to recommend clinical pathways that would facilitate linking together the other guidance NICE is currently producing on alcohol. We would expect those pathways to be of value both to service users and service

						providers.
140	SH	Royal College of Physicians	2	4.3.1	Alcohol withdrawal 4.3.1 (d,h) and delirium tremens and withdrawal fits 4.3.1 (n) are being dealt with by the clinical management program development group and should not be duplicated in the dependence guideline.	Thank you for your comment. We will be dealing with prevention and management of alcohol related organic brain disorders, including Korsakoff syndrome. This is often referred to as Wernicke-Korsakoff Syndrome in recognition of the relationship between the acute Wernicke's Encephalopathy and the residual and usually chronic Korsakoff Syndrome. Alcohol withdrawal fits and delirium tremens have now been removed from 4.3.1n as they already fall under section 4.3.1l.
159	SH	Sheffield PCT	4	4.3.1 g	No mention of Chlordiazepoxide	Thank you, this has been added to section 4.3.1g.
165	SH	Tees Esk & Wear Valleys NHS Foundation Trust	3	4.3.1 i	Doesn't mention relapse prevention. Perhaps this is implicitly included within CBT, but I think it's so important that it should be explicitly mentioned.	Thank you for your comment, we agree and have amended 4.3.1i to include relapse prevention.
166	SH	Tees Esk & Wear Valleys NHS Foundation Trust	4	4.3.1 j	Is confusing. 12 step programmes have been mentioned in the previous para. Is the distinction between a 12 step programme per se and merely referral to one? Or is the distinction between a medically based ip/op programme and attendance at self-help meetings?	Thank you for your comment. The scope of the guidance includes psychosocial interventions typically provided or funded by the NHS or local authorities. This would include some NHS programmes that provide specific "12 step facilitation" as a professionally delivered intervention to encourage engagement with AA, and 12 step programmes typically provided by the non-statutory sector, often in residential settings. The support provided by AA itself will be outside the scope of this guideline.
167	SH	Tees Esk & Wear Valleys NHS Foundation Trust	5	4.3.1 n	Why are alcohol withdrawal fits mentioned in 4.3.1n? Management of alcohol withdrawal is covered in 4.3.1l and so this much more logically belongs there - as does DTs.	This comment appears to be a near duplicate of that made by the Institute of Alcohol Studies. Please see response to comment number 63.
168	SH	Tees Esk & Wear Valleys NHS Foundation Trust	6	4.3.1 o	This section should also refer to the fact that religious and spiritual programmes (including but not exclusively 12 step programmes) are very	This comment appears to be a near duplicate of that made by the Institute of Alcohol Studies. Please see response to comment

					important. They may be outwith the guidelines - in view of 4.3.1f. However, something should be said about them.	number 65.
171	SH	Western Trust	1	4.3.1 c	Including the applicability of such methods in different settings e to detect alcohol problems manifesting in people other than the person with the alcohol problem.e.g. ante-natal services, paediatric services .	This comment appears to be a near duplicate of that made by the RCPCH. Please see response to comment number 132.
172	SH	Western Trust	2	4.3.1 e	Including care pathways for people with such problems identified by services primarily oriented towards users other than those with the alcohol problem e.g. paediatrics, obstetrics	This comment appears to be a near duplicate of that made by the RCPCH. Please see response to comment number 133.
8	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	7	4.3.2	Voluntary agencies sometimes provide some elements of the treatment, including systemic family therapy, particularly when working with children who have parents who misuse alcohol. The role of voluntary agencies in delivering family interventions needs to be acknowledged in commissioning and funding decisions.	Thank you for the comment. We recognise the important role of non-statutory services and voluntary agencies in delivering services for people with alcohol problems. We will have direct involvement on membership of the GDG from this sector and would expect that we would be looking at a wide range of interventions developed in the non-statutory sector as we would for those provided within the NHS. The matter of commissioning and funding decisions are outside the scope of this guideline. Section 4.2 b has been amended for clarification.
47	SH	European Association for the Treatment of Addiction	7	4.3.2	EATA is concerned that the scope for developing the guidelines does not appear to refer to the issues of aftercare. Aftercare is crucial in ensuring that the individual reintegrates into society and also for tackling relapse. The guidelines should stress the importance of care plans based on treatment that suits individual needs, while at the same time building in integrated aftercare support, to address issues such as employment, housing, social exclusion, education and health (including dual diagnosis). Tackling these needs for different client groups requires a multi-disciplinary process, which begins at admission and should continue after release. Treatment for alcohol dependency	Thank you for your comment. We agree that the issue of aftercare is important and have added it to section 4.3.1e.

					cannot happen within a vacuum; instead a holistic approach is vital, which the guidelines should recognise and recommend.	
54	SH	Faculty of Public Health	7	4.3.2	It is unclear how the exclusion of the separate management of comorbid conditions relates to the inclusion criteria, especially 4.3.1. (m) 'Management of common mental health problems in the context of alcohol dependence, if this differs from the management of common mental health problems alone'. This also relates to comment number 4.	Thank you for your comments. This scope is not intended to replace other existing NICE guidance on e.g. management of depression, which is common in this population. However, the intention is to examine how management of e.g. depression would differ in people with alcohol dependence compared to those who are not alcohol dependent, for which there is an evidence base that will be reviewed. The same will apply to other common mental disorders and drug misuse.
160	SH	Sheffield PCT	6	4.3.2 a	If a 'cost per case' application was made to a PCT for treatment "not normally made available by the NHS" the evidence/effectiveness would need to be known, and this could change by case law.	Thank you for your comment. The issue of the precise costing and commissioning of services by PCTs are beyond the brief of this guideline and we will not be commenting on them directly.
9	SH	Association for Family Therapy and Systemic Practice in the UK (AFT)	8	5.	For problems that will impact on families like alcohol dependence and misuse, it is important to include relevant policy documents such as Think Family.	Thank you for this comment. Our primary concern is the development of clinical practice recommendations. Of course in the development of these recommendations we take into account the wider policy and service development context. It would be in that case that we may make reference to policy documents such as that that you refer to. However it is not within our brief to review or comment directly on policy.
35	EX	Christine Godfrey		4.3 f and 4.3.2	Current levels alcohol care in the NHS is very low and many forms of evidence based treatment are not routinely available. I presume this would not exclude such treatment from consideration if there is evidence from the review of their implementation in other health care systems	Thank you for your comment. We will be looking at both treatments which are routinely available in the NHS as well as treatments which are not so commonly available.