THE UNIVERSITY OF
WARWICK

15 February, 2016

Alcohol Policy Team
6th Floor
Department of Health
Wellington House
133 -155 Waterloo Road
SE1 8UG

Dear Alcohol Policy Team,

Consultation on Chief Medical Officer's Proposed Alcohol Guidelines

I believe you seek views on the new proposed guidelines (which essentially recommend 14 weekly units for UK males). There has already been a fair amount of bad publicity about this new Alcohol Report. As a nation we cannot afford for your Department's reputation to fall into disrepute.

I am a behavioural scientist and economist at Warwick. For the last 35 years I have worked on a wide range of issues in applied statistics, and I currently serve on the board of editors of the journal Science. My research has been published in journals spanning economics, epidemiology, statistics, science, psychology, and public health.

The CMO's objectives are laudable, but I am afraid the scientific basis for parts of the Alcohol Report is not as strong as claimed. The key practical weakness is captured by looking at Figures 12 and 13 in the underlying so-called Sheffield Report. These are entitled 'Male Relative Risk of Alcohol-Related Mortality by Mean Weekly Consumption' and 'Female Relative Risk of Alcohol-Related Mortality by Mean Weekly Consumption'. These diagrams, very sensibly, break the data down by age group.

As is clear in these figures, it is effectively harmless for older males to drink 21 units smoothly through the week. Perhaps you feel that the ends justify the means when it comes to being accurate or inaccurate in the publicity about 14 units. That would be a complicated moral issue to debate. On balance, however, I think complete scientific honesty is important and thus that older men in the United Kingdom should be told the whole truth. For them, the traditional limit of 21 units is safe, and thus continues to be the one that should be recommended by the UK's Department of Health.

Yours faithfully,

[redacted]

Overall, these points demonstrate that the population-level risk curves reflect not only variations in degrees of risk across age groups but also substantial variation in the nature of risks to which different aged drinkers are exposed. As these different risks have very different relationships to alcohol consumption (e.g. linear, j-shaped, curvilinear), this means a highly heterogeneous set of age-specific risks curves are being averaged to produce the population-level curve. Neither the Australian nor Canadian approaches cope well with this heterogeneity when the approaches are applied to attempt to derive age-specific lower risk drinking guidelines.

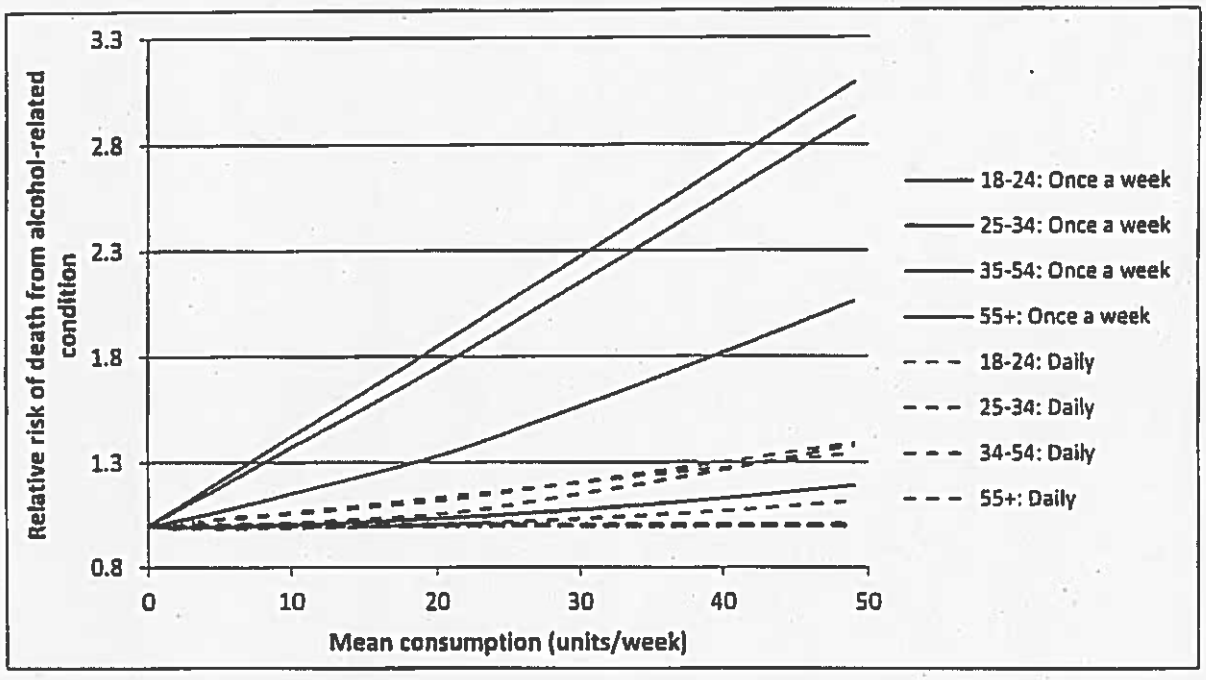

Figure 12: Male relative risk of alcohol-related mortality by mean weekly consumption, number of drinking days and age

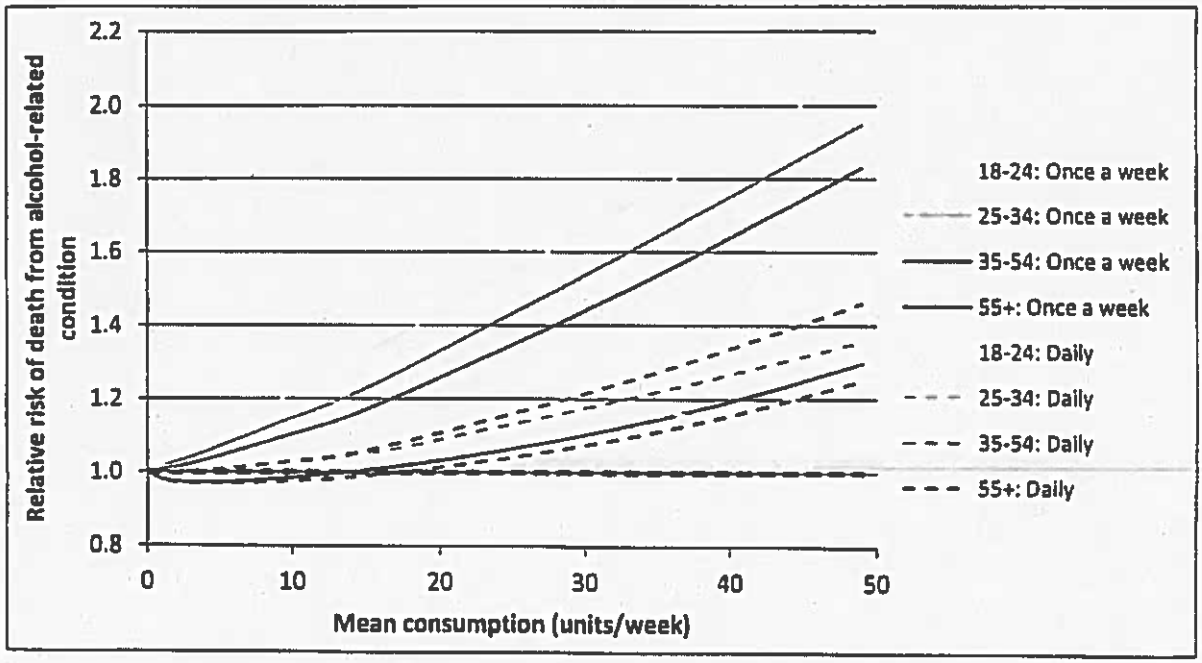

Figure 13: Female relative risk of alcohol-related mortality by mean weekly consumption, number of drinking days and age

The Royal College of Radiologists

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From the Office of the President
Dr Giles Maskell MA FRCP FRCR

By email to: UKCMOGuidelinesReview@dh.gsi.gov.uk
Alcohol Policy Team
6th Floor
Department of Health
Wellington House
133 -155 Waterloo Road
SE1 8UG

28 January 2016

Dear Sir or Madam

Health risks from alcohol: new guidelines

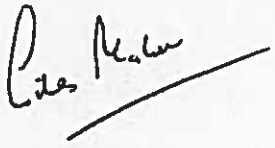
The Royal College of Radiologists has discussed the proposed new guidelines and the questions being asked in the consultation document issued by the Department In January 2016.

Our interest relates to the fact that alcohol is a well-recognised and increasingly important cause of cancer as well as other serious diseases. We have no comments to make on the guidelines as we are satisfied that they are based on the best current evidence and appear to be clear.

However, we are concerned that other decisions taken by the Government give out conflicting messages notably around the public health agenda. The budgetary reductions imposed on Public Health England and the ability of local authorities to give out effective messaging will obviously reduce the knowledge and awareness of sectors of the population who most need to review their drinking habits and understand the risks of exceeding the drinking limits in the new guidelines.

We therefore urge the Departmental of Health to reconsider those decisions as it has long been demonstrated that changing behaviours upstream can reduce costs and negative impact downstream on the overall healthcare system.

Yours faithfully



Dr Giles Maskell
President
president@rcr.ac.uk

[redacted]

From: [redacted]
Sent: 27 January 2016 09:38
To: UK CMO Guidelines Review
Subject: UK Chief Medical Officers' Alcohol Guidelines Review

Dear All,

Thank you for asking for my opinion on the UK Chief Medical Officers' consultation regarding drinking in pregnancy.

I write not only as a local MP in the 5th most deprived constituency in the UK but as the chair of the charity Rebalancing The Outer Estate which operates to combat local deprivation. The charity has three targets in the public health area, one of which is to undertake the first prevalence study of foetal alcohol spectrum disorders.

One of the biggest problems we have had has been the equivocation around the message for drinking alcohol during pregnancy. It seems that the confusion has been because of the sensitivities of health professionals rather the desire for clarity and simplicity for those mums to be in areas like mine. Mums to be, in areas like mine, are normally of lower than average education attainment (we have the lowest education, skills and training attainment in the deprivation indexes), and bluntly nuanced, wordy equivocation is often taken as a signal that drinking in pregnancy cannot be that bad. I therefore very strongly welcome the short, sharp and easy to communicate message "don't drink during pregnancy". I hope very much that the consultation supports this and help us significantly reduce the consequences, in areas like mine, of drinking alcohol and its lifelong impact of the developing foetus.

Yours faithfully,

[redacted]

[redacted]

From: [redacted]
Sent: 02 February 2016 21:15
To: UK CMO Guidelines Review
Subject: Alcohol Guidelines Consultation

How to keep health risks from drinking alcohol to a low level: public consultation on proposed new guidelines

I appreciate the opportunity to comment.

I only wish to comment on one issue and, for that reason, I am emailing rather than completing the questionnaire. I think the rest of the guidance is unproblematic.

I think the following is ambiguous and could be misinterpreted:

"14. This advice on regular drinking is based on the evidence that if people did drink regularly at or above the low risk level advised, overall any protective effect from alcohol on deaths is overridden, and the risk of dying from an alcohol-related condition would be expected to be around, or a little under, 1% over a lifetime. This level of risk is comparable to risks from some other regular or routine activities."

The phrase "or above the low level of risk advised" could be interpreted as being linked to the 1% lifetime risk when my understanding is that the 1% risk is related to drinking at the advised level of a maximum of 15 units, not above it. In other words, a person drinking 60 units week could read this and say that my lifetime risk is only 1% when, in fact, it would be considerably higher. Should the phrase "or above the low level of risk advised" be deleted and a further sentence added saying something along the lines of "Evidence suggests that regular drinking above the low risk level advised significantly increases the percentage risk of dying from an alcohol related condition".

With thanks

[redacted]

From: [redacted]
Sent: 03 February 2016 17:58
To: UK CMO Guidelines Review
Subject: Alcohol guidelines

Well let's start with the items in the governments recommendations that seem to me to be substantially correct. Firstly that drinking has its dangers, that it can all too easily be carried to excess and that is good to have regular days without alcohol, say 2 -> 3 per week.
I notice however that the risks they point out were risks associated with cancer not overall mortality. After all cancer is not the only thing that can kill you. Personally I would have preferred to see plots of mortality rates and life expectancy against numbers of drinks consumed per day. I am told these give a very different picture and that about 3 drinks per day improved life expectancy over not drinking at all.

I am also concerned that many of the figures linking amount of drinking to cancer (and anything else) may well be based not on real but reported alcohol consumption. It is well known that there is a wide discrepancy between the amount people admit to drinking and the total amount of alcohol consumed based on the tax collected by HMRC. Even that does not include alcohol legally brewed at home, legally imported as personal allowance from abroad or obtained illegally. If the recommended drinks limit is based on figures from reported drinking, and I have no means of knowing if this is so, then the recommendations could be easily wrong by a factor of 2.

The worst thing about these government recommendations of course is that the government won't do anything beyond statements, glossy brochures and notices in NHS corridors. As usual they will dump everything onto the individual. They will tell us that they have given us the facts and that they are working with the drinks industry to encourage responsible drinking. All I can say to that is "Don't make me laugh". The attitude of the drinks industry will be "Any steps we can take to encourage responsible drinking are great as long as they don't work". Even if we defined responsible drinking at the old level the drinks industry knew perfectly well that if every drinker stuck to those levels the drinks industry would lose about half its turnover. Working to the new levels would mean that it lost about 60%. They won't work towards that any more than turkeys vote for Christmas. They are more likely to sabotage it.
The Treasury won't like it either. Less drinking means less trade.

See
http://www.publications.parliament.uk/pa/cm200910/cmselect/cmhealth/151/151i.pdf

which largely confirms this. Nothing has changed since then and I don't believe it will now.

[redacted]

From: [redacted]
Sent: 08 February 2016 14:22
To: UK CMO Guidelines Review
Subject: Consultation process on "Health risks from alcohol: new guidelines"

Hullo

I am trying to understand how some of the conclusions in the guidelines were reached. Paragraph four states:
"4. Meta-analyses have identified that for some conditions, notably ischaemic heart disease (IHD), drinking alcohol at low levels may have a protective effect (compared to not drinking), particularly for all-cause mortality. However, the group noted that:

- any potential protective effect seems mainly relevant to older age groups;

- unresolved confounding and health selection (for instance, the health of people who can afford to drink more in older age may be better than those who do not) may explain a substantial part of the protection observed;

- mortality from IHD is continuing to decrease substantially; and

- the peak of any protective effect is achieved at very low levels of consumption (around one unit a day)."[1]

I find this tone rather misleading.

Looking at the Health Expert Group report from Liverpool John Moores University [2], which is linked to at "https://app.box.com/s/wlludrmim3gd83r28c4oqb3upj68cqia/1/5750515361/46692289869/1". [2] cites, inter alia, updated meta-analysis on the impact of alcohol on heart disease "http://link.springer.com/article/10.1007%2Fs10654-011-9631-0" (Wine, beer or spirit drinking in relation to fatal and non-fatal cardiovascular events: a meta-analysis; Simona Costanzo, Augusto Di Castelnuovo, Maria Benedetta Donati, Licia Iacoviello,Giovanni de Gaetano). [3]

[3] looks like the latest in a series of meta-analyses on the impact of alcohol on health, although it is specifically looking for different impacts from different types of alcohol (beer vs wine vs spirit). Like all previous meta-analyses on this matter that I have seen (e.g. "Di Castelnuovo, A., Costanzo, S., Bagnardi, V., Donati, M. B., et al. (2006). Alcohol dosingand total mortality in men and women. Archives of Internal Medicine, 166, 2437-2445." [4], cited in [2], and http://1.usa.gov/1PWiWfV) [5]. All of these papers identify protective effects for alcohol on total mortality, although [3] has been able to show that the effect is not present for alcohol consumed as spirits. It's abstract is contradictory and claims both that there is and that there is not a protective effect for beer.

It doesn't look like alcohol consumption patterns and impacts on different groups of people are yet well categorised. Nevertheless, all of these meta-analyses show some protective effect on overall mortality. What is more, the maximum protective effect across the whole population is stated in [3] at around 17 units per week at levels more effective than, say, taking regular statins. I cannot see the details of [3] to identify at what level the effect becomes a harm, but in [4] and [5], it is around 40 units per week.

From the data, it could be claimed from the numbers that drinking increases the rate of relatively rare causes of death because it ensures that consumers avoid the more common causes of death.

Is there a line of reasoning that describes how the recommendations have been arrived at from the original research findings? At first sight, the recommended levels appear harmful for the population as a whole.

regards

[redacted]

CMOWeb

From: [redacted]
Sent: 08 January 2016 13:15
To: CMOWeb
Subject: Today's new unit guidelines

Dear Sally,

I am amazed and shocked to hear this reported on the news today. This advice is completely fabricated and the studies from which this information is derived are completely flawed.

As the CMO do you honestly believe the advice your department is giving to the general public? If so you should resign and let somebody more informed take over your role. Alcohol is not damaging if consumed in moderation. Alcoholic drinks on the other hand can be as the vast majority in the UK are heavily processed. It is vital to note and to inform the general public that it isn't the alcohol which causes the cancer, but the added chemical preservatives liberally added to the drinks in the UK.

Good sulphite free wine is actually beneficial and will actually REDUCE your likelihood of contracting cancer plus loads of other diseases such as Alzheimer's, heart disease and stroke. This is why people in Mediterranean countries have historically drunk several bottles of wine daily and lived to a ripe old age - because their local wines were made properly without masses of added sulphites.

If you are going to make announcements like this you really should get your facts right. I believe this government is running scared of the global companies producing foods and drinks for the UK and are not prepared to tell the public the truth nor force these companies to make healthier food alternatives.

Come on - make another announcement and tell the truth please!

Regards

[redacted]
Goodwineonline.co.uk
Sent from my iPad

CMOWeb

From: [redacted]
Sent: 08 January 2016 16:53
To: CMOWeb
Subject: Effect of Red wine on health

Dear Professor Davies, I noted with interest your response to the question as to why red wine in moderation is no longer deemed to be good for health when asked this morning on BBC Today programme.

As I understand it, your answer was that general improvements in health care have meant that the incremental benefits that red wine can provide are no longer significant enough to justify the risks they bring. I also understand that those risks were dismissed as insignificant when red wine in moderation was accepted in prior guidance.

I take it that the general benefits you refer to are developments such as widespread prescription of statins and the many checks and treatments which are part of today's health regime.

Do you believe that we have a healthier population when that health depends on regular drugs and visits to the doctor, given that those drugs may have severe side effects in certain patients?

Would it not be better if we could promote a culture were people took care about their own health, even if this means a small consumption of red wine, for instance.

By the way, I agree that Government should, indeed must, take action to prevent excessive alcohol consumption and this may involve taxing alcohol and other substances such as sugar.

If the solution is to try to replace drinking in moderation with drugs and doctors visits, it will only hasten the day, not far off, when the health care regime becomes unaffordable for the nation as a whole.

Do not let the search for perfection and the unthinking pursuit of improvement in statistical measures become the enemy of a health regime which is affordable for the nation.

I would be grateful for a response to these thoughts.

Yours sincerely

[redacted]

From: [redacted]
Sent: 28 January 2016 13:11
To: UK CMO Guidelines Review
Subject: New Alcohol Guidelines – Possible new legislation

Email for Professor Dame Sally C Davies, Chief Medical Officer for England

Dear Professor Davies

NEW ALCOHOL GUIDELINES - PUBLISHED 8 JANUARY 2016

I refer to your recent new alcohol guidelines. The purpose of this letter is to suggest legislation which I believe you should ask the Government to consider introducing to assist people in following your recommendations.

One of the issues which leads to people drinking more than you feel they should is the way wine is sold and served in licensed premises (pubs, wine bars and restaurants). My experience is that in these premises wine is often sold in two glass sizes, 175ml and 250ml. The 250ml glass is referred to as "standard" and the 175ml glass as a "small" glass of wine. Clearly this encourages people to buy wine by the glass in quantities which will easily lead to consuming more than they readily realise and understand.

In addition, when wine is ordered by the bottle, these premises will hand out the 250ml glasses to use to drink the wine – often offering to pour the wine for the customer and thus serving excessive amounts of wine in a glass. When faced by a 250ml glass of wine it is difficult to understand just how much is being consumed and it can easily lead to drinking more than one would if one were more aware of the quantity involved.

I am sure I remember that when I was young I was told that there were six "glasses" of wine in a bottle of wine (750ml). Thus a "glass" of wine was 125ml. Clearly over the years the pubs/restaurants etc have inflated the size of glass in which they sell wine, presumably in order to sell more wine, without really considering the long term health implications, or even what customers would choose if they were given clear facts about what they were buying. I wonder if many people buying a "standard" glass of wine of 250ml realize that this represents one-third of a bottle in one glass!

I do not believe any form of voluntary code of conduct, or the like, would be effective. I therefore suggest that you should consider legislation to require the following of licensed premises;

1) Wine to be sold by the glass solely in glass sizes 125ml and 175ml, with the 125ml size to be termed "standard" and the 175ml size to be termed a "large" glass of wine.

2) Where wine is sold by the bottle, then glasses no bigger than 175ml to be given with which to drink the wine. Ideally the waiter in a restaurant should always ask if the customer wants the wine to be poured for him/her and if a top-up is desired. This would make it easier for customers, if they wish, to take personal control of the pouring (and thus quantity to be drunk) themselves.

I look forward to your response to this suggestion.

Yours sincerely

[redacted]

From: [redacted]
Sent: 26 January 2016 04:00
To: UK CMO Guidelines Review
Subject: this is nonsense

It is based on highly selective evidence and not backed up by and actually wilfully ignores most of the science on this subject.

Repeated studies have shown If you drink nothing, you're at greater risk of heart disease, strokes and living a shorter life than a drinker.

The health risk falls for moderate alcohol consumption. We all know that optimal daily consumption varies according to personal preference but might include a couple of pints of beer, a stiff gin and tonic or a couple of glasses of wine a day, with perhaps a little digestif or a glass of port before bed after a large meal.

The government should be ashamed of peddling such virtue-signing drivel.

Conclusions –

I fully believe that understanding these concepts is as easy as:- ABC –

A – Aldehydes, toxins created from alcohols and from cooking with cornoil, sunfloweroil and rapeseed oil.

B – Bacchus, the scientifically uninformed god of wine and pleasure.

C – Cancers and Cardiovascular disease.

D – Diabetes - type 2, - Insulin Resistance, Dementia.

E – Epidemics - Cancers, Cardiovascular disease, Diabetes Hyperlipidaemia, Hypertension & "Hyperflow".

F – Fat deposits on key organs becomes the Insulin Insulator!

Cancers, Diabetes and Cardiovascular Diseases.

On Friday 8th January 2016, I purchased five leading newspapers, as I was keen to compare the various reports and comments regarding the revised UK guidelines for alcohol consumption.

I was most impressed by the Chief Medical Officer's warning against drinking any alcohol at all! As that was the very same conclusion which I had reached and adopted back in October 2013, when I simply switched to alcohol free beer and merlot grape juice!

However, in none of those relevant articles did I find a single reference to acetaldehyde (CH_3CHO); yet the primary focus would appear to be on various cancers! Back in 1990 the American Clean Air Act Amendments had labelled two aldehydes, formaldehyde ($HCHO$) and acetaldehyde as carcinogenic, toxic irritants!

I had consumed alcohol on an increasingly regular basis for half a century, so why haven't I been diagnosed with some form of cancer? I would suggest that I have been blessed with some very effective toxin defence systems. However, the evidence is that I had been guilty of overloading those systems! But then I had never been provided with a copy of "pilot's notes" covering the various operating limitations on the complex systems and organs within my body! So what had been happening to me, in the absence of a comprehensive list of "pilot operating limits?"

Ethyl alcohol is an extremely impressive fuel particularly when used in supercharged and two-stroke engines. While the triglyceride castor oil provides remarkable insulating qualities; hence the brand name - "Castrol!"

However, ethyl alcohol (C_2H_5OH) is gently oxidised within the human digestive system to create acetaldehyde (CH_3CHO). But I only discovered those toxic details in late 2013. Fortunately I knew that acetaldehyde is rather similar to the toxic and carcinogenic formaldehyde ($HCHO$), which is being created in tobacco smoke! Another source of the toxic aldehydes has recently been confirmed, this is the result of cooking foods with sunflower and corn oils. I am convinced we can also add <u>rapeseed oil</u> to the toxic aldehyde formation list! As the aldehyde emission levels from diesel engines were significantly increased when rapeseed oil was tested as a bio-fuel back in 1991. (Ref:- "Alternative Fuels for Road Vehicles" - M.L. Poulton 1994)

One major role of the liver is detoxification; however, I suggest that a number of human toxic defence systems are also activated. However, I doubt if the various systems have evolved to cope with long term and constant exposure to these man-made toxins! Various problems seem prone to occur with long term moderate consumers of alcohol. I was in that category until October 2013 when I read about the creation of acetaldehyde within the human digestive system from alcohol! I introduced a self-imposed total alcohol ban! I believe that the liver lays down fat deposits as a defence against the toxic aldehydes; but over time fat upon the key organs will resist the transfer of insulin. <u>A formula for type 2 diabetes!</u>

I became focussed in 2013 upon liver fat reduction, in a matter of months I was free of type2 diabetes which I'd had since 2007, (then aged 63). My blood pressure was reduced and there was also a major reduction in the levels of cholesterols and of the triglycerides in my blood. As I had been diagnosed with angina in 2011 - PTO

at the age of 61, these were very encouraging results. It also confirmed that my "test-pilot scheme" was working very well.

I was therefore convinced that my liver had been loosing fat as it no longer had to protect itself from any acetaldehyde created from ethyl alcohol! As the fat upon my liver declined, so too did the resistance to the transfer of insulin. Fat on key organs is the "insulin insulator!" In the past acetaldehyde would have been transported around my cardiovascular system; so it would have irritated the inner sections of various blood vessels. I suspect that the production of cholesterols and of the triglycerides are then increased in order to deposit a layer of plaque (atheroma) in an effort to protect the locations within the blood vessels which are being irritated by carcinogenic aldehydes! The major reductions in my cholesterol and triglyceride levels had happened, even though I had decided to stop taking statins; then last year I read about hyperlipidaemia and noted links to alcohol consumption! But again no reference to the toxic acetaldehyde. The "Patient article" recommends the use of sunflower and rapeseed oil; they haven't yet recognised the toxicity of the aldehydes!

According to "Patient-article Hyperlipidaemia" :- "The UK population is known to have the highest average cholesterol levels in the world." Is this the response of our internal systems to the toxic aldehydes?

I have very unusual experiences with the triglycerides and with the problems which can be created when alcohols are used as automotive fuels. It seems to me that the human defence systems do a remarkable job in combatting the impacts of the toxic and carcinogenic aldehydes!

© [redacted]

14th January 2016

Defusing the Diabetes and Hypertension Time Bombs.

To remove the fuse from any form of explosive device you need to understand the systems involved. This is also true with the epidemics, irrespective of whether they relate to diabetes or cardiovascular disease!

Learning from the relevant histories is also crucial to any successful outcome. In 1950 three important medical research papers were published. One in the United Kingdom by Sir Richard Doll and Austin Bradford Hill; and two in the United States of America by Ernest Wynder and Evarts Graham; and by Morton Levin, Hyman Goldstein, and Paul Gerhardt. Each paper had reported the cleat links between tobacco smoke and lung cancer! So why did it take over half a century before the health warnings appeared upon the cigarette packets? One of the toxins in tobacco smoke is formaldehyde ($HCHO$), why would any of the other aldehydes be safe? Particularly when Cancer Research UK has already linked acetaldehyde (CH_3CHO) to a range of cancers!

Each year about 13,000 cases of cancer in the UK are being attributed to alcohol consumption. An official at Cancer Research UK recently stated that:- "alcohol is broken down into acetaldehyde, which damages DNA." This appears to be endorsed by the World Health Organisation which rates alcohol as a class one carcinogen; and this was recently confirmed by Professor Sir Ian Gilmore.

Ethyl alcohol is readily oxidised to create acetaldehyde and water. However, cooking with vegetable oils such as corn oil and sunflower oil has also created substantial quantities of toxic aldehydes! In the automotive sector the use of rapeseed oil in diesel car engine emission tests, in the early 1990's demonstrated aldehyde emissions between three and four times higher than those from diesel fuel! The enclosed article provides information upon these additional sources of toxic aldehydes, created by the cooking processes!

However, the human body and various internal organs are amazing in their functions and responses to a wide range of complex and even toxic scenarios. These responses will often mitigate the impacts of the toxins in the short term; but were these responses designed to provide long term solutions? Indeed could such responses help to create additional health problems in the long term? I would suggest that hypertension, hyperlipidaemia and high liver fat levels are each a response to common long-term toxins; but each can eventually create a new health problem!

In "The Daily Telegraph" on the 14th December 2015 there was a lengthy article linking alcohol to problems with the brain, the skin, the heart, the liver, various cancers, fertility and body weight. Acetaldehyde was mentioned just once, followed by the brief phrase:- "which damages DNA." There was a reference to the fatty liver, but no reference to hyperlipidaemia. It also seems that liver disease has risen by 400 per cent since the 1970's!

The liver plays a vital role in detoxification, however excessive detoxification, as can be the case with the aldehydes, will result in liver damage. The massive increase in liver disease in the UK probably reflects an increase in binge drinking and aldehyde consumption in foods. The fatty liver is I suggest an attempt by the liver to provide a defensive barrier against the toxic and carcinogenic acetaldehyde (and other aldehydes)! Unfortunately this build-up of fat upon the liver, over the years, will also create a barrier to the transfer of insulin,- insulin resistance; and the scene is then set for the current type 2 diabetes epidemic!

Unfortunately we are creating many other sources of the toxic aldehydes by the preparation of foods using corn oil, sunflower oil and rapeseed oil (see article enclosed)! The result is likely to be the deposition of additional fat based insulin barriers upon the liver; leading to increased insulin resistance and adding to the current diabetes epidemic!

Professor Sir Ian Gilmore recently confirmed the very clear links between alcohol consumption and high blood pressure-hypertension. I would suggest this is a very smart response by our various systems to create "hyperflow" - an increase in the velocity of the flow of blood. This is likely to help to increase the rates of detoxification! However, long term hypertension can also lead to cardiovascular disease and increased risks of heart attacks and strokes!

<u>The antidote is to minimise the aldehydes, it worked for me!</u>

© - [redacted] 11th January 2016

PS:- Poisonous Sequences.

Toxic acetaldehyde is the product of the gentle oxidation of ethanol. It is also the compound detected in the 'breathalyzer' test. Acetaldehyde has a boiling point of only 21°C. So when it is being transported within the human blood circulation system we can expect acetaldehyde to turn into vapour; whenever it is not under significant pressure.

Could this be a significant process within the human lungs? Thereby potentially creating respiratory diseases or adding to those respiratory problems caused by other toxic air pollutants! Could acetaldehyde also create toxic "vapour locks" within small blood vessels, leading to a range of potential health problems?

Type 2 diabetes is reaching epidemic proportions and high levels of blood sugar are linked to a range of serious health problems! "The Cambridge Encyclopedia" states that:- "the aldehyde function is found in most sugars, notably glucose". Are these major health problems all being accentuated by the increased exposure to the toxic aldehydes within modern society?

[redacted]

27th January 2016.

For the healthy option, fry in butter or lard not sunflower oil, say experts

By **Robert Mendick** CHIEF REPORTER

COOKING with vegetable oils releases toxic chemicals linked to cancer and other diseases, according to leading scientists, who are now recommending food be fried in olive oil, coconut oil, butter or even lard.

The results of a series of experiments threaten to turn on its head official advice that oils rich in polyunsaturated fats – such as corn oil and sunflower oil – are better for the health than the saturated fats in animal products.

Scientists found that heating up vegetable oils led to the release of high concentrations of chemicals called aldehydes, which have been linked to illnesses including cancer, heart disease and dementia.

Martin Grootveld, a professor of bioanalytical chemistry and chemical pathology, said that his research showed "a typical meal of fish and chips", fried in vegetable oil, contained as much as 100 to 200 times more toxic aldehydes than the safe daily limit set by the World Health Organisation.

In contrast, heating up butter, olive oil and lard in tests produced much lower levels of aldehydes. Coconut oil produced the lowest levels of the harmful chemicals.

Concerns over toxic chemicals in heated oils are backed up by separate research from a University of Oxford professor, who claims that the fatty acids in vegetable oils are contributing to other health problems.

Professor John Stein, Oxford's emeritus professor of neuroscience, said that partly as a result of corn and sunflower oils, "the human brain is changing in a way that is as serious as climate change threatens to be".

Because vegetable oils are rich in omega 6 acids, they are contributing to a reduction in critical omega 3 fatty acids in the brain by replacing them, he believes.

"If you eat too much corn oil or sunflower oil, the brain is absorbing too much omega 6, and that effectively forces out omega 3," said Prof Stein. "I believe the lack of omega 3 is a powerful contributory factor to such problems as increasing mental health issues and other problems such as dyslexia."

He said sunflower oil and corn oil were now banished from his own kitchen, replaced by olive oil and butter.

NHS advice is to replace "foods high in saturated fat with lower-fat versions" and warns against frying food in butter or lard, recommending instead corn oil, sunflower oil and rapeseed oil. Saturated fats raise cholesterol levels, increasing the risk of heart disease.

But Prof Grootveld, of De Montfort University in Leicester, who carried out a series of experiments, said: "For decades, the authorities have been warning us how bad butter and lard was. But we have found butter is very, very good for frying purposes and so is lard.

"People have been telling us how healthy polyunsaturates are in corn oil and sunflower oil. But when you start messing around with them, subjecting them to high amounts of energy in the frying pan or the oven, they undergo a complex series of chemical reactions which results in the accumulation of large amounts of toxic compounds."

The findings are contained in research papers. Prof Grootveld's team measured levels of "aldehydic lipid oxidation products" (LOPs), produced when oils were heated to varying temperatures. The tests suggested coconut oil produces the lowest levels of aldehydes, and three times more aldehydes were produced when heating corn oil and sunflower oil than butter.

The team concluded in one paper last year: "The most obvious solution to the generation of LOPs in culinary oils during frying is to avoid consuming foods fried in PUFA [polyunsaturated fatty acid]-rich oils as much as possible."

Prof Grootveld said: "This major problem has received scant or limited attention from the food industry and health researchers." Evidence of high levels of toxicity from heating oils has been available for many years, he said.

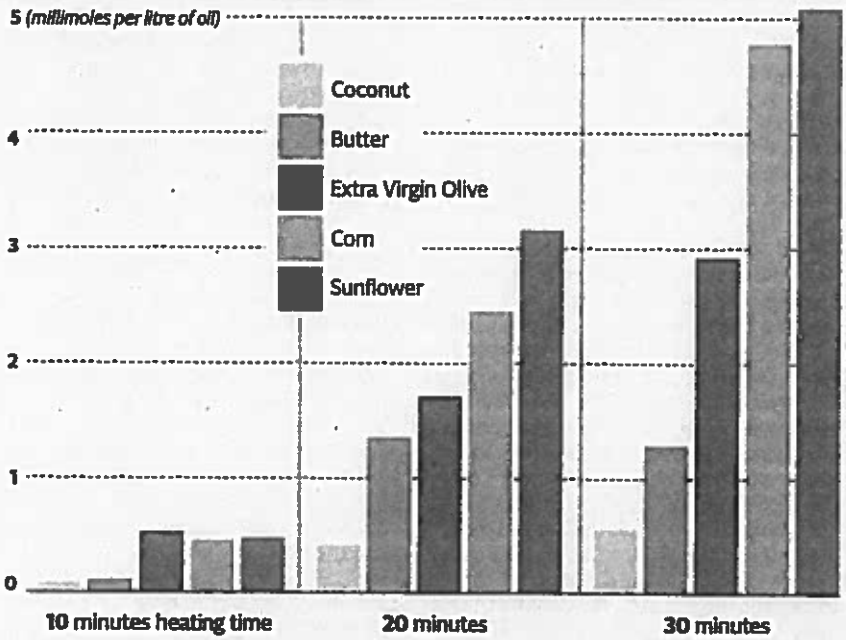
Health concerns linked to the toxic by-products include heart disease; cancer; "malformations" during pregnancy; inflammation; risk of ulcers and a rise in blood pressure.

He said the oils when "completely pure [and] authentic ... offer no threats to human health" but that "LOPs arising from the frequent and common use of polyunsaturated fats" for frying "certainly do so".

Public Health England says saturated fats, including butter and coconut oil "can be eaten occasionally in small amounts as part of a healthy balanced diet".

How the oils turn toxic

Concentrations of toxic aldehyde per litre of oil when heated at 180°C



LIVERPOOL
HEALTH PARTNERS

"ACHIEVING EXCELLENCE THROUGH COLLABORATION"

26 January 2015

Dear [redacted]

Many thanks for your letter and enclosures, and I'm very sorry you had to send the material twice. Congratulations on curing your diabetes through giving up alcohol. You are absolutely right that alcohol is a toxin and this is partly through the failure to metabolize acetaldehyde properly when alcohol is ingested in large doses.

Fatty liver is a real challenge and weight reduction, alcohol avoidance and exercise all play a part in reducing it.

Good luck in the future. I am more than half-way through "Dry January".

Kind regards

Ian Gilmore

Professor Sir Ian Gilmore
Chairman
ian.gilmore@liverpool.ac.uk

British Racing Green Karting

Protection for Competition Drivers

Driving and alcohol don't usually mix. However, give the 'basic' 2-stroke kart engine a few litres of the 'hard stuff' and you really transform its performance and improve its exhaust emissions! Britain is waking up to the risks of 'binge drinking' and those involved in motorsport should consider the intelligent use of alcohol as a fuel, rather than just spraying it round the podium after a Formula 1 competition! The UK's North Sea oil production has declined steeply every year since 1999; and today the 'petrol giants' are finding it increasingly difficult to gain access to reserves of crude oil.

Ethyl alcohol - ethanol is now being created from waste, so we should consider what alcohol does for competition 2-stroke kart engines. We tried it at Whilton Mill in 2004 and were immediately impressed by the kart driver's positive reaction. Karting can help develop 2-stroke solutions for chainsaws and other small power-units; but we need the regulators to 'release their toxic petrol handbrake!' Karting is already well behind the Cougar Red 125cc 2-stroke competition motorcycle engine, developed at Kettering!

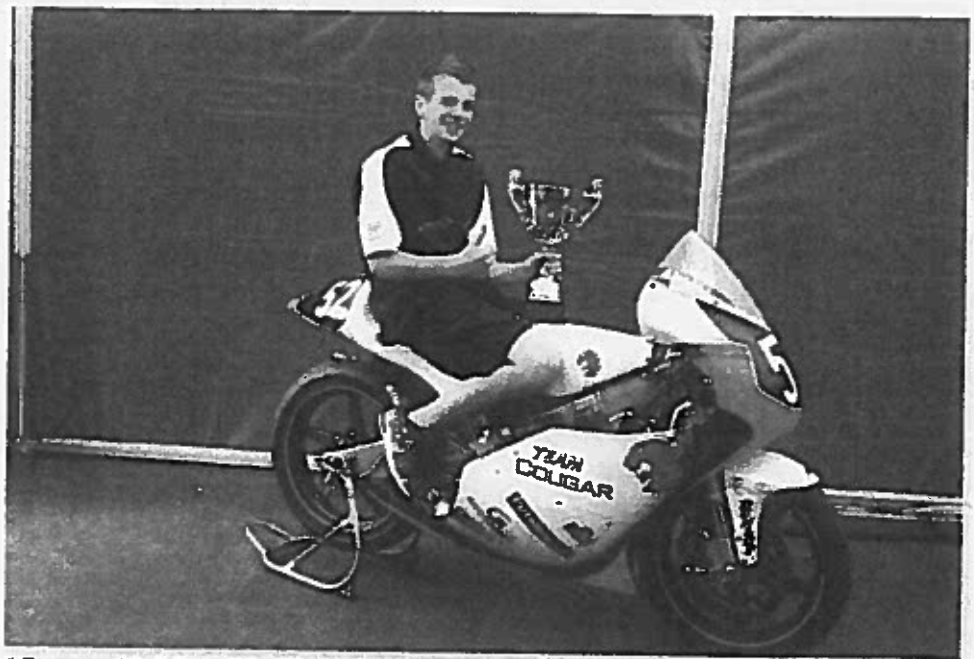
Cougar Red's 2-stroke goes better on ethanol; and back in the summer it beat 34 Honda motorcycles, at Donington Park; and they all used competition petrol. There are good reasons for this; but what about exhaust emissions? Keeping the poisons out of the fuel tank is a good step towards reducing the poisons in the exhaust gases and ethanol is by far the cleanest liquid fuel. How clean would a 2-stroke engine be using hydrogen as the fuel? However, I'm not suggesting karting should start using hydrogen; it's far too explosive for me!

The most energy efficient engines on this planet are the marine 2-stroke diesels; so only some "certified half wit" would want to ban 2-stroke engines throughout motorsport and everywhere else! 2-stroke turbocharged aero-diesel engines were flying the Atlantic before World War II, that's historic proof of the 2-stroke's fuel economy and superior power-weight ratio. Good fuel economy reduces our carbon footprint. However, then the jet engine arrived and 2-stroke aero-engine development stalled for half a century; even though Rolls-Royce had demonstrated a 26% fuel saving with their 2-stroke Crecy aero-engine. Since then, too many folk have rushed around this planet, with excessive fuel consumption, only to burn their way through the world's limited reserves of fossil fuels!

We need clean answers to 2-stroke emission problems. Keith Duckworth, Cosworth's founding father, told us that: "In engineering there is an answer to everything, it's just that we're usually too ignorant or too dim to see it." Today Cosworth is developing a small 2-stroke diesel aero-engine; while Lotus is focused on a sophisticated 2-stroke to maximise fuel efficiency with renewable alcohol fuels and petrol!

"Out of history the future is born," and in 1921 Frank Halford and Sir Harry Ricardo delivered impressive results using a 500cc 4-stroke, four-valve Triumph motorcycle. Halford came 2nd at the last meeting at Brooklands; but in 1922 he achieved several easy wins against motorcycles with considerably larger engines. Halford was using an ethanol fuel blend, with a higher octane rating than petrol blends of the 1920s.

Those racing successes led to the launch of 'Shell Racing Spirit' and 'Discol R' fuels which were in fact identical and came from the same source. The immediate effect of those Halford - Ricardo victories was that, very soon, all self-respecting motorcycle riders had their tanks filled with either the Shell or Distillers product. The key to Halford's success was an ethanol based



15 year-old Adam Blacklock beat 34 Hondas on his ethanol-fuelled Cougar Red motorcycle

fuel; which had been developed as a result of a fuel testing programme carried out by Ricardo.

History has a way of repeating itself, and on July 25th this year, Adam Blacklock won his very first GP3 125cc 2-stroke motorcycle race, almost 12 seconds ahead of the nearest competitor; and a minute ahead of most of the field. The race took place at Donington Park; and Adam was riding Cougar Red's 125cc motorcycle against 34 Honda machines. He led the race from the first lap and lapped a few of the slower competitors. Adam's father Kirk said: "He just cruised round at lower rpm than the Honda bikes!" Ethanol is a renewable fuel and it was part of Adam's winning formula. What does ethanol do for exhaust emission? It reduces smoke and it also reduces the hazardous invisible toxins!

We initially selected ethanol as our way to address the exhaust emission problems from 'basic' 2-stroke engines. I was also concerned about the use of synthetic lubricants in engines with 'total loss' lubricating systems. A number of pilots and aircrew have been badly poisoned through inhaling synthetic oil fumes inside pressurised aircraft. We therefore focused on a fuel and lubricant package with the lowest possible toxicity. We expected to improve engine torque, and ethanol was one key factor in Adam's victory.

The fundamental problem with 'basic' 2-stroke engines is that the inlet and exhaust ports are both open during the same part of the cycle so some fuel will invariably flow into the engine's exhaust system. The emission of unburnt fuel - unburnt hydrocarbons is the main problem with 'basic' 2-stroke engines; and petrol contains hundreds of different hydrocarbons. However, the competition 4-stroke is far from clean; and why would 4-stroke road vehicles require expensive catalytic converters?

The 2-stroke exhaust becomes very much cleaner with the use of direct petrol injection; but how do we make such expensive high-tech equipment work at 12,000+ rpm on small 2-stroke engines? Do we really require all of these additional complications and costs when we need to keep the costs of karting and motorsport down!

In competition engines, power and torque are part of the winning formula. We require a high compression ratio and this demands a fuel with a high octane rating to avoid 'spark knock'. Spark knock can soon wreck an engine. But power depends on more than octane rating; power is also related to how much fuel and air we can trap above the piston. Petrol has a low latent heat of evaporation, ethanol's is much higher; and this cools down the fuel-air mixture before compression. Then, those smart 2-stroke exhaust systems complete the supercharging process and up go torque and power. In the 1940s German and British supercharged aero-engines used water-alcohol injection systems to increase take-off power; it's time for karting to learn from aero-engine history!

Raising the octane rating of petrol is a major task for chemical engineering. For decades the petrol industry used tetra-ethyl lead; what an evil way to poison those involved in motorsport and transport! Today, because of its hazardous properties, lead is widely banned and octane rating is increased by the addition of aromatics. Today up to 35% of competition petrol can consist of aromatics. These have a 'hazard index' over one hundred times higher than that of ethanol (*Ref. Table AF5.1 Transport Fuels Technology by Dr. Eric M Goodger*).

Benzene can cause leukaemia, but today benzene is often limited to 1%; however up to 5% benzene has been included in UK's MSA gasoline under international rules! Two men I knew have died from leukaemia and both were exposed to excessive amounts of petrol vapour and aromatics. We must start by protecting younger competition drivers from these petroleum poisons. If 2-strokes end up going too fast on ethanol then we can always save aluminium, energy and costs by using smaller engines!

You will soon appreciate just how clean ethanol burns when you examine a spark plug from an engine which has been using this fuel; and now NGK is sponsoring Cougar Red! Only a twit would put diesel fuel into spark ignition engines; or petrol into compression ignition engines! The 'basic' 2-stroke also has a different operating cycle and it needs a different fuel and lubricant package to deal with its problems and to optimise its performance and capabilities. Lower flame temperatures and lower charge temperatures are also good news for air-cooled engines so we should encourage ethanol powered, air-cooled engines to further reduce the costs of karting!

If certain FIA officials remain opposed to 2-stroke engines on principle, perhaps I should calculate and release data on the emissions from Formula 1 engines together with the emissions from the air transport required for staging a Grand Prix in South Korea! I'm sure the FIA will appreciate receiving this information from Karting magazine, as they established the Environmentally Sustainable Motorsport Commission last year!

So let's encourage all those involved in karting to inhale fewer toxins, to use a renewable fuel, to increase torque and engine durability, while reducing their carbon footprint. Banning the 2-stroke is about as dim as those who have demanded it! The 2-stroke was a British invention and the British used ethanol fuel at Brooklands in 1921. Now we need to encourage renewable fuels, and we should all appreciate that the 2-stroke engine doesn't have one stroke for power and three strokes to wear it out!

believes in the 'simple' 2-stroke engine, clean fuel and protecting the health of competitors

The 'Basic' or Simple 2-Stroke

The simple "Two-stroke engine is not going to be competitive with a four-stroke engine in terms of hydro-carbon emissions. In all other respects, be it specific power, specific bulk, specific weight, manoeuvrability, manufacturing cost, ease of maintenance, durability, fuel consumption, or CO and NO emissions, the simple two-stroke is equal, and in some respects superior to its four-stroke competitor. There may be those who will be surprised to see fuel consumption in that list, but investigation shows that small capacity four-stroke engines are not particularly thermally efficient. The reason is that the friction loss of the valve gear begins to assume considerable proportions as the cylinder size is reduced, and this deteriorates the mechanical efficiency of the engine." (Basic Design of Two-Stroke Engines - Prof. Gordon Blair, Queen's University Belfast)

If we eliminate the toxic hydrocarbons from two-stroke fuel by replacing gasoline with ethanol, then the emissions of unburnt fuel are largely emissions of ethanol which has very low toxicity and is biodegradable. The oxygen in ethanol assists in reducing CO emissions; ethanol's lower flame and charge temperatures help reduce NOx emissions!

BASW

THE BRITISH ASSOCIATION OF SOCIAL WORKERS

SIG STATEMENT ON UK CHIEF MEDICAL OFFICERS' ALCOHOL GUIDANCE & CONSULTATION

BASW Alcohol specialists welcome new government drinking guidance

We welcome the UK Chief Medical Officers' revised guidance on alcohol which is currently out for consultation until the end of March 2016.

Social workers are often in the front line in helping people and families cope with alcohol and other drug problems. We typically work with people who have experienced deprivation and research shows this makes them more vulnerable to harm from alcohol.

We particularly look forward to the outcome of the consultation on this guidance. We hope it will result in clear information that will help social workers to support people affected by problematic alcohol use. Helping people to make informed decisions on how to manage risks in everyday life is a constant challenge for social workers. Social workers, social work educators and employers will welcome all the evidence-based guidance available.

Bridget N. Robb.

Bridget Robb
Chief Executive, BASW

24th February 2016

BASW's expert Special Interest Group (SIG) on Alcohol and other Drugs runs regular conferences and events. The group has produced a range of resources to inform and support social work and social care professionals including five Pocket Guides https://www.basw.co.uk/pocket-guides/ .
For further comment contact [redacted]
Alcohol and other Drugs on [redacted]

[redacted]

From: [redacted]
Sent: 28 February 2016 19:02
To: UK CMO Guidelines Review
Subject: Alcohol advice

Dear Team

I am a GP of 36 years' experience and am somewhat dismayed by Sally Davies' recent pronouncement on alcohol intake.

This does not strike me as rational or reasonable. It makes no attempt to differentiate between different alcoholic drinks and denigrates other studies which have indicated the benefits of red wine as opposed to spirits and beer (e.g. oral and oesophageal malignancy is a recognised risk in heavy spirit drinkers).

Men can metabolise alcohol at a much faster rate than women, a large glass of 13% wine (3 units) will result in a blood alcohol level of 89 in women but only 42 for men. Logically one would suppose that higher BAL's are more harmful, so why limit males to the same as females and to what many of my male patients see as a risible alcohol recommendation and therefore will ignore it?

The per capita annual consumption of alcohol in the UK is 10.3 litres per year (1030 units) amounting to a weekly consumption of 19.8 units for every man, women and teenager over 15 years. Given that many do not drink and another group drink moderately at 30 units or less per week, this leaves a hardened, heavy-drinking minority. These are the people I worry about in my surgery and have indeed spent many hours of my life trying to wean them off their dangerous habit and coping with the consequences, which are what A&E and liver unit staff see all too often.

Sally Davies is focusing on the wrong issue as to what is "safe drinking" (probably nil, but this also applies to sugar, inactivity, driving cars, cycling, living in our polluted cities and so on) and not concentrating on the real problem of alcohol.

Yours sincerely,

[redacted]

[redacted]

From: [redacted]
Sent: 09 March 2016 11:24
To: UK CMO Guidelines Review
Subject: Re: Alcohol Guidelines - Feedback

I am re-sending my email as I noticed a couple of typos. Please accept my apologies.

From: [redacted]
To: "UKCMOGuidelinesReview@dh.gsi.gov.uk" <UKCMOGuidelinesReview@dh.gsi.gov.uk>
Sent: Wednesday, March 9, 2016 11:05 AM
Subject: Alcohol Guidelines - Feedback

For years we have been told that women's bodies can tolerate less alcohol than men's. Below is an extract from "Drinking and You":

"Women's bodies are generally smaller and have less body water, so alcohol concentrations rise more quickly. So, if a woman weighing 60 kgs drinks a double vodka then a man of the same size will need to drink a triple in order to reach the same blood alcohol level. There is also some evidence that women break down alcohol slightly differently. The enzyme ADH breaks down alcohol in the liver and in the lining of the stomach; and women have less of it, so alcohol is broken down more slowly."

If this is still the case then it makes no sense for the guidelines for men and women to be the same. If previously the guidelines were 21 units for women and 14 units for men, and it has been determined that 14 units is a sensible limit for women, then it should remain at 21 units for men. If on the other hand it has been decided that the sensible limit for men should now be 14 units, then it should be reduced to 9 units for women. Anything else would indicate that these new limits contradict previous advice and are probably meaningless.

Also, whenever the harm done by alcohol is illustrated, the problems associated with people who drink a couple of bottles of wine or even a bottle of vodka a day, which represent well over 100 units a week, are cited. If alcohol really is as dangerous and toxic as suggested by these new limits, some evidence should be presented to the general public showing the dangers represented by, say, 20-30 units a week. Otherwise these new levels are so low, they will be ignored by the heavy drinkers who are the ones who really need to heed good advice.

Regards

Prof. Sally Davies
Department of Health

22 March 2016

What is a unit of alcohol?

Dear Prof. Davies

I am writing in response to your public consultation on 'Health risks from alcohol: new guidelines'. However, I wish to comment on an issue that is not covered by the consultation questions, which is why I am writing a separate letter.

This is the very basic issue of explaining to the public what a unit of alcohol is. The present consultation document has a page covering this, but I hope you won't mind if I make some suggestions that I believe would make this easier for the public to understand.

The explanation in the consultation document (on its last page) is as follows

> A unit is a measure of the pure alcohol in a drink, that is, the amount of alcohol that would be left if other substances were removed. A unit is 10ml, or one hundredth of a litre of pure alcohol.
>
> Units are calculated by reference to:
> - the amount or volume of the drink
> - the alcoholic strength (Alcohol by Volume, or ABV)
>
> So, a one litre bottle of whisky at 40% ABV has 400ml, or 40 units of alcohol [1000ml x 40% = 400ml or 40 units].

This explanation risks confusing the reader because it does not sufficiently clearly make the simple point that a unit is 1% of a litre of alcohol. Indeed it goes out of its way to avoid making this connection by using the alternative description 'one-hundredth' in the first sentence. And the example at the end includes 8 numbers, and 4 scales of measurement (%, litre, ml, unit of alcohol) in one sentence, to set out a calculation which essentially consists of multiplying by 1 !

The other problem with the explanation is that in trying to be comprehensive and precise it spells things out that are better left to the common sense of the reader. This applies to the first and third sentences (the latter being the one with bullet points).

I suggest that something like the following would be better understood by the general public:

> A unit of alcohol is 10 millilitres (ml), which is exactly 1% of a litre.
>
> Therefore the % ABV for a drink tells you directly how many units are in 1 litre of that drink.
>
> So, a one litre bottle of whisky at 40% ABV contains exactly 40 units.
>
> *Note: ABV stands for 'alcohol by volume"; by law the % ABV and volume in ml must be displayed for any alcohol on public sale.*

The following paragraph on beer starts with the logically incorrect and confusing statement that 'A unit is roughly half a pint of beer ...'. This whole paragraph duplicates the excellent graphics and could be omitted.

Communications Service

.org.uk

Alcohol Policy Team
6th Floor
Department of Health
Wellington House
133 -155 Waterloo Road
SE1 8UG

Re: Health risks from alcohol: new guidelines Consultation

On behalf of The Salvation Army I wish to express our support for the new guidelines on the health risks from alcohol.

The Salvation Army is a Christian Church and charity, which seeks to serve a wide range of clients from a holistic perspective. It has a long history of supporting people with alcohol problems, and members of The Salvation Army refrain from the use of alcohol in their own lives, standing in solidarity with those who suffer from its harm. We currently offers a range of addiction services, including residential addiction treatment services, harm services within Lifehouses (residential homelessness hostels) and community based support. In addition we work closely with addiction referral services to ensure that those we seek to serve can access the services they need.

The Salvation Army welcomes the updating of the guidelines on the health risks from alcohol based on the latest scientific evidence. We particularly welcome the recognition of a wider range of health harms than previously, including the contribution of alcohol misuse to a range of cancers. In addition, the recognition of different, but ultimately equivalent, risk for men and women enables the greater clarity of the same weekly guideline for men and women. The Salvation Army also welcomes the explanation that no level of regular drinking can be considered as completely safe. The new guidelines offer both clarity and consistency of message and recognition that 'problem drinkers' are not essentially different from the population as a whole.

We would be very interested in learning more about the plans for public education and dissemination of the guidelines in different contexts, including in schools and in alcohol outlets.

Thank you for the opportunity to contribute to this important subject.

Yours sincerely

[redacted]

From: [redacted]
Sent: 24 March 2016 16:17
To: UK CMO Guidelines Review
Subject: Opinion on the new alcohol consumption guidelines

Dear Committee,
Having looked at the new guidelines I see no need to change the existing ones. Men tend to have larger bodies and more water content than women, so can take alcohol better, as reflected in the current recommendations.
I would also strongly object to any decrease in levels for driving, which would kill much social life, as well as pubs and restaurants. Tiredness is a big hazard in driving, but difficult to legislate for.
Yours truly,

[redacted]

[redacted]

From: [redacted]
Sent: 26 March 2016 22:20
To: UK CMO Guidelines Review
Subject: Consultation to Health risks from alcohol: new guidelines
Attachments: ARPS References 2-16.docx

Alcohol Policy Team

6th Floor
Department of Health
Wellington House
133 -155 Waterloo Road
SE1 8UG

Dear Alcohol Policy Team,

It maybe inappropriate for an American Group to respond to the recently release draft alcohol guidelines. However with the publication of the statistical bulletin on adult drinking habits in Great Britain 2014, we re-examined all of the guideline materials and the accompanying recommendations for dealing with this important problem.

We are particularly concerned about the lack of emphasis on the problem in older persons and are enclosing a bibliography of our publications in the field. These deal with screening, education of older persons in the use of alcohol and training of health professionals at all levels in dealing with this important public health problem

As a background to our concern are the following observations.

Over 40% of U.S. adults 65 to74 years of age and 30% of adults 75 years and older are current drinkers, with about 14.5% consuming alcohol in excess of the National Institute on Alcohol Abuse and Alcoholism's (NIAAA) recommended limits. Excessive drinking is only part of the problem, however. Older adults can experience unfavorable health effects even at relatively low consumption levels because of age-related physiological changes and alcohol's potentially adverse interactions with chronic illness, increased medication-use and diminishing functional status. When health and drinking patterns are taken into account, about half of all drinkers 65 years of age or older may be at risk for experiencing alcohol-related harm even if they drink within recommended limits leading to increased health services use and higher medical costs. Alcohol is implicated in many medical problems common in older adults including hypertension, depression breast cancer, and falls and fractures. More than 60% of older adults

regularly use medications. From 2011-2012, people 65 and older increased their use of five or more prescription drugs from 24% to 39%. Many of these medications, such as nonsteroidal anti-inflammatory drugs (NSAIDs), anticoagulants, and sedatives are commonly used by older people, and they are known to have the potential to interact adversely with alcohol.

Although the quantity and frequency of alcohol use tends to decline with age, consumption now appears to be declining more slowly than in previous generations. Baby-boomers, some of whom are approaching 70 years, have patterns of substance use that differ from previous cohorts', and this has resulted in combined alcohol and recreational drug use and increased risk for emergency department use and hospitalizations. According to the National Institute on Aging, drinking even a small amount can increase the risk of falls, household accidents, and car crashes; also, alcohol is a factor in 30 percent of suicides, 40 percent of crashes and burns, 50 percent of drownings and homicides, and 60 percent of falls. CDC statistics show that binge drinking (more than 4 or 5 drinks at one sitting), which greatly increases the chances of injury to self or others due to car crashes, violence, and suicide, is a serious problem in older adults who drink less intensely per occasion than their younger counterparts but binge more frequently than any other age group. According to the CDC, drinking too much contributes to over 54 different injuries and diseases(including car crashes and violence), and the chance of getting sick and dying from alcohol problems increases significantly for those who binge drink more often. Some older adults begin drinking later in life for reasons as diverse as self-medicating for pain and coping with loneliness and loss. Others begin to drink as result of new opportunities provided by increased leisure time. Previous research has found that without intervention, as many as 18% of current non-problem drinkers may incur risks over a 12-month period. Considering that about 10,000 people will turn 65 every day for the next decade, and that the number of older adults will increase to more than 20% of the U.S. population by 2030, the number of older people with alcohol-related risks and problems will increase even if drinking prevalence remains constant.

We have some additional comments on the alcohol guidelines review text executive summary.

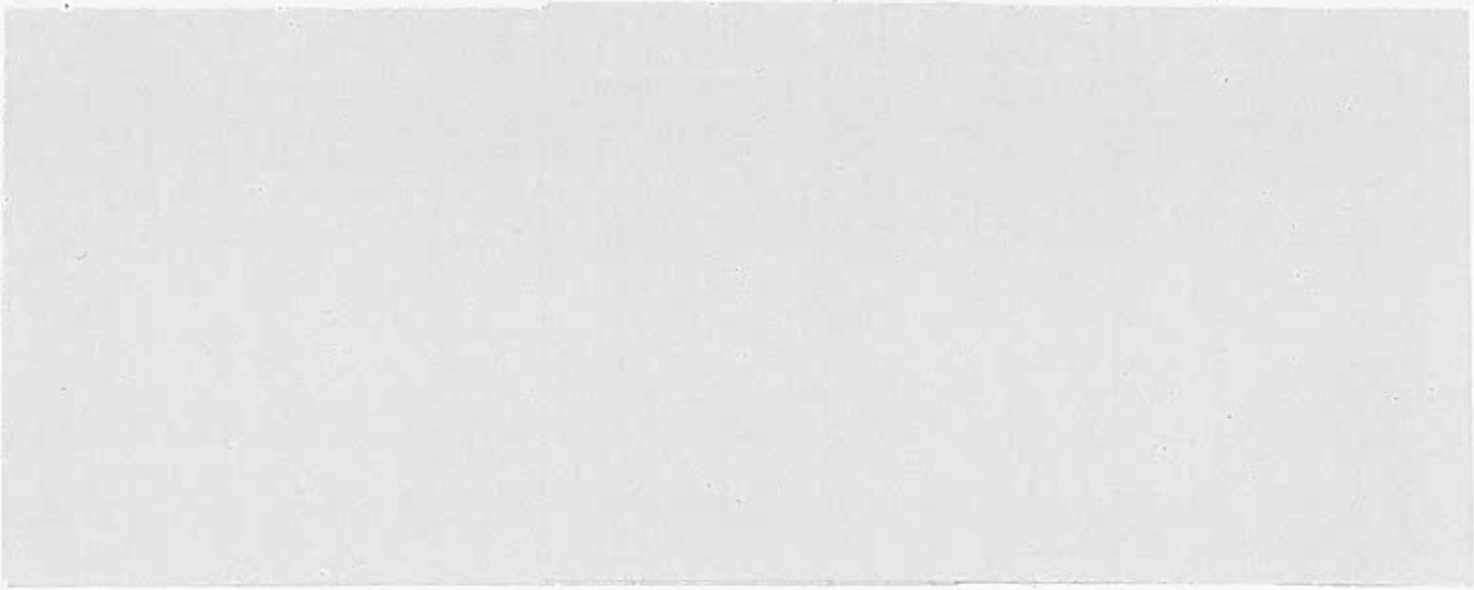
1) On page 3, it is stated that there is no justification to use age in the guidelines with no evidence cited for this opinion; yet

2) On page 6 there is mention of fall risk in older people;

3) On page 7 the interaction of alcohol and medication is mentioned in the report from the Guidelines Development Group there is a scattering of statements addressing the problems in older persons with chronic conditions and increased medication use which addresses some of our concerns, but they would be lost to the uninformed reader. I refer to statements on pages 16, 20, 23, 30, 31, 33. Our view is that the alcohol problem in older persons solution lies with the primary health care system and an appropriately educated population.

We hope these comments will be useful and are prepared to respond to any questions which you may have.

Regards,



P.S. We would also call your attention to a relatively recent publication. (Qato DM, Manzoor BS, Lee TA. Drug-Alcohol Interactions in Older U.S. Adults. JAm Geriatr Soc. 63(11):2324-31, 2015.)

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[redacted]

From: [redacted]
Sent: 30 March 2016 16:57
To: UK CMO Guidelines Review
Subject: response to consultation

The old guidelines were regarded, by me and others, as strict. I and others did not adhere to them. Nonetheless they influenced my and others' behaviour. They provided a strict but recognisable benchmark against which to measure and moderate one's alcohol consumption.

The proposed new guidelines are ridiculous. They are so tight as to be unrealistic. They will not influence my behaviour nor, I suggest, that of others. The only effect they might have is to bring into disrepute the whole concept of government health guidelines. In the case of alcohol, they remove guidelines which had a moderating effect and replace them with guidelines widely regarded as laughable, without support, and therefore ineffective.

Indeed, these new guidelines appear to be based on no new medical evidence. They appear to be based on an arbitrary decision to alter the level of acceptable risk.

[redacted]

Alcohol Policy Team
6th Floor
Department of Health
Wellington House
133 -155 Waterloo Road
SE1 8UG

cc. Jane Ellison MP, Parliamentary Under-Secretary of State for Public Health
Mark Davies, Department of Health

29th March 2016

Dear Sir,

UK Chief Medical Officers' Alcohol Guidelines Review

I write on behalf of SIBA, the Society of Independent Brewers, which represents around 850 British independent brewing businesses.

In addition to this letter, SIBA has responded to the public consultation on the guidelines via the consultation questionnaire. The purpose of this letter is to expand on the views expressed in our response to the consultation and make further points, since it is our view that the scope of the consultation is far too restrictive to enable legitimate businesses and individuals to raise their concerns about the process behind and the outcomes of the review.

As our members are responsible producers of alcohol, we are disappointed that the review process failed to engage with the UK brewing industry at any level or indeed with consumers. This has not led to a balanced, transparent and reasonable process and the lack of transparency behind the review process and its consideration of evidence is of serious concern to our members. In particular, the failure to publish details of the modelling used largely in the formulation of the guidelines is unacceptable.

SIBA accepts fully the need for clear guidance on how people can enjoy alcohol responsibly, sensibly and safely. We therefore support the use of guidelines which are useful, clear and practical and which enable consumers to make informed choices about their drinking. However, we share the concerns surrounding the new guidelines and the process behind them which have been raised by many commentators, international experts, politicians and industry groups in the national press since January.

We are concerned that the guidelines will not be regarded as credible by the majority of consumers, thereby undermining attempts to provide useful health advice in other areas. This is compounded by our view that the process of the review was unsatisfactory and focused on the use of selective evidence, sidelining or disregarding other established scientific evidence which is widely accepted across the World. It is a serious problem that new guidelines appear to have been constructed and presented to Government which do not accurately reflect this body of evidence.

We are deeply concerned by claims that there is 'no safe level' of alcohol consumption. We believe this statement is inaccurate and misleading. To suggest there is no safe level of consumption ignores the huge body of international epidemiological evidence to the contrary which provides evidence of the health benefits of moderate drinking. It has also been challenged by the Royal Statistical Society as failing to represent the evidence base.

The New Guidelines

- It is of concern that the guidelines have been changed to such a large extent when there is clear evidence that the previous approach was proving to be effective. The majority of UK consumers (70%), according to the Office of National Statistics, drink sensibly in moderation

and within the previous guidelines. The percentage of those drinking within the guidelines has been increasing since 2007. This demonstrates that consumers will respond to sensible, balanced and well-evidenced health advice which provides useful information to enable them to make informed choices. This has had a positive effect in that total consumption of alcohol has fallen in the UK by 19% since 2004.

- The removal of daily unit guidelines, with which people have become accustomed and their replacement with weekly guidelines is likely to cause confusion for many people. Since some consumers will only drink alcohol once or twice a week, this may lead to the conclusion that they can increase their consumption on each occasion without exceeding the new weekly guidelines.
- The introduction of the same levels for men and women is flawed and unlikely to be regarded as credible by many male drinkers who have previously consumed alcohol at levels between 14 and 21 units per week. We believe that several million people are in this group and many will be concerned that, having paid heed to previous Government advice, they might now be regarded as 'problem' drinkers or that their drinking may be unsafe.
- In this respect the new guidelines are seriously out of line with the approach taken in thirty other countries which set different guidelines for men and women based on the recognition that men's and women's bodies deal with alcohol differently due to size, weight, water content and fat levels.
- Furthermore, the new guidelines suggest that women can now safely drink as much as men, which is generally not the case. There is widespread recognition that women cannot generally tolerate as much alcohol as men.
- It seems that the CMO's conclusion that similar guidelines for men and women should be introduced is based largely on an assessment, for men, of risk of acute harms such as accidents or injuries while the risks for women are based more on longer-term effects. It is highly questionable for different risks to be compared in this way and is very confusing for consumers seeking to make well-informed decisions about their alcohol consumption. There is no transparency behind how the modeling was used to reach this conclusion.
- Recent reviews of guidelines in Canada and the USA, which would have considered the same evidence as the UK review, have maintained different levels for men and women. In Canada, the UK equivalent (since the unit measurements are unfortunately not internationally aligned) is 17 units for women and 25 units for men. In the US it is 12 units for women and 24 units for men. This draws the consideration of evidence and the use of modeling into question.
- In the US it is recognised that moderate consumption 'is associated with reduced risk of all-cause mortality' and the National Institute of Alcohol Abuse and Addiction has estimated that 26,000 deaths in the US were avoided in 2005 alone because of the benefits associated with moderate consumption.

Cancer and mortality from all causes

- We are concerned that the review has not considered the full body of evidence on the links between alcohol consumption and cancer and has therefore not presented an accurate picture to consumers.
- The guidelines and comments from the CMO in the press have suggested that the risk of developing cancers increases with any amount we drink. However, the evidence from around the world suggests that the links between alcohol and cancer are not this simple. Indeed, evidence suggests that alcohol has different impacts on cancers and can have either no effect or a protective effect for some. The link between alcohol consumption and cancer has been overstated and simplified to an extent that it is not credible or accurate. It shows no consideration of lifestyle, age and existing health problems. Consumers are therefore not being provided with balanced and accurate information to enable them to make their own decisions about their alcohol use.
- It is a serious weakness of the new guidelines that they do not acknowledge the overwhelming evidence that total mortality for moderate drinkers is lower than for non – drinkers and that moderate consumption can have health benefits and protective effects,

most notably for cardiovascular disease, cognitive decline and some cancers. The references behind this ppint are detailed and numerous and we would be happy to provide examples.

- The review has paid little attention to the wellbeing aspects associated with the sensible and sociable enjoyment of alcohol, a benefit that the majority of consumers are likely to recognise. The report from the Guidelines group states that *'we recognise that many people obtain benefits from drinking alcohol, including social pleasure'*. It would provide a more balanced approach if this important point was properly considered and reflected in the guidelines.

No safe level of regular drinking

- Advice related to the guidelines states that *'there is no level of regular drinking that can be considered as completely safe'*. It is our view that this is misleading and cannot be regarded as useful information for consumers without being presented alongside other daily risks in life. This view is flawed in two ways when considered as a means of providing advice to people. Firstly, it is meaningless when considered in isolation. It is like saying 'the best way to avoid a road traffic accident is to stay off the roads', and secondly, there is a wide body of evidence related to various cancers which dispute the clarity and simplicity of the suggested causal link between alcohol consumption and cancer.
- The claim that there is no safe level of alcohol consumption is a major change in the stance of the alcohol guidelines, which may lead to moderate and sensible drinkers with a balanced and healthy lifestyle stopping drinking altogether without the evidence that this is necessary or would be beneficial to their health. This core message of the new guidelines is irresponsible given the widely accepted body of evidence that alcohol can be enjoyed in moderation as part of a healthy lifestyle.
- The claim also suggests that the overall objective of the guidelines is to encourage consumers not to drink at all. This is contrary to the international consensus on the benefits of moderate alcohol consumption and threatens the credibility of other public health advice
- It is of serious concern that this claim, according to the Royal Statistical Society, this position does not accurately reflect the scientific evidence provided to the review. The RSS have raised a number of serious concerns in how evidence has not been properly considered. This view has been reinforced by others including Dr Augusto Di Castelnouvo who commented in the media that the recommendation was misleading as low to moderate alcohol consumption significantly reduces the risk of cardiovascular disease.
- A particular risk of the claim that there is 'no safe level' of alcohol consumption is that it lacks common sense and will undermine this and other health advice for consumers. It is unfathomable that risks of disease can be attached in isolation to alcohol consumption without putting them in the context of other risks associated with being alive. How, for example, should consumers consider the low risks associated with drinking less than the guidelines (thereby giving a less than 1% chance of dying from an alcohol-related condition) to the other things they do which are likely to be more risky over the course of a lifetime. It is a major failing of the guidelines to advise consumers appropriately, meaningfully and usefully on this point. It is not possible for people to make informed choices based on this aspect of the guidelines.

Concerns about the review process

- We are very concerned by references that the intention of the guidelines may not just be to allow consumers to make informed choices but also to influence future government policy related to alcohol. Public health advice should have as its aim the provision of accurate and useful information in the interests of the public. It should not be used for setting policy.
- Reports in the media based on comments from one member of the Behavioural Expert Group, Dr. Theresa Marteau stated that the guidelines *'are unlikely to have a direct impact of drinking. But they may shift public discourse on alcohol and the policies that can reduce our consumption.'* It is fair to conclude from this viewpoint that one objective of the guidelines is

to influence Government policy which is an entirely different objective to enabling consumers to make informed choices.

- A similar viewpoint appears in the Minutes of the CMO's advisory group. *'while guidelines might have limited influence on behaviour, they could be influential as a basis for government policies.'*
- We are disappointed that suitable representatives of the industry (an industry which has taken many steps via the responsibility deal and in other ways to promote safe and sensible drinking) were not included or consulted in the review process, or invited to join the advisory group. Indeed, several advisors to the CMO have been involved in campaigning for policy action on alcohol and are members of the Institute of Alcohol Studies, which is related to the temperance movement.

SIBA believes the new guidelines are flawed and based on a poor and selective use of evidence. The modeling used to arrive at the guidelines is unclear and is not transparent and therefore the guidelines will lack credibility and legitimacy with consumers and industry, who have not been consulted appropriately.

SIBA is therefore calling for:

1. the consultation to be extended and expanded to enable interested parties and consumers to give their views on the guidelines and the scientific evidence behind them with the objective of revising the guidelines to ensure they are not only clear, but are accurate and useful having been based on a full and transparent assessment of the evidence.

2. In the meantime and to avoid undermining this consultation process, the guidelines should be withdrawn, or at least be regarded as provisional and claims that there is 'no safe level' of alcohol consumption should be rescinded.

3. That a new independent group of experts should be established to reconsider the guidelines and the evidence and the feedback provided by this consultation. The consultation responses should not be considered by the original group alone.

If you would like to discuss our views further please do not hesitate to contact me.

Yours sincerely

[redacted]

From: [redacted]
Sent: 30 March 2016 16:57
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[redacted]

New CMO Alcohol Guidelines Consultation

Response from [redacted], Director of Public Health for Stockport

31st March 2016

The consultation predominantly asked whether the guidelines are clear.

They are clear. That is my answer to all the questions where this is asked.

However to me that isn't the issue. The guidelines are clear and I accept that they are scientifically based (although I do think they are overconfident in rejecting the evidence of benefit and I prefer the statement by the American Heart Association that the evidence of benefit has been weakened).

The problem is that the guidelines give warnings about a very small risk and advise conduct that many people will find hard, whilst not reinforcing this with guidance about how to avoid the much more serious risks that will arise with heavier drinking.

At the time of the Paddington rail crash, caused by nobody having done anything about trains repeatedly passing a signal at danger, the railway industry was engaged in intense work on discussing how to stop people falling off the edge of railway platforms. This is what happens when a sense of proportion is lost.

I have previously exchanged correspondence with CMO about this issue and there is little point in repeating it here when the subject of the consultation assumes the continuation of the guidelines.

I believe that the duty of public health doctors is not only to give scientific advice (although they must do so and the CMO is right to do so) but also to consider how to help people move towards a healthier lifestyle. My concern with this guidance is that whilst it discharges the first of these duties it probably undermines the second.

Having regard to this issue, and also to the need to disagree with the guidelines to no greater extent than is necessary so as to avoid confusion, the following is the guidance that I am intending to give to the people of Stockport.

Drinking causes cancer and liver disease. A few drinks a week cause little harm and may perhaps be beneficial. More than 14 units (seven typical drinks) a week increases the risk and eliminates any benefit. Think very carefully before having three or more drinks in a day and certainly don't do it regularly or it would definitely be harmful. Don't drink and drive and don't assume you will be OK the next morning - after drinking allow one hour for every unit that you have drunk before driving, using dangerous machinery or performing skilled tasks. Have several drink-free days each week. Don't drink in pregnancy. Beware of drinks that are stronger or larger than the 2 units a drink that this advice assumes.

This is a change from the advice that I have for a long time given to the people of Stockport in relation to alcohol. The first three sentences of the above would in the past have been replaced by a single sentence.

"The first drink of the day may be beneficial, the second drink eliminates any benefit of the first, and the third and subsequent drinks are harmful".

There is a danger that risk-averse advice detracts from more important advice and even that is discredits the whole concept of lifestyle advice. I think public health needs to be about "yes" not "no" – about the joys and benefits of a healthy lifestyle not a list of obsessive prohibitions. I am not convinced any useful purpose is served by advising people that it is dangerous to drop into the pub and have a pint.This is not compatible with the current emphasis in my formulation of the dangers of the third and subsequent drinks. I think it is a mistake, given the extent and seriousness of the alcohol problem, and the very low likelihood that a 14 unit limit will be observed. We need to give especial emphasis to the serious risks of the third and subsequent drink.

I have always advised stopping after 14 units ("the second drink of the day eliminates the benefit of the first") but I have emphasised and intend to continue emphasising the dangers of the third and subsequent drinks.

"Have several drink-free days each week" is less specific than, but not incompatible with, the recommendation for 3 or 4 drink free days a week.

The case for spreading the weekly limit over most days of the week is that if there is a metabolic benefit from small amounts of drinking it is best to experience it most of the time, that you drink less on each day and that it promotes patterns of drinking like having a glass of wine with a meal rather than binge drinking which is the biggest problem.

The case against is that it is easy, if drinking becomes routine, to let it gradually increase.

The case for a drink free day is that it allows detoxification and it ensures that drinking does not become routine. I am not aware of a case against.

I have a concern about recommending 3 or 4 drink free days a week that it advises against some patterns of drinking that I think are particularly healthy like having one glass of wine with each evening meal.

Recently clinical opinion has been firming up into believing that two drink-free days a week are necessary.

I can see how drinking regularly may gradually deteriorate into drinking excessively but I can also see how drinking irregularly might deteriorate into binge-drinking.

I don't intend in future to recommend "drink most days" now that the evidence of benefit is much weaker. I intend to continue recommending "don't drink every day". I don't intend at present to recommend 3 or 4 drink free days a week but do intend to recommend "several drink free days a week" which is compatible with two but doesn't clearly conflict with the CMO guidance of 3 or 4.

The purpose of explaining why this is what I intend to do is to point out that, now the guidelines have been finalised, there is a real question of how to use them in practice in the process of reducing excessive alcohol use. I am not saying that the solutions found in this paper are the only solutions. I certainly believe however that for the consultation not to address that question is to ignore the most significant part of the process.

CLUB SODA
change your drinking

Response: Health risks from alcohol: new guidelines

A bit about Club Soda (joinclubsoda.co.uk)

Club Soda is a blended online and real world support service for people who want to change their drinking. We let individuals undertake a self-guided journey, guiding them with proven behaviour change techniques to a healthier lifestyle. A bit like Weight Watchers but with booze.

At Club Soda, individuals set their own goals: to cut down, stop for a bit, quit, or stick. We bring everything they need into one place:

- Tools to set goals and monitor progress
- Curated content for help and advice
- A community of people online sharing advice and tips
- Connecting with helpful experts and distractions
- Real world social events (often in pubs), workshops and online programmes to boost their chances of success
- Reassurance to access clinical services and other help if needed.

We have:

- Over 3,000 members - many updating their progress weekly using our email prompts and online tools
- A programme of supportive workshops and events in London
- Two online email and content based programmes - "The MOB" and "8 weeks to change your drinking"
- Member-led socials and events.

We have also completed a year-long study into behaviour change with pubs and bars, funded by Hackney Council called Nudging Pubs. We have further funding to build a product for licensed venues to promote sensible drinking. You can see more about this work here.

Response to the guidelines

Our members:

In general guidelines mean little to our members. They already know they are drinking at higher levels than the guidelines, and are more concerned about how alcohol is affecting their lives. They have often tried to moderate or quit. Characteristics of our members:

- Men and women who are working and mostly successfully holding down full time work and/or family commitments
- Aged 35 - 75
- Non-dependent habitual drinkers who are drinking in the highest quartile of AUDIT scores
- Comfortable using email and basic online technology
- Resistant to putting labels on their alcohol use, and are often giving up alcohol for a specified time, or attempting to learn techniques to moderate
- Do not like the language of recovery or words like "alcoholic".

Many of our members are in the **5 million** people in the UK who, based on Drinkaware figures, have already tried to cut down and still want to change their drinking[1]. A majority of them are habitual drinkers, trying to disrupt their 'reach for the bottle' autopilot, or resist temptation on a night out.

We feel that drinking guidelines have little impact on these people, as they already know they are drinking above the guidelines and struggle with moderation. There are few services for this group of drinkers, and much more could be done to support them.

Taking active steps to support those who already want to help themselves could help reduce dangerous drinking quicker. It also does not have to be expensive. Below are some enabling steps to consider.

1. **Support tribes**. Whether your goal is to cut down or to quit drinking, there is no one solution that fits everyone. Our personal drinking identities are many and varied, which means that the places and people we look to for support are just as diverse. Be it women, men, queer only, online, real world, bootcamps, workshops, 12 step, or healthy lifestyle approaches - finding a cheerleading team who share your view of how to change your drinking is as important as the decision about who you go to the pub with.

[1] Drinkaware Monitor 2014 - Page 49. 34% of drinkers have said they have tried to cut back, 41% of those say they would still like to reduce their consumption. This figure is based on the 87% of the drinking population that Drinkaware use.

2. **Help us help ourselves.** Not every problem has to be solved through ongoing revenue funding from the Government. Most Club Soda members are working, they pay for health insurance and gym memberships, and they are happy to pay for help to change their drinking habits too. But finding the right services, professionals, and peer support is hard. There is nowhere to discuss what worked for others and what was useful. We need to blur the lines between public and private services, and signpost people to the right support for them. There is no online marketplace for services and distractions that could support people to change their drinking (we have made various bids for this work and have a proposal). **Seed funding new start-ups** in this space would create a mixed market place that can support different people in different ways.

3. **Fund something better than Drinkline.** It is worse than using Google to find help. It can only tell you about council services, and closes at 8pm. The budget to promote it has also been cut. When a majority of problem drinkers are working people, the solution to finding help and support in 2016 needs to go beyond a poorly designed phone line service.

4. **Alcohol is a big part of our diet.** For many people their alcohol intake is the biggest single factor affecting the food they put in their mouths. Losing weight and controlling diabetes are two common reasons people join Club Soda, but public health treats alcohol issues as alcoholism, and not as part of our diet when it comes to funding innovation. It needs to be seen as both, and factored into diet and healthy living initiatives.

5. **Take VAT off and don't apply the sugar tax to soft drinks in pubs and bars.** Yes we know this flies in the face of the fight against sugar, but it is a good example of the dangers of a blanket approach to health behaviour change. A big barrier for people to change their drinking is the fact that they may have to forgo their social life. Better and more varied non-alcoholic drink choices in pubs and bars would give customers a better chance of switching to an alternative they will actually enjoy rather than endure. But at the minute a bottled soda (which is already lower in sugar than traditional soft drinks) is nudging dangerously close to being the same price as a pint of beer. If you slap on an extra sugar tax, then why would anyone bother?

   Our work with pubs and bars in Hackney shows that if you give pubs a financial incentive to serve something better they will. Pubs operate on tight margins - and they create jobs. They are sociable places - part of the solution, not the problem. If you give customers permission to not drink

alcohol by providing something better than a lime and soda, they will switch.

With thanks

Club Soda
joinclubsoda.co.uk
@joinclubsoda

nudgingpubs.co.uk

[redacted]

From: [redacted]
Sent: 31 March 2016 19:57
To: UK CMO Guidelines Review
Cc: [redacted]

Subject: Health risks from alcohol: new guidelines

The BSG liver section would like to add the following comments:

Alcohol guidelines review BSG LIVER section

This is a sensible and well thought out guideline and the Liver section of the BSG would certainly commend the committee for their hard work.

The general public (and not infrequently the health care professionals) struggle to calculate and accurately assess units of alcohol. The overview is helpful, so it may be useful to add the recommendations in terms of standard drinks i.e. 14 units as a bottle plus a 1/3rd wine or 7 pints of standard beer – this will help with patients becoming familiar with the terminology of units.

Terminology and nuance can sometimes risk shrouding the main message. Hence phrases such as "*you are safest not to drink regularly more than 14 units of alcohol per week*" might be best replaced with a more direct phrase such as: "Don't drink more than 14 units per week". The phrase: "*recommend that it is best, if you do drink as much as 14 units per week, to spread this evenly over 3 days or more. If you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and from accidents and injuries*" Again the language here is a bit ambiguous. What is the definition of a heavy drinking session? - may be better to specify "No More Than 4 units on one occasion (and then add in a 'standard drink reference such as ~2pints beer, 1.5 glasses wine etc)". In the same vein, it is acknowledged that a significant percentage of the population drink on Friday and Saturday night only – hence the advice might be enhanced by explicitly stating "not to drink 7 units on both days"

There were no references to the known co-factor of obesity/overweight to risk of alcohol related liver disease. The guideline should point out that whilst data is difficult to collect on this there are very real concerns of "pouring petrol on the fire", and that the 14unit/week might actually be too much in obese/overweight patients. Clearly the main message of this guideline relates to alcohol and mentioning obesity might be too many 'causes' to address.

The Tables 1 and 13 are not well annotated and need some further explanation. Figure 13 needs clearer colours in picture (too ambiguous). Also on both Fig 12 and 13 - the black dash line needs identifying and annotating.

Para 82 states: "*There is therefore good evidence of risks from occasional, single episodes of drinking and that such risk increases with amounts consumed, particularly above around 5-7 units.*" Translate this into volumes of wine/beer etc as above.

The paragraph entitled *Equity of Health Information with Alcohol Promotion* : would benefit from a clearer recommendation on limiting advertising etc if that is what is believed by the committee after completion of the research. Otherwise it risks endorsing the opposite.

Finally, there is no mention of Minimum Unit Price and the known correlation between price and mortality from alcohol.

MRC Integrative Epidemiology Unit

University of BRISTOL

CLAHRC West
Collaboration for Leadership in Applied Health Research and Care West

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To [redacted]
[redacted] Department of Health

Re: The effects of light alcohol intake in pregnancy: A systematic review of the evidence

Attached is a draft manuscript detailing our work which systematically reviews the evidence regarding the effects of drinking lightly during pregnancy – a collaboration between the MRC funded Integrative Epidemiology Unit and the NIHR funded CLAHRC West at the University of Bristol. This work has not yet been published - it is likely to be submitted for publication within the next few weeks. However, given that the public consultation about the new guidelines is drawing to a close, and the relevance of our work which we feel may be useful, we attach the report in draft format.

Our systematic review and meta-analysis is unique in that we specifically address the issue of drinking up to 32g per week, the equivalent of two drinks, twice a week, a "permissible" quantity according to previous UK guidelines. We set out to include high quality evidence and therefore decided to include prospective observational studies and alternative study designs such as quasi-experiments and Mendelian randomization studies that yield more accurate results than observational epidemiological studies.

In brief, we found very little relevant evidence as only very few studies reported on this specific level of alcohol intake. The few observational studies that are available do not demonstrate harmful effects of light alcohol intake in pregnancy on a wide range of pregnancy and offspring outcomes. We also identified two Mendelian randomization analyses based on the same UK cohort study. In these studies, researchers examined the association between genetic variants that are known to be associated with fetal alcohol exposure (as they affect alcohol metabolism in the fetus, mother or both) and offspring cognitive outcomes. These two UK reports suggest that higher maternal alcohol intake is associated with lower school results and that babies with different alcohol clearing abilities (i.e. metabolic rates) show differences in IQ. Whilst these two studies did not address light alcohol intake per se, the study population consumed relatively little alcohol. Therefore, these studies suggest that even light alcohol intake in pregnancy might affect offspring outcomes.

We hope that this report is of use in the process of assembling new guidelines to minimise the risks associated with drinking alcohol. Please let us know whether we can be of further assistance.

Yours,

Balance - The North East Alcohol Office's response to the Chief Medical Officer's Alcohol Guidelines Review 2016

Balance, The North East Alcohol Office welcomes the opportunity to comment on the clarity and practicality of the new alcohol guidelines. Balance, with partners in the North East, work to encourage people to reduce their consumption and reduce the impact that alcohol is having in our region. We do this by; Educating and informing; Sharing best practice and Calling on Government for change – asking them to adopt those measures which robust, international evidence tells us will reduce the harm caused by alcohol misuse.

We would comment on the guidelines as below:

- The weekly guideline is extemely clear in communicating you are safest not to drink regularly more than 14 units, to keep health risks from drinking alcohol to a low level.
- The new guidelines communicate clearly the risk of a number of cancers increases from any level of regular drinking- there is no level of drinking that can be considered as completely safe.
- The recommendation for women who are pregnant or planning a pregnancy to not drink any alcohol at all is clear.
- The advice on single occasion drinking is clear- it is advisable to spread this drinking over three days or more and have 'alcohol free days'. It is communicated clearly if you have one or two heavy drinking sessions, you increase your risks of death from long term illnesses and accidents and injuries.
- The guidelines are clear in stating people have a right to accurate information and advice about alcohol and its health risks, and there is a responsibility on Government to ensure the information is provided for people, so they can mae informed choices.

However, the success of the new guidelines in informing the UK public will largely depend on their communication and dissemination. An inherent difficulty of developing alcohol guidelines is facilitating public understanding of 'units'; 'weekly guidelines' and 'health risks' from consuming alcohol and as such we welcome the CMO statement that it is the Government's responsibility to ensure information is provided to citizens so they can make informed choices.

Low awareness among UK citizens about the health risk from consuming alcohol

In 2009, a survey by the Office for National Statistics (ONS) showed that overall, 90 per cent of respondents "said they had heard of measuring alcohol consumption in units"[1] however, this does not necessarily mean that people knew what they were. The new alcohol guidelines provide an opportunity to help people better the health risks from any level of alcohol consumption.

The evidence review which formed the basis of the new CMO drinking guidelines identified two key research developments relating to alcohol's impact on health: (i) the acknowledgement of stronger evidence linking alcohol consumption with increased cancer risk and (ii) weaker evidence of health protective effects from alcohol. Public opinion polling indicates a lack of awareness of the link between alcohol consumption and cancer. Survey data collected for Cancer Research UK for their report 'An investigation of public knowledge of the link between alcohol and cancer' found that, 87 per cent of people in England don't associate drinking alcohol with an increased risk of cancer[4]

The results also highlighted a lack of understanding of the link between drinking alcohol and the risk of developing certain types of cancer. When prompted by asking about

seven different cancer types, 80 per cent said they thought alcohol caused liver cancer but only 18 per cent were aware of the link with breast cancer. In contrast alcohol causes 3,200 breast cancer cases each year compared to 400 cases of liver cancer.[5] This low level of public awareness implies there is a need for better information for consumers about the health risks associated with drinking alcohol. Today's consumers are seemingly not equipped to make informed choices about their drinking and their health.

Strong public support for more information and better labelling

Another important finding from public opinion surveys is that there is strong support amongst UK citizens for better public information on alcohol and health risks. A large majority of respondents to a survey carried out by the Alcohol Health Alliance survey (86%) agreed to the statement that it is important that people know how alcohol can affect their health, and 4 out of 5 (81%) support the introduction of alcohol labels which include information on how alcohol can affect health. Similarly high levels of support (84%) were reported for the introduction of a warning that, when pregnant, the safest option is to avoid alcohol completely.[6]

Communication of the guidelines

The CMO report states the following principles for the guidelines[7]:

- People have a right to accurate information and clear advice about alcohol and its health risks.
- There is a responsibility on Government to ensure this information is provided for citizens in an open way, so they can make informed choices.

We fully support these principles, and would like also to support the expert group's recommendations about campaigns, health professionals and labelling[8]

- Recommend that the Government should run supportive social marketing campaigns for the public. There should be a well funded Big Launch campaign.
- Recommend that the Department of Health works with health professionals and experts to review its guidance on higher risk drinking levels, in light of the new evidence underlying this report
- Recommend that health warnings and consistent messaging appear on all alcohol advertising, products and sponsorship

Given the low levels of public awareness regarding the health risks associated with drinking outlined above, and the strengthened evidence base around the health harms linked to alcohol, we recommend that the communication of the new CMO guidelines is prioritised and given appropriate resources as per the recommendations of the expert group.

Mass Media & Social Marketing Campaigns

The current Government's approach to reducing alcohol harm is based on the individual's right to choose how much they drink. Given that starting point, it is imperative that the decisions which individuals make are based on the latest information relating to the risks associated with drinking alcohol. As we can see from the figures above, the British public is largely unaware of the fact that alcohol is linked to an increased risk of cancer.

What is equally worrying is that many increasing and higher risk drinkers class themselves as light or moderate drinkers - 92% in a survey carried out by Balance, the North East Alcohol Office in 2015.[9] Mass media campaigns, carried out in the right way and supported by sufficient resources, have the potential to increase the

proportion of people who are aware of alcohol's links with cancer and therefore provide them with a reason to reflect on their drinking habits. Taking evidence from tobacco control which says that hard hitting TV based campaigns are effective in changing the public discourse around a harmful product, Balance ran a campaign in 2015 highlighting the links between alcohol and breast cancer. After two waves of the TV-led campaign the awareness amongst the general population of the link between alcohol and breast cancer had risen from 33 per cent to 45 per cent.[10] Replicating this approach at the national level would mean that more people were making informed choices when it came to how much alcohol they chose to consume.

Evidence to support alcohol labelling

There is evidence that the inclusion of health warnings on alcohol products increases consumers' knowledge and awareness of the adverse health impacts of alcohol.[11/12] Several countries currently mandate that alcohol producers include health warnings on all product labels, including France, Portugal, US, Australia and South Africa.

The United States introduced a mandatory written health warning in 1989. Research show that the label have prompted discussions about the dangers of drinking, steadily increased public awareness of the labels, and there is evidence of increased public support for alcohol labelling by the US public following its introduction[13] In 2006, France introduced a mandatory message, either a pictogram or a set written text, informing about the risk of drinking alcohol during pregnancy. Furthermore, France has found evidence of positive results of public awareness regarding the dangers of drinking alcohol during pregnancy help change of the social norm towards 'no alcohol during pregnancy.'[14]

Mandatory labelling is not in conflict with EU regulations

It is mandatory to provide nutritional information on all foodstuffs in the UK and Europe through the EU regulation 1169/2011 provision of food information to consumers[15]. However, alcoholic beverages stronger than 1.2% ABV are exempt from this regulation. This essentially means that consumers have more information about the contents of a glass of milk, including ingredients and calorie content, than they do a glass of whiskey. The UK Government has the powers to introduce mandatory labelling for alcohol products, as other Member States have done[16] In France, alcohol products must include health information about alcohol and pregnancy, either as text or pictogram. In Germany, alcohol products must include 'Not for supply to persons under 18', and in Portugal, health warning labels are legally required on bottles and containers of alcoholic beverages.

Self regulation and the Public Health Responsibility Deal has not given desired results

In the UK, labelling of alcoholic beverages has been part of the Public Health Responsibility Deal (RD), a voluntary partnership between government and the alcohol industry, launched in 2011. Pledge A1 of the RD addresses alcohol labelling: "We will ensure that over 80% of products on shelf (by December 2013) will have labels with clear unit content, NHS guidelines and a warning about drinking when pregnant". (101alcohol industry signatories) However, several evaluations of the Responsibility Deal show that the industry has fallen short of this target: An industry-commissioned audit found 79% of products in the off-trade complied with this pledge, but this fell to 70% of products when weighted by market share[17] It concluded that "the best estimate is that 80% content compliance had not been achieved"[18]. Furthermore, only 47% of labels have been found to reflect what is considered 'best practice' by industry-agreed standards[19].

An independent academic study corroborated these findings, reporting 78%

compliance with the pledge in an unweighted sample[20] This report found the average font size for health information on labels was 8.17, well below the 10-11 point size that is optimal for legibility. In addition, 60% of labels display health information in smaller font than then the main body of information on the label, contrary to official industry guidance. Pregnancy warning logos are significantly smaller on drinks targeted at women than those aimed at men. Moreover, they are frequently grey in colour, with only 10% in more eye-catching red[21]
Consequently, we therefore call for the introduction of mandatory regulation of labelling of alcoholic beverages to ensure that consumer information is introduced in the best possible format to enable fully informed choices.

Health professionals

In order to deliver accurate information to the public it is essential that healthcare professionals are equipped with the most up to date evidence and guidance. We recommend that a comprehensive engagement programme with healthcare professionals including GPs, midwives, health visitors, dentists, community pharmacists and others is conducted to educate and inform about the new low risk drinking guidelines and how they relate to existing identification, screening and brief advice tools such as AUDIT-C. In addition to this engagement programme, information on the new guidelines should be included in CPD modules for healthcare professionals, and incorporated into the education and training programmes completed by healthcare professionals in training.

Conclusion

Balance believes The Chief Medical Officers' low risk drinking guidelines have effectively considered the evidence on the health effects of alcohol in order to subsequently form clear and understandable recommendations. However thorough dissemination and communication of the new guidelines is essential to ensure the guidelines are successful in educating the public about the known health risks of different levels and patterns of drinking.

The Government must acknowledge the considerable time spent by the Chief Medical Officers and Expert Group in formulating the guidelines and act upon the CMO's statement that the Government has a responsibility to ensure information is provided to allow citizens to make an informed choice. Investment in social marketing campaigns, training of health care professionals and health warning labels will be crucial to ensuring the new guidelines fulfil the very objectives on which they have been formulated.

Contact:

For further information please contact Colin Shevills, Director Balance The North East Alcohol Office - Colin.Shevills@balancenortheast.co.uk Tel: [redacted]

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HEINEKEN Response to the Department of Health consultation exercise.

"How to keep health risks from drinking alcohol to a low level: public consultation on proposed new guidelines"

1st April 2016

ABOUT HEINEKEN UK

HEINEKEN is the UK's leading cider, beer and pub business and the name behind drinks brands such as Strongbow, Bulmers, Heineken®, Foster's, Kronenbourg 1664 and Desperados, together with a full range of speciality brands. Our business is built around 4 core values – passion for quality, brands and pubs that people love, enjoyment of life and respect for people and the planet.

We employ around 2,000 people across our 8 sites in the UK. We have breweries, cideries and offices in Edinburgh, Livingston, Tadcaster, Manchester, London, Hereford and Ledbury.

More than 90% of our beer sold in the UK is brewed in the UK and we are a major supporter of British agriculture, sourcing 100% of our malt and barley for our UK brewed beer from UK farms and maltsters. Around 30% of all UK apples are used to produce our ciders.

HEINEKEN is also a passionate supporter of the great British pub. Since 2010, HEINEKEN has invested £650m in developing our Star Pubs & Bars business and we own a nationwide estate of around 1,100 high quality invested pubs.

HEINEKEN is a founding member of the Public Health Responsibility Deal and, through its legacy business Scottish & Newcastle, founder members of the Portman Group and Drinkaware. We have made long term and recognisable commitments to the promotion of responsible drinking and moderation. The business was also amomgst the first to include unit information and CMOs guidance on all bottles and cans.

OUR OBSERVATIONS ON THE SCOPE OF THE CONSULTATION

The purpose of the consultation is defined as follows: "The Chief Medical Officers would like to know whether you think their recommendations, and the reasons behind them, are clear and easy to understand. That is the purpose of this questionnaire. We are trying to make sure that the new guidelines are as practical and useful as possible."

The consultation then rules out respondents providing "thoughts on the scientific evidence or how the expert group has used it to decide on their recommendations".

We believe that it is a missed opportunity to limit the consultation in this way rather than build credibility and develop a shared platform for promoting responsible consumption.

Credibility is crucial. For consumers to find the new guidelines clear, easy to understand, practical and useful, they must also believe that they are credible. To be credible, they must be tested to ensure that the evidence on which they are based is robust. The communication must then be simple, easy to understand and put in the context of everyday life. This is particularly important when it comes to communicating relative risk to consumers in a way that allows them to make meaningful choices about their behaviours.

Media reaction to the launch of the guidelines has already challenged their credibility, and questioned the likely reaction of consumers when presented with such advice. A number of high profile commentators and experts have questioned the evidence considered, the conclusions reached by the review group and the way the recommendations have already been communicated to the public. The suggestion that consumers should "consider their cancer risk every time they reach for a glass of wine" risks alienating the public and turning them off from both the message and the messenger.

Concerns have been raised by commentators, experts and consumers that should be addressed as part of the consultation, such as:

> The guidelines break with international evidence and make the UK an outlier in the advice provided to consumers around the world. We live in an ever more interconnected and digital world. Consumers accessing information through the Internet and social media will wonder why UK guidelines are so out of step with most other countries;
>
> In particular, the new weekly guidelines recommend the same levels for men and women, breaking with established international precedent, mixing acute and chronic harms and implying women can drink the same as men – a potentially dangerous message to consumers;
>
> The health benefits of moderate alcohol consumption have been down-played in the determination of the new guidelines, and have been dismissed in public as "an old wives' tale" by the Chief Medical Officer. This is despite overwhelming international evidence, and widespread scientific consensus, that total mortality among moderate drinkers is lower than among non-drinkers and that moderate consumption of alcohol can have protective effects against, for example, cardiovascular disease and cognitive decline;
>
> The full picture regarding alcohol and cancer has not been openly and accurately communicated to consumers. Alcohol has a range of effects on cancer risk including no impact on certain cancers, and in some cases, a protective effect. This is not being openly and accurately communicated to consumers;
>
> Consumers may not consider the guidance to be common sense. In particular the message that there is "no safe level of alcohol consumption" does not provide consumers with contextualised information about the relative risks versus other activities. It may also be viewed as contradictory to advice that a drinker shouldn't regularly exceed 14 units per week. In an open letter, the Royal Statistical Society challenged the interpretation of risk;
>
> Comments made by advisors in public and in the official minutes of the advisory group meetings indicate that the new guidelines were not intended to help consumers make informed choices about drinking, but "formulated to influence future government policy". The balance of the membership was weighted towards active campaigners with a predetermined view on alcohol policy. There was a lack of any expertise on communicating to consumers.

Given the extent of these challenges, we believe that the best way forward now is to conduct a full and open consultation on the process, evidence and recommendations.

A process of transparent and constructive challenge can only be a good thing for all stakeholders. Indeed the Chief Medical Officers should actively embrace such a process. To do so would demonstrate confidence in their conclusions. If a full consultation supports their original conclusions, it would build credibility and consensus across stakeholders. If it led to amendments, this too would build credibility as it would demonstrate that the recommendations have been reviewed, tested and adapted accordingly.

PRODUCT LABELLING

HEINEKEN is committed to tackling alcohol related harm and promoting responsible consumption. We have always been an active and willing partner. We are a founding member of the Public Health Responsibility Deal and have made a major contribution to the industry's billion unit reduction pledge. We have a strong track record of working in partnership to tackle alcohol related harm through our various partnerships with Drinkaware, Best Bar None, Community Alcohol Partnerships, PASS, Scottish Government Alcohol Industry Partnership, and Addaction. We actively use our brands to promote responsible consumption including through the Heineken® brand campaigns 'Sunrise', 'Dance More Drink Slow' and 'Moderate Drinkers Wanted'.

There has been a significant shift in consumption patterns in the past decade and we believe there is a real opportunity to take a targeted approach to build on the momentum and encourage more people to drink responsibly.

We remain committed to working in partnership with the Government in order to tackle alcohol related harm. An important example of what can be achieved through partnership working was the agreement with industry which has resulted in provision of unit information and CMO guidance on the vast majority of alcohol packaging sold in the UK.

We are disappointed that no thought appears to have been given to the impact of the new guidelines on the existing labelling commitment, or the practical timelines involved in changing labels across our products.

We believe that this labelling commitment is an important agreement that should continue. Therefore, we have focused our attention in the remainder of this consultation response on how best to adapt the existing agreement to ensure consumers are presented with clear and consistent information on pack.

To communicate the proposed new guidelines and the explanation behind them on pack is difficult given the complexity of messaging. There are a number of caveats and explanations which sit behind the 14 units per week guidelines that are not easily conveyed to consumers. In particular, the concept of 'spread over three or more days' difficult to convey and risks conflicting with the advice on several drink free days. 14 units allows for daily consumption and it is difficult to see how a distinction could be made on pack between spreading this out over three or more days (which could include seven days) and advice to have alcohol free days for those seeking to reduce their consumption.

If the Government chooses to proceed with the 14 units per week guidelines, then we strongly recommend that on pack labelling focusses on this figure without caveats or further explanation. It is impractical to communicate the explanations behind the 14 unit figures as well as; the ABV of the drink; specific unit content; weekly consumption guidelines, Foetal Alcohol Syndrome warning logo, anti drink driving logo and a Drinkaware message – all in the same field view and in a coherent manner. It is likely to be confusing to consumers to introduce a third 'unit' number on pack were the Government to proceed with a 'single episode' recommendation. The clear priority message on pack would be to inform consumers of the new weekly guideline.

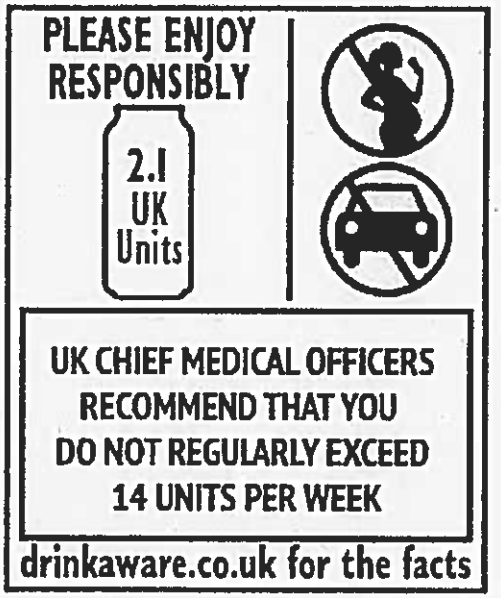
Information on reducing consumption, spreading consumption over three or more days, or limiting daily amounts would be best provided to consumers who seek guidance relating to their individual circumstances, through the functionality of the Drinkaware website, which would continue to be highlighted on all packaging.

We recommend that on pack the guidelines should be referred to as 'UK Chief Medical Officers recommend that you do not regularly exceed 14 units per week'. Many consumers will find the decision to align men and women's guidance confusing and running counter to their experience and perception. It is not possible on labelling to explain why this change has been made, therefore we believe it is advisable to simply present a single figure on pack.

If the Government does pursue this in the guidelines we would be happy to work on options to see whether this could be communicated in other formats without causing confusion and undermining the broader mention on 14 units per week.

In order to inform the consultation process, we have outlined below in APPENDIX 1, a simple option to update on pack labels which we would be happy to discuss with Government and other partners including the Portman Group.

Ends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drinkaware.co.uk for the facts


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RECOMMEND THAT YOU
DO NOT REGULARLY EXCEED
14 UNITS PER WEEK
DRINKAWARE.CO.UK for the facts

1st April 2016

ACS | the voice of local shops

Alcohol Policy Team
6th Floor
Department of Health
Wellington House
133 -155 Waterloo Road
SE1 8UG

To Whom It May Concern

How to keep health risks from drinking alcohol to a low level: public consultation on proposed new guidelines

ACS (the Association of Convenience Stores) welcomes the opportunity to respond to the Department of Health consultation on the UK Chief Medical Officers' (CMO) new guidelines on low-risk alcohol consumption. ACS represents 33,500 local shops across the country including the Co-operative Group, Spar, Costcutter and thousands of independent retailers. In this letter we will address the implementation of the proposed alcohol unit guidelines and the effect on alcohol labelling.

Alcohol is an important part of the product mix that is sold in the convenience sector, with average alcohol sales making up 13.8% of total sales. Therefore, any changes in alcohol policy can have a considerable impact on retailers. The implementation of the new guidelines will primarily affect our members which have own-brand alcohol products, as they will have to adapt their current alcohol labelling to accommodate the new guidelines. This is a considerable burden which we do not believe had been accounted for prior to the release of the new CMO guidelines.

Retailers will need to ensure their stock features the correct labelling or face enforcement action. We welcome the Food Standards Agency letter to local authorities, which urged that no enforcement action should be taken on the "basis of out of date CMO guidance appearing on labels of alcoholic beverages" until final wording and timescales has been agreed. We recommend that a proportionate timescale is implemented to ensure retailers will have enough time to sell-through stock which have labels with out of date CMO guidance.

We urge the Government to continue to consult and work with the alcohol industry on the development of the new alcohol labelling in order to incorporate the CMO guidance. This will ensure that the changes to labelling will not disproportionately burden the alcohol industry.

For more information on our submission, please contact [redacted]

Yours sincerely

James Lowman
Chief Executive

Association of Convenience Stores Limited
Federation House, 17 Farnborough Street
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T 01252 515001 F 01252 522560

www.acs.org.uk

[redacted]

From: [redacted]
Sent: 01 April 2016 18:53
To: UK CMO Guidelines Review
Subject: Dale Quentin...Suggest You Publish the Following

Suggest You Publish the Following

It's straight to the point, found in a magazine...

"The Taste of Death"

Hamburgers beefburgers and cheeseburgers too
Taste very nice but proven no good for you
Should you persist and not take the WARNING
Will discover one day from the doctor this warning

If you persist in eating these fast and fatty foods
It is with regret I have to inform you
You will also have to cut back on the booze
As if you don't your life you will lose

You must be aware that the producers of such food
Want you to become addicted, and lace their food
With sugar and salt, and lager that's great
If you continue then sudden death be your fate

Your veins will become clogged with a greasy fat
Known as cholesterol, you ask yourself; what that?
It's a killer of that you can be sure
Causing the undertaker come knocking on your door

Your children if you don't change will end up the same
Next time you look in the mirror remember you are to blame
You've got the willpower, and sense to change today
This way it's guaranteed your live till your old and grey

One last thing to remember should you smoke
Remember is reducing your life and is Fact..NOT a JOKE
Do you want to die young in an agonising way?
Of course NOT is the answer so stop smoking today

By Dale Quentin

TREASURY WINE ESTATES

SUBMISSION TO THE DEPARTMENT OF HEALTH CONSULTATION ON THE UK CHIEF MEDICAL OFFICERS' ALCOHOL GUIDELINES

TREASURY WINE ESTATES

Treasury Wine Estates (TWE) is one of the world's largest wine businesses and is listed on the Australian Securities Exchange (ASX). TWE's European head office is based in Twickenham, UK.

TWE crafts some of the world's most iconic wine brands including Lindeman's, Penfolds, Blossom Hill, Wolf Blass, Matua and Beringer.

TWE owns or leases more than 11,000 hectares of winegrowing land in Australia, the United States, New Zealand and Italy. We sell more than 30 million cases of wine in over 70 countries. We directly employ over 3,000 people, and support the employment of many more throughout our global supply chain.

We are committed to the responsible consumption of our wines, and actively promote it internationally, including through the British Government's Responsibility Deal, our commitment to provide calorie information on all of our wines, and our membership of the Portman Group and our annual funding of Drinkaware.

SUBMISSION

TWE welcomes the opportunity to respond the Department of Health's consultation on the UK Chief Medical Officers' (CMOs) Alcohol Guidelines (the Guidelines). TWE supports the submissions of the Wine and Spirit Trade Association (WSTA) and the Portman Group, and the comments in this submission are intended to complement and build on those submissions.

While we note that the consultation questionnaire states that the Government is 'not asking for [our] thoughts on the scientific evidence', TWE has concerns about the draft Guidelines that are intrinsically linked to how the Government can ensure the Guidelines are as practical and useful as possible – the stated intention of the consultation.

Specifically, TWE would like to make four overarching comments:

1. **TWE is concerned that the Guidelines, as currently drafted, do not appear to have been developed with the principle purpose of helping consumers make informed choices about consumption.**

This concern stems from public comment made by advisors to the CMOs and in the official minutes of the Guidelines Development Group meetings, which have identified that the Guidelines were developed with the intention of influencing future government policy.

For example, the Chief Medical Officer Dame Sally Davies gave evidence to the House of Commons Science and Technology Committee on the new Guidelines, stating:

> *"[The expert groups] found remarkably little evidence about the impact of guidelines, but we did not do them to have direct impact so much as to inform people and provide the basis for those conversations and for any campaigns that, for instance, Public Health England and others might run in the future."*[1]

The Guidelines Development Group meeting minutes from 8 April 2015 state: *'[it is] important to bear in mind that, while guidelines might have limited influence on behaviour, they could be influential as a basis for government policies.'*[2]

2. **The new Guidelines are contradictory to widely available and understood peer-reviewed evidence.**

As detailed by Professors Peter Diggle and Sir David Spiegelhalter from the Royal Statistical Society, the current Guidelines do not meet the principle of "informed choice", because the new Guidelines do not appear to reflect existing statistical evidence.

Concerns with the content of the draft Guidelines is inextricably linked to the communication of them.

---

[1] House of Commons Hansard, Evidence to Science and Technology Select Committee (2 February 2016). See also Marteau, T.M. Will the UK's new alcohol guidelines change hearts, minds – and livers?, BMJ (February 2016).
2 Alcohol Guidelines Review, Guidelines Development Group, Note of a meeting (8 April 2015).

For example, well-established links between low to moderate alcohol consumption and reduced risk of Cardio-Vascular Disease – supported by multiple pieces of peer reviewed academic evidence across the globe – are not reflected in the Guidelines. TWE considers that the Guidelines should reflect the findings that low to moderate alcohol consumption can be part of a balanced diet and healthy lifestyle.

Dr Mladen Boban, Professor of Biomedicine and Public Health at the University of Split Medical School has commented stated that:

> *"The guidelines do not mention the health benefits associated with moderate alcohol (especially wine) intake, thereby ignoring huge scientific evidence - for example, reduced incidence of type 2 diabetes and the strong cardiovascular benefits of alcohol. Moderate intake may even be protective against some cancers."*[3]

Curtis Ellison, Professor of Medicine and Public Health Boston University School of Medicine and Director of the International Scientific Forum on Alcohol Research, has also stated that:

> *"Statements suggesting abstinence is better than light drinking in terms of health and mortality are erroneous and do not reflect current scientific literature, with well-conducted studies showing that mortality is lower for light-to-moderate drinkers than for lifetime abstainers... The well-demonstrated benefits of regular light-to-moderate alcohol consumption are primarily in middle-aged and older adults; it tends to lower their risk of most diseases of ageing (including coronary heart disease, stroke, diabetes, and even dementia)."*[4]

3. **The draft Guidelines are unclear and confusing for the consumer.**

TWE is concerned that the proposed Guidelines are unclear and confusing, with a number of elements of the Guidelines appearing to conflict. Most significantly, one Guideline states that there is no safe level of alcohol consumption, which is contrary to the remaining content of the Guidelines, and reliable and robust international evidence which shows a positive association between low to moderate alcohol consumption and overall mortality.

The Guidelines outline the following seemingly contradictory messages:

- Recommends 14 units per week for all people, while also stating that there is no safe level of consumption.
- Recommends that alcohol should not be consumed in a 'heavy episode', but consumption should be spread over a number of days, while also having a number of days off consuming alcohol.
- That a number of factors can influence the impact of alcohol consumption (eg gender and weight) while also recommending one weekly limit for all people.

The previous daily Guidelines were well understood by consumers and well communicated by the drinks industry, with over 80% over products on shelf in the UK contained the unit information on

[3] *Why those killjoy alcohol rules are just plain wrong*, Daily Mail (January 2016)
[4] *Why those killjoy alcohol rules are just plain wrong*, Daily Mail (January 2016)

label. TWE is concerned with the significance of the departure and lack of continuity with the former Guidelines, and the ability to inform consumers on the new Guidelines given the seemingly contradictory messages.

Writing in the BMJ, David M Shaw, Senior Researcher at the Institute for Biomedical Ethics at the University of Basel highlighted this:

> *"...the "no amount is safe" message undermines the new recommended limit for men and the retention of the limit for women. Why should people attempt to adhere to the new limits rather than the old ones if they are also being told that the new recommended levels are not safe? Giving such a mixed message further increases the likelihood that the guidelines will not be taken seriously."*[5]

If the proposed Guidelines progress in their current form, TWE considers that the Government will need to provide significant resources to inform consumers of the new Guidelines, and why and how they differ from the previous Guidelines. In order to minimise the risk of confusion, TWE also considers that communications should be focused on the overarching recommended weekly consumption and the pregnancy Guideline.

4. **Guidelines should be developed and implemented with independence as a key principle**

TWE is concerned that actual or perceived conflicts between key decision makers and anti-alcohol advocacy groups may have influenced the development of the Guidelines, resulting in Guidelines that are not effective in informing consumer choice.

TWE notes the importance of ensuring all further steps in the Guideline process, including communication, implementation and effectiveness reviews are undertaken by individuals who are independent and free from potential conflicts of interest.

Submitted on 1 April 2016 by:

[5] Drunk on risk: how the chief medical officers' alcohol guidelines are demonising drink, BMJ (16 February 2016)

ROYAL STATISTICAL SOCIETY

DATA | EVIDENCE | DECISIONS

Response from the Royal Statistical Society (RSS) to the Department of Health's consultation on proposed new alcohol guidelines

The Royal Statistical Society (RSS) is a learned society and professional body for statisticians and data analysts, with almost 8,000 members in the UK and across the world. As a charity, we advocate the key role of statistics and data in society, and have done so since we were founded in 1834. One of our six key strategic goals is for society to be more statistically literate, so that people's understanding of data, risk and probability can inform their daily decision-making.

Summary points and recommendations

1. *Communications should genuinely reflect the principle of informed choice. There should be no unqualified prescriptive phrases such as 'men should only drink less than 14 units a week'.*

2. *Communications should acknowledge the minimal risks of the recommended low levels of alcohol consumption.*

3. *Focus should also be given to higher-risk levels of consumption, for example at a weekly consumption of 35 units for women and 50 for men.*

4. *More detailed information should be provided for those who want it, for example by using info-graphics.*

5. *The low-risk threshold could be set as an 'aspirational' target, and people encouraged towards this, while acknowledging there is a trade-off against the perceived benefits of moderate levels of alcohol consumption. The table below shows a possible message.*

Risk level	*Weekly consumption Women*	*Weekly consumption Men*	*Guidance*
	35 units or above	50 units or above	Unacceptable, high risk – must reduce from this level
	14 to 35 units	14 to 50 units	Try to reduce to 14 units, or as low as you can
	14 units or below	14 units or below	Broadly acceptable, low risk

1. The 'low-risk' threshold

1.1. We recognise that this is a contested area of science with considerable uncertainties, and that the Government has a complex task in communicating complex statistical information to the public.

1.2. We support the basic idea of a 'low-risk' threshold. When communicating the draft guidance, the Guidelines Development Group (1) identified 14 units a week as a 'low-risk' level, equivalent to less than a 1% chance of dying from an alcohol-related condition. They correctly avoided the term 'safe', since this could give the misleading impression that consumption above this level was 'unsafe'.

1.3. Given that low-levels of alcohol consumption can provide both pleasure and relaxation, and is an integral part of our culture, we also strongly support the principle of 'informed choice' clearly articulated in the Guidelines Development Group report (1): "*People have a right to accurate information and clear advice about alcohol and its health risks. There is a responsibility on Government to ensure this information is provided for citizens in an open way, so they can make informed choices*".

1.4. However, the current communications by Department of Health do not seem to make any attempt at this balance – the tone is peremptory and prescriptive. For example the Department of Health website states that men "*Men should not drink more than 14 units of alcohol each week, the same level as for women*" (2). Categorical statements such as this run counter to the proclaimed aim of 'informed choice'.

1.5. In spite of the risks at the revised guidelines being acknowledged as minimal, the communications have also strongly emphasised potential harms of low-level consumption, particularly cancer. This appears to have been built into the commissioned analysis from the start, and it could be argued that the main change from the previous guidelines has been due to a statistically-unjustified assumption imposed by Public Health England[1]. There has been a continued emphasis on inducing fear through mentions of cancer, and consistent downplaying and even denial of any health benefit - the Press release says that "*the protective effect of alcohol against heart disease has now been shown not to apply to men*", which directly contradicts the estimates published in Table 10 of the Guidelines Development Group report (1).

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[1] In previous analyses there had been a threshold under which no increased risk of acute harm was assumed, but the Sheffield Report (3) states that *"At the request of the commissioners (Public Health England), this threshold effect was removed for the base case analysis meaning there is no threshold mean weekly or peak daily alcohol consumption level below which risks of acute alcohol-related mortality or morbidity are equivalent to that of abstainers."* Table 13, p49 of the Sheffield Report shows that, without this enforced assumption, the threshold for males to reach a 1% lifetime risk would have been 21 rather than 14 units, exactly the previous Guideline. We also note the statistically implausible assumption of a linear relationship between relative risk of acute harm and alcohol-consumption, instead of the standard log-linear relationship. This again serves to increase the apparent harm of low levels of consumption by forcing the statistically unjustified assumption that the number of acute deaths arising from a change in peak daily consumption from, say, 0 to 2 units would be the same as a change from, say, 20 to 22 units.

1.6. We can understand the thinking behind this communication strategy. The 'Rose' idea is that making small improvements to the mass of lower-risk people will improve the overall public health more than focusing on the far fewer high-risk individuals. But we would question the ethics of trying to do this by giving an exaggerated impression of the harms of low-levels of alcohol.

1.7. There has been substantial negative comment in the media about the guidelines failing to live up to the stated aim of providing information for adults to make their own choices, including considered editorials in the Guardian and the Times. Our concern is that scepticism about public health advice might apply to future pronouncements concerning arguably much greater health risks associated with inactivity, poor diet and obesity that, unlike alcohol consumption, are increasing problems. Once public trust has been lost, it is extremely difficult to win back.

1.8. Specific recommendations.

- *Communications should genuinely reflect the principle of informed choice. There should be no unqualified prescriptive phrases such as 'men should only drink less than 14 units a week'.*

- *Communications should acknowledge the minimal risks of the recommended low levels of alcohol consumption.*

2. Higher thresholds

2.1. The matching Guideline of 14 units a week for men and women gives the misleading impression that men and women have the same resilience to alcohol.

2.2. The Guideline Development Group recommended examining higher risk thresholds. Figure 1 below is taken from Tables 10 and 11 of the Guideline Development Group report, and illustrates the risk of higher levels of consumption. We have added horizontal lines indicating the level of 'acceptable risk' used by the Guideline Development Group (1% lifetime), and added a possible line for an 'unacceptable' level of risk, at 12.5%, or the level at which 1 in 8 people die from their drinking. From this picture we can conclude:

- At one unit a day (half a standard glass of wine), they estimate a very small overall benefit for men and a larger overall benefit for women.
- The 'broadly acceptable' 1% risk is at around 14 units a week for both men and women
- There is a dramatically increased risk for higher consumption, with women having a steeper gradient than men.
- An 'unacceptable' 12.5% risk would be at around 35 units a week for women, and 50 units a week for men. These are precisely the current definition of 'higher-risk drinking', and also the level of 'harmful drinking' as defined by the World Health Organisation.

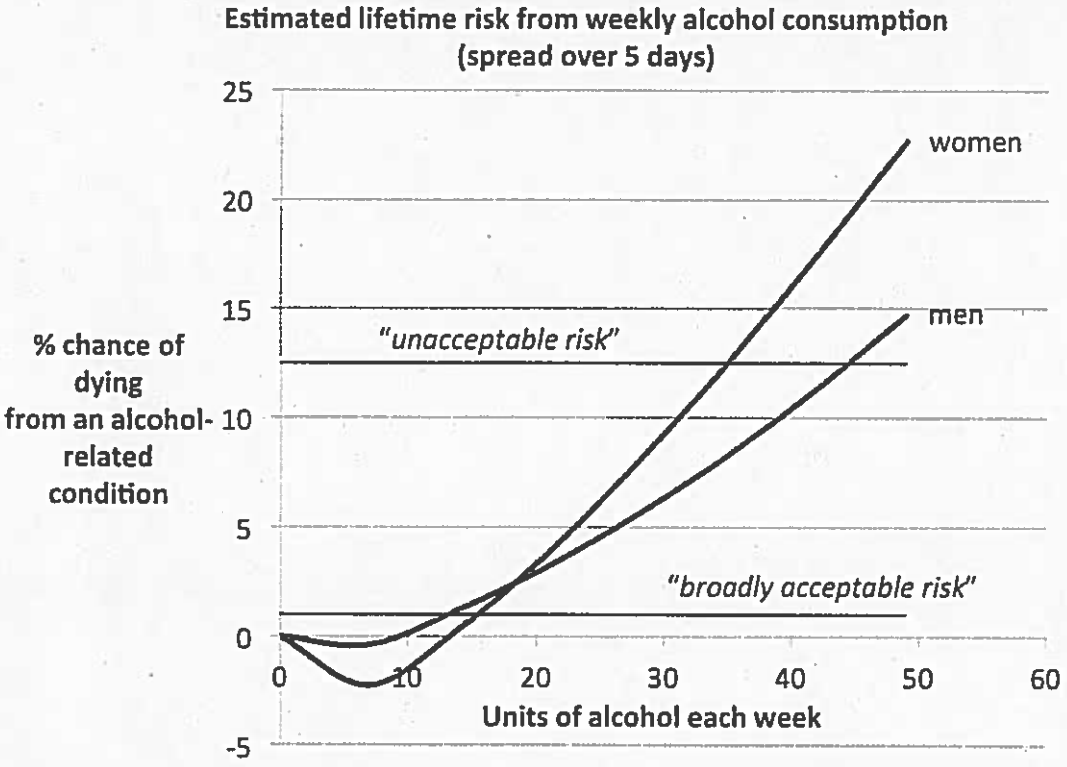

Figure 1 Risks from Tables 10 and 11 of Guideline Development Group report, with superimposed 'broadly acceptable' and 'unacceptable' risks

2.3. This approach fits within the extraordinarily successful 'tolerability of risk' framework developed and used very effectively by the Health and Safety Executive for many years. This avoids any idea of 'safe' or 'unsafe', and keeps in mind at all times the benefits that may be generated by undertaking the hazardous activity in the first place. 'Broadly acceptable' and 'unacceptable' regions are assessed, and between them lies a 'tolerable' region. In this region every effort should be made to reduce the risks *As Far As Reasonably Practicable (ALARP) (4)*.

Figure 1: HSE framework for the tolerability of risk

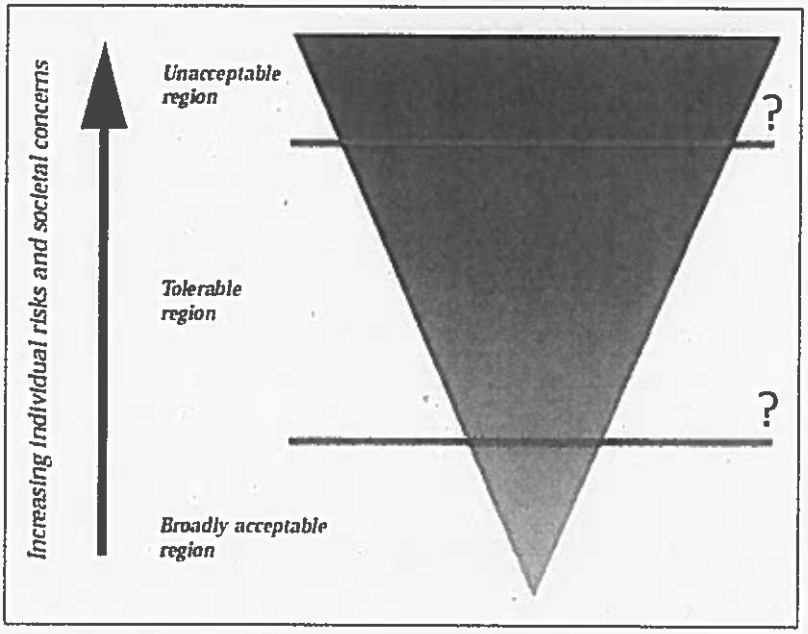

Figure 2. HSE Framework for the tolerability of risk (4)

2.4. We are not necessarily suggesting the use of this precise terminology. It may be better to set the low-risk level as an 'aspirational' target, and encourage people to make their drinking 'As Low As Reasonably Achievable' (ALARA) – another HSE term. This treats people with respect, acknowledging that we all make risk trade-offs every day. A possible message could be as follows:

Risk level	*Weekly consumption Women*	*Weekly consumption Men*	*Guidance*
	35 units or above	50 units or above	Unacceptable, high risk – must reduce from this level
	14 to 35 units	14 to 50 units	Try to reduce to 14 units, or as low as you can
	14 units or below	14 units or below	Broadly acceptable, low risk

2.5. Specific recommendations

- *Focus should also be given to higher-risk levels of consumption, for example at a weekly consumption of 35 units for women and 50 for men.*

- *More detailed information should be provided for those who want it, for example by using info-graphics.*

- *The low-risk threshold could be set as an 'aspirational' target, and people encouraged towards this, while acknowledging there is a trade-off against the perceived benefits of moderate levels of alcohol consumption.*

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