

NHS Health Scotland Commentary on NICE Public Health Intervention Guidance	
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NICE ref:	Public health guidance 7 (PH007)
HS ref:	NICEPHG007
Title:	Interventions in schools to prevent and reduce alcohol use among children and young people
Date issued:	November 2007

Subject area:	Alcohol
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Background to this Commentary

The National Institute for Health and Clinical Excellence (NICE) in England produces two types of guidance on public health topics: Public Health Intervention Guidance (interventions being defined as involving single measures, eg GP advice to patients to be more active) and Public Health Programme Guidance (on broader activities, eg strategies for smoking cessation). In Scotland, such Guidance has no formal status but attracts interest and provides a useful source of reviewed evidence.

As part of its role in promoting and supporting evidence-informed action for health improvement in Scotland, NHS Health Scotland (HS) produces Commentaries on NICE Public Health Guidance. Each Commentary, with Comments/Conclusions on the Recommendations set out in the NICE Guidance, is produced in collaboration with an appropriately constituted specialist Reference Group with members from within and beyond HS. The process involves consideration of the evidence cited and the Recommendations presented in the NICE Guidance, in the context of policy and practice in Scotland.

Purpose and limitations of this Commentary

By offering Comments/Conclusions on NICE Guidance, this Commentary is intended to help organisations, professionals and others make use of that Guidance in a Scottish context. It does not in itself constitute formal Guidance or Guidelines.

The scope and contents of the Commentary are limited by those of the NICE Guidance on which it is based. The Commentary should not be seen as a full action plan or full basis for a health improvement strategy on the subject area concerned, but rather as one evidence-informed contribution to such an action plan or strategy. By not only addressing the NICE Recommendations but also presenting in an accessible way the cited evidence statements on which these are based, the Commentary gives decision makers the opportunity to formulate their own action points informed by the evidence statements, combining these with evidence from other sources and taking account of other relevant considerations.

The Commentary

General HS Notes:

- 1. For the purposes of NICEPHG007, and thus this HS Commentary (subject to adaptation to fit Scottish institutional structures), the term 'schools' is used to include:
 - state-sector, special and independent primary and secondary schools
 - city technology colleges, academies and grammar schools
 - pupil referral units, secure training and local authority secure units
 - further education colleges.*
- 2. NICEPHG007 also looks at how to link interventions in schools with community initiatives, including those run by children's services.*
- 3. NICEPHG007 points out that, under UK law, children and young people can consume different types of alcohol in different contexts depending on their age (eg young people aged 16 or 17 may consume beer, cider or wine with a meal when under adult supervision on licensed premises), but that in all other circumstances it is illegal for anyone under 18 'knowingly' to consume alcohol on licensed premises, or to buy or attempt to buy alcohol. NICEPHG007 states that it is important that schools take this legal framework into account when planning and delivering alcohol education and when developing partnerships to tackle alcohol issues (within and outside schools).*

General HS Notes, contd:

4. *NICEPHG007 refers to different countries' favouring different approaches to alcohol education. It states that alcohol use is considered normal for a large proportion of the population in the UK, where a 'harm reduction' approach is favoured for young people, but that in the US, where most of the research on school-based interventions comes from, abstinence is encouraged among children and young people.*
5. *In the absence of guidance on safe and sensible levels of alcohol consumption for children and young people, NICEPHG007 focused on: encouraging children not to drink; delaying the age at which young people start drinking; and reducing the harm it can cause among those who do drink. It indicates that practitioners will need to use their professional judgement to determine the type of content needed for education programmes aimed at different groups, and that they will also need to judge whether or not a child or young person is drinking 'harmful amounts of alcohol'.*
6. *In developing the Recommendations set out in NICEPHG007, NICE's Public Health Interventions Advisory Committee (PHIAC) considered a review of effectiveness evidence, an economic appraisal, stakeholder comments and the results of fieldwork. In this Commentary, the evidence statements cited for each of the NICEPHG007 Recommendations for action are presented immediately under the corresponding Recommendations, for ease of reference. The term 'Inference derived from the evidence' is used by PHIAC where a Recommendation is not directly taken from the evidence statements but is inferred from the evidence.*
7. *NICEPHG007 indicates that the evidence on school-based interventions was not extensive and that, as most of it was US-based, it has to be applied with caution. NICEPHG007 highlights a number of common shortcomings in the evidence reviewed, but concludes that some evidence was of sufficient quality and applicability to England to inform the recommendations. Another limitation of the evidence base is that studies commonly evaluate single curriculum packages rather than the 'whole school approach' (see overleaf) promoted in the UK.*
8. *It is important to note that, due to the limitations of the evidence, it was not possible to determine the differential effectiveness of the interventions in relation to disadvantaged and minority groups. In addition, it was not possible to determine what impact the action Recommendations in NICEPHG007 may have on health inequalities.*

General HS Notes, contd:

9. Scottish contextual points –

- *NICEPHG007 is primarily intended for teachers, school governors, and practitioners with health and wellbeing as part of their remit working in education, local authorities, the NHS and the wider public, voluntary and community sectors. This Commentary is of relevance to such groups (subject to adaptation to fit Scottish organisational structures, posts and roles), to community planning partnerships, and to relevant multiprofessional, interagency teams working with schools and school age children.*
- *This Commentary should be read together with: Plan for Action on Alcohol Problems Update (Scottish Executive, 2007); Being Well – Doing Well: A Framework for Health Promoting Schools in Scotland (Learning and Teaching Scotland, 2004); Health Education 5-14 National Guidelines (Learning and Teaching Scotland, 2000); Guide for Teachers and Managers: Health Education 5-14 (Learning and Teaching Scotland, 2000); Health Promotion: Issues for Councils and Schools (Her Majesty's Inspectorate of Education, 1999); Ambitious, Excellent Schools – Our Agenda for Action (Scottish Executive, 2004); New Community Schools: The Prospectus (The Scottish Office, 1998); and the Schools (Health Promotion and Nutrition) (Scotland) Act 2007.*
- *The Schools (Health Promotion and Nutrition) (Scotland) Act 2007 requires education authorities to endeavour to ensure that schools managed by them, and hostels provided and maintained by them for pupils, are health-promoting, ie provide activities and an environment and facilities which promote the physical, social, mental and emotional health and wellbeing of pupils. The health promoting school concept, which has long been promoted in Scotland, is a 'whole school approach' to promoting and protecting health – through the formal and informal curriculum, a safe and healthy school environment, appropriate health services, and involvement of the family and wider community.*
- *Scottish schools are undergoing transformation through the phased implementation of 'Curriculum for Excellence' (CfE) (see www.curriculumforexcellencescotland.gov.uk/index.asp), which will supersede the national 5-14 curriculum guidelines. One of the eight curriculum areas of CfE is 'Health and Wellbeing', which will be of relevance to education on alcohol and other substances.*
- *One of the actions set out in the Plan for Action on Alcohol Problems Update is to use a commissioned evaluation of effectiveness of drugs education in Scottish schools to develop an alcohol education programme as part of a wider, robust substance misuse education programme for schools.*
- *Other specific Scottish contextual considerations are highlighted where relevant in this Commentary.*

<p>Scope of the Guidance:</p>	<p><u>Groups covered</u> Children and young people under 18 years old in educational institutions including, but not limited to:</p> <ul style="list-style-type: none"> ▪ state sector primary and secondary schools ▪ city technology colleges, academies, pupil referral units, secure training and local authority secure units, grammar schools, special and independent primary and secondary schools ▪ further education colleges. <p><u>Areas covered</u> Interventions in primary and secondary schools that aim to prevent or reduce alcohol use – including, but not limited to:</p> <ul style="list-style-type: none"> ▪ lessons delivered by teachers or other professionals as part of personal, social and health education (PSHE), or as part of the National Curriculum ▪ peer led education by other pupils ▪ interventions delivered by external agencies and individuals (including, but not limited to, contributions from the police, theatre in education (TIE) providers and life education centres) ▪ school policies ▪ the ‘informal’ curriculum; this could include pastoral care and other extra-curricula activities such as parent evenings and school trips. <p><u>Primary outcomes</u> Changes in alcohol consumption among children and young people including:</p> <ul style="list-style-type: none"> ▪ the percentage who drink ▪ the volume they drink – and how frequently ▪ the age when they first drink alcohol ▪ unsupervised use. <p><u>Secondary outcomes</u> The following secondary outcomes were to be assessed where a study reported a primary outcome:</p> <ul style="list-style-type: none"> ▪ attitudes towards – and knowledge about – alcohol ▪ interpersonal skills, including the ability to refuse alcohol ▪ alcohol-related absence from school and poor school attainment ▪ alcohol-related violence and crime (including arrests for drink driving), prosecutions, incarcerations and antisocial behaviour ▪ illegal sales of alcohol ▪ alcohol-related morbidity including hospitalisation ▪ alcohol-related mortality.
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<p>Scope of the Guidance, contd:</p>	<p><u>Key question</u> What are the most effective and cost-effective school-based interventions to prevent or reduce alcohol use among under 18 year olds?</p> <p><u>Target audiences and settings</u></p> <ul style="list-style-type: none"> ▪ Teachers, school governors and others (including school nurses and healthy school leads) who work in or with primary and secondary schools and further education colleges ▪ All those who train teachers ▪ Relevant professionals in local authorities, including directors of children’s services and drug and alcohol action teams, and leads on crime disorder reduction partnerships (CDRPs) and local area agreements (LAAs).
<p>HS Comments on scope:</p> <ol style="list-style-type: none"> 1. <i>Groups and areas covered, outcomes, and key question supported.</i> 2. <i>It is unclear why the target audience described in NICE's Scope document differs from that indicated in the Guidance itself. See also relevant Scottish contextual point under 'General HS Notes'.</i> 	

<p>Study selection criteria etc</p>	<p><u>Review of effectiveness evidence</u> A number of databases and websites were searched for systematic reviews, randomised controlled trials (RCTs), non-randomised controlled trials, and controlled before and after studies published since 1990.</p> <p>Studies were <u>included</u> if they:</p> <ul style="list-style-type: none"> ▪ involved children and young people under 18 years old ▪ were undertaken in primary and secondary state-sector maintained schools, city technology colleges, academies, grammar, non-maintained special and independent schools or pupil referral, secure training and local authority secure units, or further education settings ▪ examined interventions in schools which aimed to prevent or reduce alcohol use, including: <ul style="list-style-type: none"> - lessons delivered by teachers or other professionals as part of a classroom-based curriculum - peer-led education by other pupils - external contributions (eg from the police, theatre in education [TIE] organisations and life education centres) - implementation of school policies - activities carried out as part of the informal curriculum (eg learning experiences in assembly/collective worship and parent evenings)
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<p>Study selection criteria etc, contd:</p>	<ul style="list-style-type: none"> ▪ compared the intervention with a control or with another approach ▪ reported changes in alcohol-related behaviour, including: <ul style="list-style-type: none"> - percentage who reported drinking alcohol (lifetime, monthly or weekly use) - amount of drinking and its frequency - age at which children/young people first drank alcohol - unsupervised alcohol use. <p>Studies were <u>excluded</u> if they examined interventions:</p> <ul style="list-style-type: none"> ▪ aimed at children and young people who did not attend any of the types of schools listed above, eg those in secure institutions or receiving home education ▪ without a school-based component, including: <ul style="list-style-type: none"> - 'server' and 'responsible beverage service' (RBS) training, media campaigns and diversionary activities delivered in the wider community - regulatory schemes such as taxation, restrictions on alcohol sales and advertising, proof of age schemes and warning labels - drink-driving schemes and driver training - treatment of alcohol misuse or alcohol dependence, including psychosocial interventions. <p><u>Economic appraisal</u> The economic appraisal consisted of a review of economic evaluations and a cost-effectiveness analysis. The review involved a search using 3 economic databases. The inclusion and exclusion criteria were as for the effectiveness review.</p>
<p><i>HS Comments on study selection criteria etc:</i></p> <p>1. <i>Supported for the purpose in question, on the understanding that the categorisation of schools used did not militate against inclusion of relevant studies from outside England.</i></p>	

<p>Study appraisal methods etc:</p>	<p><u>Review of effectiveness evidence</u> Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the relevant NICE technical manual.</p> <p>Each evidence source was categorised as one of four <u>types</u>:</p> <ul style="list-style-type: none"> ▪ Meta-analyses, systematic reviews of randomised controlled trials (RCTs) or RCTs (including cluster RCTs) ▪ Systematic reviews of, or individual, controlled non-randomised trials (CNRTs), case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies, correlation studies ▪ Non-analytical studies (eg case reports and case series) ▪ Expert opinion, formal consensus. <p>Each study was quality rated as ++, + or – according to the risk of potential bias arising from its design and execution/other criteria as appropriate. The main reasons for studies being assessed as (-) were:</p> <ul style="list-style-type: none"> ▪ limited reporting of methodological details such as methods of random assignment ▪ high level of participant attrition ▪ lack of detail about baseline equivalence of intervention and control groups. <p>Interventions were also assessed for their applicability to the UK and the evidence statements were graded as follows:</p> <ul style="list-style-type: none"> A harm-reduction approach and likely to be applicable across a broad range of settings and populations B harm-reduction approach and likely to be applicable across a broad range of settings and populations, assuming they are appropriately adapted C harm-reduction approach but applicable only to settings or populations included in the studies – broader applicability is uncertain, or approach unclear D clear abstinence approach or applicable only to settings or populations included in the studies. <p>The findings from the studies were synthesised and used as the basis for a number of evidence statements relating to each key question. The evidence statements reflect the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.</p>
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HS Comments on study appraisal methods etc:

1. *Supported.*

NICEPHG007 Recommendations and HS Comments/Conclusions

HS Note: The Recommendations for action in NICEPHG007 are presented under 2 headings: School-based education and advice, and Partnerships.

A. School-based education and advice

Recommendation

1:

Target population

- Children and young people in schools.

Who should take action?

- Head teachers, teachers, school governors and others who work in (or with) schools including: school nurses, counsellors, healthy school leads, personal, social and health education (PSHE) coordinators in primary schools, and personal, social, health and economic (PSHE) education coordinators in secondary schools.

What action should they take?

- Ensure alcohol education is an integral part of the national science, PSHE and PSHE education curricula, in line with Department for Children, Schools and Families (DCSF) guidance.
- Ensure alcohol education is tailored for different age groups and takes different learning needs into account (based, for example, on individual, social and environmental factors). It should aim to encourage children not to drink, delay the age at which young people start drinking and reduce the harm it can cause among those who do drink. Education programmes should:
 - increase knowledge of the potential damage alcohol use can cause – physically, mentally and socially (including the legal consequences)
 - provide the opportunity to explore attitudes to – and perceptions of – alcohol use
 - help develop decision-making, assertiveness, coping and verbal/non-verbal skills
 - help develop self-esteem
 - increase awareness of how the media, advertisements, role models and the views of parents, peers and society can influence alcohol consumption.
- Introduce a ‘whole school’ approach to alcohol, in line with DCSF guidance. It should involve staff, parents and pupils and cover everything from policy development and the school environment to the professional development of (and support for) staff.

<p>Recommendation 1, contd:</p>	<ul style="list-style-type: none"> ▪ Where appropriate, offer parents or carers information about where they can get help to develop their parenting skills. (This includes problem-solving and communication skills, and advice on setting boundaries for their children and teaching them how to resist peer pressure.)
<p>Evidence base for Recommendation 1:</p>	<ol style="list-style-type: none"> 1. There is evidence from a high-quality systematic review (++) that three programmes: Strengthening Families, Botvin’s life skills training (LST) and a culturally focused curriculum for Native American students, can produce long-term reductions (greater than 3 years) in alcohol use. 2. There is evidence from two classroom-based, teacher-led programmes that targeted children between the ages of 12 and 13 years, to suggest that interventions using the life skills approach (three RCTs [+]) or focusing on harm reduction through skills-based activities (School Health and Alcohol Harm Reduction Project [SHAHRP]) (one CNRT [+]) can produce medium- to long-term reductions in alcohol use and, in particular, risky drinking behaviours such as drunkenness and binge drinking. However, the applicability and transferability of these programmes requires further study. 3. There is evidence (one RCT [+]) to suggest that a culturally-tailored skills training intervention for Native American students may have long-term effects on alcohol use. However, given the cultural specificity of this programme, it has limited applicability to UK practice and policy. 4. There is evidence to suggest that programmes that begin early in childhood, combine a school-based curriculum intervention with parent education, such as the Seattle Social Development Project (SSDP) (one CNRT [+]) and Linking the Interests of Families and Teachers (LIFT) (one RCT [-]), which target a range of problem behaviours including alcohol use, can have long-term effects on heavy and patterned drinking behaviours. In addition, the Healthy School and Drugs Project (one CNRT [+]), which targeted secondary school students, had short-term effects on alcohol use. However, longer-term effects of the programme have not been examined.

HS Comments/Conclusions on Recommendation 1:

1. *Cited evidence lacking in respect of the whole school approach and limited in relation self-esteem, but Recommendation considered appropriate and supported subject to adaptation to fit Scottish organisational structures, policies, processes etc.*
2. Scottish contextual points –
 - *For 'PSHE' curricula read 'the Health and Wellbeing curriculum area of CfE'.*
 - *In the 2002/03 survey of drug education in schools in Scotland, 94% of schools reported providing drug education in line with existing national advice, meaning (among other things) that alcohol was covered in addition to tobacco, solvents, controlled drugs, and safe use of medicine.*
 - *An evaluation of the effectiveness of the drug education in Scottish schools conducted in 2004-05, which similarly covered alcohol, tobacco and other substances), found considerable duplication of drug education content for different age groups, with content and approaches, particularly for Primary 6 through to Secondary 2/3, often tending to be very similar regardless of age or stage. CfE will address continuity and progression in learning, and the need for adequate, age-appropriate teaching resources will be an important consideration in that regard.*
 - *A literature review undertaken to inform the above evaluation found evidence to suggest that some types and features of drug education are more effective than others. In particular, drug education using highly interactive methods and social influences approaches, specifically including resistance skills and normative education elements (the latter addressing any erroneous perceptions about the prevalence of drug use among peers or in the community), was consistently found to be more effective.*
 - *The Scottish Schools (Parental Involvement) Act 2006 strongly supports the involvement of parents and carers in decision making. Alcohol – What Every Parent Should Know, developed by HS in partnership with the Scottish Executive and Alcohol Focus Scotland, provides information to help parents decide what to discuss with their children, and how and when to do it. It is available through Drinkline (Freephone 0800 917 8282).*
 - *In 2007, The Scottish Government established a Substance Misuse Education in Schools Steering Group to help guide the development of effective substance misuse education in schools and drive forward a programme of improvement and innovation over a three-year period. A work plan is being developed in collaboration with a range of agencies. It will be particularly important to ensure that teachers have adequate training and support to deliver substance misuse education, and that teaching materials are used effectively. It is anticipated that early tasks will include an audit of the resources currently used and an assessment of external contributions to schools substance misuse education.*

<p>Recommendation 2:</p>	<p><u>Target population</u></p> <ul style="list-style-type: none"> ▪ Children and young people in schools who are thought to be drinking harmful amounts of alcohol. <p><u>Who should take action?</u></p> <ul style="list-style-type: none"> ▪ Teachers, school nurses and school counsellors. <p><u>What action should they take?</u></p> <ul style="list-style-type: none"> ▪ Where appropriate, offer brief, one-to-one advice on the harmful effects of alcohol use, how to reduce the risks and where to find sources of support. Offer a follow-up consultation or make a referral to external services, where necessary. ▪ Where appropriate, make a direct referral to external services (without providing one-to-one advice). ▪ Follow best practice on child protection, consent and confidentiality. Where appropriate, involve parents or carers in the consultation and any referral to external services.
<p>Evidence base for Recommendation 2:</p>	<ol style="list-style-type: none"> 1. There is evidence to suggest that brief intervention programmes that involve nurse-led consultations regarding a young person's alcohol use, such as the STARS for Families programme (two RCTs [++], seven RCTs [+]), that target children aged 12–13, can produce short-, but not medium-term reductions in heavy drinking. However, these types of programme may have limited applicability as they are based on an abstinence approach. 2. There is evidence to suggest that programmes that begin early in childhood, combine a school-based curriculum intervention with parent education, such as the Seattle Social Development Project (SSDP) (one CNRT [+]) and Linking the Interests of Families and Teachers (LIFT) (one RCT [-]), which target a range of problem behaviours including alcohol use, can have long-term effects on heavy and patterned drinking behaviours. In addition, the Healthy School and Drugs Project (one CNRT [+]), which targeted secondary school students, had short-term effects on alcohol use. However, longer-term effects of the programme have not been examined.

HS Comments/Conclusions on Recommendation 2:

1. *Cited evidence limited, particularly in respect of longer term effectiveness, but Recommendation considered appropriate and supported subject to the following amendments and Scottish contextual points –*
 - *The term 'school nurses' should be widened to 'relevant health and social care professionals, including school nurses'.*
 - *In Scotland multiprofessional, interagency teams are involved in consideration of referral to external services.*
 - *Safe and Well – A Handbook for Staff, Schools and Education Authorities (Scottish Executive, 2005), designed to complement local guidance on child protection, is intended to be used as a benchmark for standards.*

B. Partnerships	
<p>Recommendation 3:</p>	<p><u>Target population</u> Children and young people in schools.</p> <p><u>Who should take action?</u></p> <ul style="list-style-type: none"> ▪ Head teachers, school governors, healthy school leads and school nurses. ▪ Extended school services, children’s services (including the Children’s Trust/children and young people’s strategic partnership), primary care trusts (PCTs), drug and alcohol action teams, crime disorder reduction partnerships, youth services, drug and alcohol services, the police and organisations in the voluntary and community sectors. <p><u>What action should they take?</u></p> <ul style="list-style-type: none"> ▪ Maintain and develop partnerships to: <ul style="list-style-type: none"> - support alcohol education in schools as part of the national science, PSHE and PSHE education curricula - ensure school interventions on alcohol use are integrated with community activities introduced as part of the ‘Children and young people’s plan’ - find ways to consult with families (parents or carers, children and young people) about initiatives to reduce alcohol use and to involve them in those initiatives - monitor and evaluate partnership working and incorporate good practice into planning.
<p>Evidence base for Recommendation 3:</p>	<p>'Inference derived from the evidence.'</p>
<p>HS Comments/Conclusions on Recommendation 3:</p> <ol style="list-style-type: none"> 1. <i>No specific evidence cited, but Recommendation considered appropriate and supported subject to adaptation to fit Scottish organisational structures, policies, processes etc.</i> 2. <i>Scottish contextual points –</i> <ul style="list-style-type: none"> ▪ <i>For 'PSHE' curricula read 'the Health and Wellbeing curriculum area of CfE'.</i> ▪ <i>For 'extended school services' read 'integrated community schools, also known as community schools'.</i> ▪ <i>For 'children and young people’s plan' read 'Children's Services Plan'. In addition, Joint Health Improvement Plans, within community planning, can contribute to the integration of school interventions and community activities.</i> 	

<p>Recommendations for Research:</p>	<p>NICEPHG007 recommends that the following research questions should be addressed in order to improve the evidence relating to interventions in schools to prevent and reduce alcohol use among children and young people.</p> <ol style="list-style-type: none"> 1. In relation to universal interventions delivered in English schools to prevent and reduce alcohol use among children and young people: <ul style="list-style-type: none"> ▪ How does effectiveness and cost effectiveness vary according to: the setting (eg state sector schools, pupil referral units, and further education colleges); who delivers the intervention (eg teachers, and peers); the target group (eg in terms of age, gender, and those who engage in risky behaviour)? ▪ What is the best way to ensure universal alcohol interventions do not lead to some children and young people increasing their intake of alcohol? ▪ How do the following factors influence effectiveness and cost effectiveness: method of delivery (eg session format, learning materials); content; frequency and duration of follow-ups; and parental/carer involvement? 2. How does effectiveness and cost effectiveness vary according to whether an intervention is delivered alone or as part of a wider substance misuse intervention? 3. What are the most effective and cost effective ways of identifying children and young people in schools who are at significant risk from drinking harmful amounts of alcohol? 4. What is the best way to ensure universal alcohol interventions carried out in schools meet the needs of children and young people who are disadvantaged or from a minority group? 5. What is the incidence, prevalence and consequence of: <ul style="list-style-type: none"> ▪ short-term health and non-health-related outcomes resulting from alcohol use in childhood and adolescence (eg absence from school, violence)? ▪ attributable long-term health and non-health outcomes (eg poor academic achievement, convictions, violence, adult socioeconomic status)?
<p><i>HS Comments/Conclusions on Recommendations for Research:</i></p> <ol style="list-style-type: none"> 1. <i>Recommendations for Research supported subject to adaptation to the Scottish setting and addition of explicit emphasis on research in the context of a whole school approach.</i> 	

Members of Reference Group for NHS Health Scotland Commentary on NICE Public Health Guidance 7

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