Stakeholder	Document	Page No	Line No	Comments	Developer's response
Alcohelp	Guideline	General	General	Our experience of working with many thousands of young adults between 11 and 18 indicates that a vastly different approach to educating them on alcohol is required between, say, ages 11, 14 and 18. With or without any 'formal' education on the subject they have acquired views on alcohol derived from a number of key influences such as their peers, media (particularly social media) and perhaps most importantly their parents / carers / home life.	Thank you for your comment. The committee agree that it is important that alcohol education is age appropriate due to the different approaches needed and made the following recommendation: "1.1.4 When planning alcohol education: • ensure it is appropriate for age and maturity and aims to minimise the risk of any unintended adverse consequences (see recommendation 1.2.1). • tailor it to take account of each pupil's learning needs and abilities • tailor it to the group's knowledge and perceptions of alcohol and alcohol use • take into account that those aged 18 and over can legally buy alcohol. The committee considered it was also important to involve parents and carers to help with giving a consistent message on alcohol. We have added text around parental responsibility to the Rationale section (page 12) as follows "One of the elements of the whole-school approach is to involve parents and carers. The committee acknowledged that parents or carers have an influence on their child's healthy behaviours and therefore there is benefit in involving them in the school's

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					approach to alcohol education. This can also help to improve the consistency of messages that pupils receive." The committee also acknowledged that peers and social media have an influence on drinking behaviours and note that many children are choosing not to drink. The committee added text to the Rationale section (page17) which says: "The committee acknowledged that the number of children and young people drinking is decreasing. They considered that this trend will help to frame alcohol education in a positive way by normalising non-drinking behaviours. It will also promote inclusivity for those who choose not to drink or choose, to delay starting to drink, or who do not drink for cultural or religious reasons.
Alcohelp	Guideline	General	General	Again, our experience shows that it is often difficult to get the parents involved in determining what and how to educate their children on alcohol. Not wishing to generalise but the attitude we have found is that parents either consider their children do not need to be told, that there is no reason to scare them or that "its never done me any harm". This attitude is often the result of ignorance on the subject or denial that it is an issue for them.	Thank you for your comment. The evidence also showed that there was difficultly in engaging parents with alcohol education. The committee discussed this issue and drafted a research recommendation on the best way to engage parents and carers with alcohol education. See research recommendation 6 "Engaging parents and carers in the whole-school approach to alcohol education"

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Alcohelp	Guideline	General	General	Related to 2 above, we have also found a very varied interest and engagement from the teachers. Very rarely do we find that teachers ask questions or request further information on what we have told the young adults.	Thank you for your comment. The committee drafted the following recommendation to outline how alcohol education in schools can be supplemented by external providers. In drafting this they were mindful of the need for schools and staff to follow existing guidance on how to work with external agencies. The committee also made clear that it is the school's responsibility to ensure that any alcohol education provided by external providers is consistent with their plan and therefore the recommendations aim to encourage more engagement from schools and teachers. "1.2.3 If using external providers to supplement alcohol education: • use providers offering content that is consistent with the school's planned alcohol education • follow guidance on quality assurance and delivery (see section on Working with external agencies in the Department for Education's draft guidance on relationships education, RSE and health education). "
Alcohelp	Guideline	General	General	There is no reference to the responsibilities of parents in the education of alcohol use within the guidelines	Thank you for your comment. The evidence showed that there was difficulty in engaging parents with alcohol education. The committee drafted a research recommendation on the best way to engage parents and carers with alcohol education. See research recommendation 6 "Engaging parents and carers in the whole-

					school approach to alcohol education" The committee considered it was an important to involve parents and carers to help with giving a consistent message on alcohol. We have added text around parental responsibility to the Rationale section (page 12) as follows "One of the elements of the whole-school approach is to involve parents and carers. The committee acknowledged that parents or carers have an influence on their child's healthy behaviours and therefore there is benefit in involving them in the school's approach to alcohol education. This can also help to improve the consistency of messages that pupils receive."
Alcohelp	Guideline	4	4	Should this also include 'providers of alcohol education'?	Thank you for your comment. We have now removed this sentence following feedback and "Providers of alcohol education" are now listed under "Who is it for?" section.
Alcohelp	Guideline	5	5 & 6	Young adults are exposed to alcohol 'influences' from so many places that we do not believe that many (if any) will try alcohol due to curiosity created by what they have learnt in the classroom. The risk of this is far outweighed by the benefits of outlining the risks of alcohol.	Thank you for your comment. The committee noted the evidence provided by expert testimony supporting the need to plan for unintended consequences for all interventions. The committee agreed that education should be planned appropriately to minimise any potential harms.

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Alcohelp	Guideline	6	9	Question arises as to how you ascertain the knowledge and perceptions – our experience shows that this varies enormously from young adult to young adult, school to school, class to class, area to area, social group etc. etc	Thank you for your comment. The committee discussed this and acknowledged that ascertaining knowledge and perceptions of pupils is something schools will be doing for all subjects, not just alcohol education. They agreed it was the school's responsibility to ensure that the educational resources and providers used are appropriate and consistent to their alcohol education plan and wrote this recommendation with the aim that schools will be more engaging with providers.
Alcohelp	Guideline	6	21 & 22	Disagree with this point – providers are often much better placed to determine	Thank you for your comment. The committee discussed the role of external providers and acknowledged they are beneficial in supporting schools with alcohol education. However, they committee strongly agreed that it is the school's responsibility to ensure that they are appropriate and are consistent with the alcohol education plan. The Rationale section (page 18) was amended to clarify this "The committee agreed that it is the school's responsibility to ensure that external providers they choose meet standards that allow pupils to learn safely and effectively. The committee were aware of examples of how to access guidance to assess external providers, for example PSHE Association and Mentor-ADEPIS. "

Alcohelp	Guideline	8	3	Impossible to split out drinkers and non drinkers. Young adults in lower age bracket (11) may be starting to 'experiment' whereas others will not yet have tried. Alternatively 18 yr olds will almost all have tried it or be using regularly. Both sets need the info that is relevant to their age group not split between whether they are or are not already drinking	Thank you for your comment. We have now removed the example about drinkers and non-drinkers and the recommendation now says "1.3.7 Avoid normalising unhealthy drinking behaviours when delivering targeted group interventions (for example, by not mixing different age groups)." The committee also added a new recommendation to clarify that this is also considering when selecting pupils for a targeted intervention: "1.3.5 Ensure a targeted group intervention is appropriate for age and maturity of the pupils and aims to minimise the risk of any unintended adverse consequences and stigma (see recommendation 1.3.7)."
Alcohelp	Guideline	11	20 & 21	We would disagree. We have the opportunity of talking to the same young adults firstly at the age of 10/11 and then later when they are 14/15 – our experience is that they do specifically remember the info they were first given	Thank you for your comment. Our evidence reviews compared specific universal alcohol interventions to usual care (e.g. PSHE) but found they were similarly effective. Therefore, the committee did not recommend any one intervention over usual alcohol education.
Alcohelp	Guideline	12	8	Where would these existing examples come from – we are not aware of them?	Thank you for your comment. We have reworded the text for clarity and it now reads as follows "The committee discussed that schools share experiences in knowledge and adopt examples of alcohol education that have

					worked in other local schools. However, there was no evidence to support this practice. There was also concern that adapting examples of good practice for local needs may alter the effectiveness of interventions (for example straying too far from key content and processes)."
Alcohelp	Guideline	12	14 & 15	We would completely endorse the vital importance in schools including alcohol education as part of their curriculum	Thank you for your comment
Alcohelp	Guideline	13	2, 3, 4, 5	We completely agree that alcohol education needs to be tailored for age and not in mixed age groups. Tailoring to the need and maturity is often difficult as this varies widely across groups	Thank you for your comment. The committee made the following recommendation which aims to help tailor alcohol education for age: "1.1.4 When planning alcohol education: • ensure it is appropriate for age and maturity and aims to minimise the risk of any unintended adverse consequences (see recommendation 1.2.1). • tailor it to take account of each pupil's learning needs and abilities • tailor it to the group's knowledge and perceptions of alcohol and alcohol use • take into account that those aged 18 and over can legally buy alcohol."
Alcohelp	Guideline	13	7 & 8	Disagree – see point 6 'Young adults are exposed to alcohol 'influences' from so many places that we do not believe that many (if any) will try alcohol due to	Thank you for your comment. The committee agree with the points you made however evidence provided by expert testimony supported the need to plan for unintended

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				curiosity created by what they have learnt in the classroom. The risk of this is far outweighed by the benefits of outlining the risks of alcohol'.	consequences for all interventions. The committee agreed that education should be planned appropriately to minimise any potential harms.
Alcohelp	Guideline	14	4 & 5	We agree – often, following a presentation, a young adult will approach us to tell us of their own experiences with their peers but more often their home environment. It is crucial that we have a knowledgeable member of staff that we can gently refer them to	Thank you for your comment
Alcohelp	Guideline	15	25, 26, 27	We agree that the information must be relevant and appropriate, however, we would note that young adults have a surprising knowledge that they have acquired from a variety of sources and that there is very little that 'scares' them	Thank you for your comment and your agreement that information should be relevant and appropriate. The committee did note however that scare tactics were not effective and were aware that these were still being used and so retained the recommendation that providers avoid using these tactics.
Alcohelp	Guideline	16	1 & 2	We agree – our work supports this. Our own experience with alcohol abuse and therefore our 'expertise' in the subject resonates deeply with many young adults	Thank you for your comment
Alcohelp	Guideline	16	4	'Healthy lifestyle' is an increasingly important factor – particularly when they are shown evidence of how their looks and appearance can be damaged by alcohol	Thank you for your comment. The committee discussed the need for a positive approach to alcohol discussion. There is text in the Rationale section which says that: "education that encourages discussion, for example around healthy lifestyle decisions, is more beneficial than merely giving out information through, for example, leaflets or 'one-way' lectures"

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Alcohelp	Guideline	16	10, 11, 12	Disagree that teachers are the most effective as teachers often lack knowledge on the subject. If the external provider is enthusiastic, knowledgeable and the material delivered is relevant (maybe having been agreed with the school prior) this is successful	Thank you for your comment. The committee discussed the use of external providers and acknowledged they are beneficial in supporting schools with alcohol education. However, they committee strongly agreed that it is the school's responsibility to ensure that they are appropriate and are consistent with the alcohol education plan. The Rationale section (page 18) was amended to clarify this "The committee agreed that it is the school's responsibility to ensure that external providers they choose meet standards that allow pupils to learn safely and effectively. The committee were aware of examples of how to access guidance to assess external providers, for example PSHE Association and Mentor-ADEPIS. "
Alcohelp	Guideline	16	20, 21, 22	Disagree – see previous comment on external providers and material used	Thank you for your comment. The committee discussed the use of external providers and acknowledged they are beneficial in supporting schools with alcohol education. However, they committee strongly agreed that it is the school's responsibility to ensure that they are appropriate and are consistent with the alcohol education plan. The Rationale section (page 18) was amended to clarify this "The committee agreed that it is the school's responsibility to ensure that external providers they choose meet standards that allow pupils to learn safely and effectively. The committee were aware of examples of how to access guidance to assess

					external providers, for example PSHE Association and Mentor-ADEPIS. "
Alcohol and Families Alliance	Guideline	4	12	It is welcome that the guideline includes activities involving families and communities as an example of the types of activities to take place under the guideline. The 2016 Public Health England evidence review of the effectiveness and cost-effectiveness of alcohol control policies notes that the lack of evidence to demonstrate that school-based alcohol education programmes lead to behaviour change may be due to the ubiquity of commercial alcohol marketing, which serves to normalise alcohol use.[5] Though wider policy changes are required to reduce the impact of alcohol marketing on young people and the alcogenic environment in which they are growing up, (specifically restrictions on alcohol marketing, an increase in the price of alcohol and reductions to alcohol availability, as recommended by the World Health Organisation.[6]) involving families and communities in alcohol education can at least help to improve the consistency of messaging received by children and young people. The PHE evidence review also notes that children's access to alcohol may be through parents as parents will often provide alcohol in an attempt to protect their child from alcohol-	Thank you for your comment. NICE did not review any evidence on regulation such as marketing or alcohol pricing as this is outside of our remit. The committee have added some text to the Rationale for the recommendations in section 1.1 as follows "One of the elements of the whole-school approach is to involve parents and carers. The committee acknowledged that parents or carers have an influence on their child's health behaviours. They considered that involving them in the school's approach to alcohol education is essential to improve the consistency of messages that pupils receive. "

				related problems later in life.[7] However, the Chief Medical Officers' guideline states that "an alcohol-free childhood is the safest and best option."[8] Evidence shows that children who start drinking earlier are more likely to become frequent and binge drinkers.[9] It is therefore important for alcohol education to involve parents to help spread the message to parents about the best way to protect their children from problematic alcohol use. Involving parents in alcohol education also presents an opportunity to speak to parents about how their own drinking can affect their children's future drinking behaviours. A 2017 systematic review identified parental drinking as one of seven longitudinal predictors of both alcohol initiation and levels of later alcohol use.[10] Parents may be unaware that their drinking has an impact: research by the Alcohol and Families Alliance found that many parents assume their children do not notice their drinking.[11] Better guidance and education about the impact of parental drinking is therefore needed.	

Alcohol and Families Alliance	Guideline	4	15 - 17	Public Health England has found that "the delivery of education messages by the alcohol industry has no significant public health effects."[15] To avoid conflicts of interest in information provision, resources should be developed free from the influence of the alcohol industry.	Thank you for your comment. The committee discussed resources and materials and agreed that schools should be responsible for choosing the appropriate resources to suit their needs. The following text was added to the Rationale section: "The committee also reiterated that it was the school's responsibility to use materials that are free from bias and evidence-based where possible. Also, the committee were mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see the public health burden of alcohol: evidence review). The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)."
Alcohol and Families Alliance	Guideline	5	3	The purpose of the guideline is to reduce alcohol use among children and young people aged 11 to 18. However, in planning alcohol education, professionals should be clear that alcohol education is also an opportunity to communicate with those children and young people who may not drink themselves but who are affected by a family member's drinking. It is estimated that there are almost 200,000 children living with an alcohol dependent parent in England, and between 14,390 and 32,887 children living with two alcohol-dependent	Thank you for your comment. The committee have used this group as one of the examples of vulnerable young people in the Rationale section (page 20): "The committee also noted that other groups (for example children who do not drink but are vulnerable to other people's drinking, and those in the criminal justice system) may also be considered to be particularly vulnerable." In addition, the committee acknowledged that there will be groups of vulnerable children that

				parents.[16] These children are twice as likely to experience difficulties at school, three times more likely to consider suicide, and five times more likely to develop eating disorders.[17] Teachers should therefore be equipped with resources to enable them to talk about familial alcohol use and its impacts on other family members (including financial impacts, domestic abuse and neglect, children having to care for other siblings).	will require more support than targeted prevention interventions and so made a recommendation on referring for further support : "1.1.11 Use clear referral pathways, for example into school nursing, school counselling, early help services, voluntary sector services, young people's drugs and alcohol services or to a youth worker, as needed. "
Alcohol and Families Alliance	Guideline	6	20	As noted above, Public Health England has found that "the delivery of education messages by the alcohol industry has no significant public health effects."[20] To avoid conflict of interest, providers of alcohol education should ensure that they are free from alcohol industry influence.	Thank you for your comment. The committee discussed resources and materials and agreed that schools should be responsible for choosing the appropriate resources to suit their needs. The following text was added to the Rationale section: "The committee also reiterated that it was the school's responsibility to use materials that are free from bias and evidence-based where possible. Also, the committee were mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see The public health burden of alcohol: evidence review). The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)."

Alcohol and Families Alliance	Guideline	7	10-12	As per comment 3, this should include pupils who are assessed as vulnerable to alcohol misuse themselves and those who are vulnerable to another's alcohol misuse.	Thank you for your comment. The committee have used this group as one of the examples of vulnerable young people in the Rational section (page 20): "The committee also noted that other groups (for example children who do not drink but are vulnerable to other people's drinking, and those in the criminal justice system) may also be considered to be particularly vulnerable." In addition, the committee acknowledged that there will be groups of vulnerable children that will require more support than targeted prevention interventions and so made a recommendation on referring for further support : "1.1.11 Use clear referral pathways, for example into school nursing, school counselling, early help services, voluntary sector services, young people's drugs and alcohol services or to a youth worker, as needed. "

Alcohol Education Trust	Guideline	Gener al	Gener al	The NICE draft guidelines are practical and reflect best practice of taking a holistic age appropriate approach that encourages healthy choices, is fact based, does not highlight extremes of behaviour or use scare tactics. The guidelines recognise the practicality of the classroom and the importance of PSHE teachers delivering alcohol education, while accepting that some external practicioners, such as school nurses may also be suitable for delivery. The guidelines recognise the spiral approach of building layers of knowledge over time. However the guidelines do not highlight the number of lessons needed to make alcohol education effective – one or two lessons will not be enough to engender behaviour change, the evidence suggests that a minimum of 6 lessons in KS3 on alcohol are needed. The importance of emphasising social norms is also not mentioned, whereby teachers are encouraged to focus on the 60% of under 15's who are choosing not to drink rather than highlighting the problematic behaviour of smaller numbers.	Thank you for your comments. The committee were unable to make specific recommendations on the optimal number of sessions that are needed as the evidence was inconclusive on this point. Because of this, they made a research recommendation looking at what the effective components of alcohol education are, such as number of sessions needed. See research recommendation "1 Components of alcohol education delivery". The committee agreed with your comment about emphasising social norms and noted the following in the Rationale and Impact section (on page 17) "The committee acknowledged that the number of children and young people drinking is decreasing. The committee considered that this trend is helpful in framing alcohol education in a positive way by normalising non-drinking behaviours. This will

				We are very pleased that children with SEND are highlighted as requiring specific approaches and that in some cases targeted alcohol education may be needed for children at most risk of alcohol related harm or living in families where problematic alcohol use is a factor. Finally it would be helpful if a list of key providers of alcohol education was provided, including charities who should be signposted for further sources of help for young people. This should include www.alcoholeducationtrust.org , ADFAM, ADDACTION, NACOA, Action on Addition and www.talkaboutalcohol.com	also promote inclusivity for those who choose not to drink, to delay drinking onset or do not drink for cultural or religious reasons." Thank you for your comment regarding children with SEND and targeted education. As the committee did not evaluate specific providers of alcohol education they are unable to provide a list of providers. They strongly agreed that it was the school's responsibility to ensure they choose appropriate resources or providers and added the following text in the rationale section (page 13) : "The committee also reiterated that it was the school's responsibility to use materials that are free from bias and evidence-based where possible. Also, the committee were mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see the public health burden of alcohol: evidence review). The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)."

Alcohol Education Trust	Guideline	Gener al	Gener al	**Question 1 - Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. 2. Would implementation of any of the draft recommendations have significant cost implications?** The guidelines are realistic and are not asking teachers or schools to deliver more than what is currently good practice for PSHE. We would like the PSHE CPD programme for teachers to be highlighted as this really equips a PSHE lead to be able to plan and deliver PSHE on all topics with confidence. It is run by The University of Roehampton and Babcock Education. It should be remembered that the PSHE Assocation has membership fees and all its courses cost money, which most schools do not have for PSHE, so 'paid for ' elements for PSHE will remain a challenge. Healthy schools networks and PSHE networking groups do still exist and could be strengthened, especially as most local authorities now provide PSHE support on a 'business model' charging for their services. With schools facing substantial budget cuts there is unlikely to be funding for improving PSHE provision. Our main concern remains those schools where PSHE provision is currently poor. Any guidance from NICE or DfE	Thank you for your comment. The committee have signposted to examples of where accredited resources may be found. However, as we have not evaluated all of these resources, we are unable to specify which should be used. Whilst the committee could not recommend which tools and resources to use, they agreed that schools are responsible for choosing the materials that are consistent with their plan. Some text has been added to the Rationale section as follows (page 13) : "The committee strongly agreed that it is the school's responsibility to ensure that the materials used meet the standards and plans of the school. The committee were aware of accredited materials and training resources (although not reviewed by NICE) based on their experience of current practice. These include materials from PSHE Association, Public Health England and Mentor-ADEPIS. The committee also reiterated that it was the school's responsibility to use materials that are free from bias and evidence-based where possible. Also, the committee were mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see the public health burden of alcohol: evidence review). The committee were also

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				must make accessing resources and planning tools as easy and transparent as possible. There is a risk that a commissioned subject association or charity meant to 'share best practice' will protect their own agenda and income over what might be the 'greater good' of what is best for schools.	aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)."
Alcohol Education Trust	Guideline	Gener al	Gener al	**Question 4 - What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.)** The Alcohol Education Trust has been providing its evidences resources (evaluated by NFER, The Early intervention Foundation, PSHE Association, Mentor Adepis CAYT, UCL IOE and The European platform for Investing in Children) for 10 years now. The free lessons plans, films worksheets and resources are used by over 1500 schools across Britain and it offers a 'one stop shop' for busy time poor teachers,. There is no charge and all lessons are planned by topic, age appropriateness and ability. We have regionally based trainers to work with schools to help implementationThere are resources specifically for children with learning difficulties who are at higher risk of alcohol related harm. Teachers can access the free resources via www.alcoholeducationtrust.org and the	Thank you for your comment. The committee have signposted to examples of where accredited resources may be found. However, as we have not evaluated all of these resources, we are unable to specify which should be used. Whilst the committee could not recommend which tools and resources to use, they agreed that schools are responsible for choosing the materials that are consistent with their plan. Some text has been added to the Rationale section as follows (page 13): "The committee strongly agreed that it is the school's responsibility to ensure that the materials used meet the standards and plans of the school. The committee were aware of accredited materials and training resources (although not reviewed by NICE) based on their experience of current practice. These include materials from PSHE Association, Public Health England and Mentor-ADEPIS. The committee also reiterated that it was the school's responsibility to use materials that are

				information zone for young people is www.talkaboutalcohol.com	free from bias and evidence-based where possible. Also, the committee were mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see the public health burden of alcohol: evidence review). The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)."
Alcohol Education Trust	Guideline	12	3-7	Recs 1.11- 1,12 We are concerned that this recommendation may imply that teachers will expect to find alcohol education programmes by visiting OFSTED or Public Health England. Mentor Adepis CAYT offers a framework for drugs and alcohol education in schools with a databank of evaluated drug and alcohol resources that are available to schools and this should be made clear with a link. The PSHE Association offers a Quality Mark for programmes submitted for analysis (paid for) by topic and a link to the relevant section should be included, noting that this is not comprehensive.	Thank you for your comment. We have provided a list of examples of resources. However, as we have not evaluated all of these resources, we are unable to specify which should be used. We have removed OFSTED from the list as you suggest. The committee noted that PHE provide links to educational materials. The committee strongly agreed that it is the school's responsibility to ensure that the materials used meet the standards and plans of the school. The following text was added in the Rationale section: "The committee were aware of accredited materials and training resources (although not reviewed by NICE) based on their experience of current practice. These include materials from

					PSHE Association, Public Health England and Mentor-ADEPIS. The committee also reiterated that it was the school's responsibility to use materials that are free from bias and evidence-based where possible. Also, the committee were mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see the public health burden of alcohol: evidence review). The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)."
Alcohol Education Trust	Evidence review A	Gener al	Gener al	The exclusion criteria for evidenced universal alcohol education programmes sadly mean that the most practical alcohol education programmes that are extensively in use and comprehensively evaluated appear to be excluded, This includes Michael McKay trial (Journal article)McKay, M., Agus, A., Cole, J., Doherty, P., Foxcroft, D., Harvey, S., . . . Sumnall, H. (2018). Steps Towards Alcohol Misuse Prevention Programme (STAMPP): a school-based and community-based cluster randomised controlled trial. BMJ OPEN, 8(3). doi:10.1136/bmjopen-2017-019722 DOI: 10.1136/bmjopen-2017-019722	Thank you for your comment. We can confirm the McKay 2018 paper (STAMPP) trial is included in the evidence review as a secondary publication of Sumnall 2017. The second McKay 2018 paper (The influence of time attitudes on adolescent alcohol use behaviours: a 33-month prospective study in the United Kingdom, Addiction Research & Theory, DOI: 10.1080/16066359.2018.1478414) was not identified in our searches. However, on

				The influence of time attitudes on adolescent alcohol use behaviours: a 33-month prospective study in the United Kingdom (Journal article)McKay, M. T., Morgan, G. B., Wells, K. E., Worrell, F. C., Cole, J. C., & Andretta, J. R. (2018). The influence of time attitudes on adolescent alcohol use behaviours: a 33-month prospective study in the United Kingdom. Addiction Research & Theory, 1-9. doi:10.1080/16066359.2018.1478414 and Talk About Alcohol: impact of a school-based alcohol intervention on early adolescents Sarah Lynch, Anneka Dawson & Jack Worth International Journal of Health Promotion and Education, Volume 52, 2014 - Issue 5 available via https://www.tandfonline.com/doi/full/10.1080/14635240.2014.915759 and Fabbiano Fabrizio and 'Unplugged'	assessment of the abstract, it does not meet our inclusion criteria as time attitudes profiles were not the focus of the evidence reviews. The Lynch 2014 paper was excluded as it did not meet our inclusion criteria. This is because we searched for RCTs. The Lynch paper was not an RCT. The Maggiano 2014 paper reported the findings of a 4-arm trial. The 3 intervention arms (student alone, student plus parent activity and student plus peer activity) were not reported separately and therefore the paper was excluded as the results were not presented in a way that could be used for our evidence reviews.
Balance	Guideline	General	General	There is no reference to the responsibilities of parents in the education of alcohol use within the guidelines. We believe that this is an omission, which should be acknowledged in the guidelines. Evidence shows that parents have a huge influence upon their children's behaviour and that if parents do not approve of their children drinking, then they are less likely to do so than those under-18s whose parents	Thank you for your comment. The committee discussed the influence of parents and carers on their child. They considered it was an important part of the whole-school approach to involve parents and carers in alcohol education to help with giving a consistent message on alcohol and added have text around parental responsibility to the Rationale section which now says "One of the elements of the whole-school approach is to involve parents and

				have more permissive attitudes towards alcohol.	carers. The committee acknowledged that parents or carers have an influence on their child's healthy behaviours and therefore there is benefit in involving them in the school's approach to alcohol education. This can also help to improve the consistency of messages that pupils receive." The evidence also showed that there was difficultly in engaging parents with alcohol education. The committee discussed this issue and drafted a research recommendation on the best way to engage parents and carers with alcohol education. See research recommendation 6 "Engaging parents and carers in the whole-school approach to alcohol education"
Balance	Guideline	4	4	We feel that this should also include a reference to 'providers of alcohol education'?	Thank you for your comment. We have now removed this sentence following feedback and "Providers of alcohol education" are now listed under "Who is it for?" section.

Balance	Guideline	4	10	We would recommend that alcohol is included within the relevant school policy (e.g. substance misuse policy) applying to both staff and students, to deliver a consistent, inclusive and equal approach. Balance has undertaken a recent survey which showed that most school policies are aimed at the pupils only. Consequently the policies could be seen as confusing and unequal; for example, a policy might state that pupils cannot have alcohol on site yet the school permits alcohol as gifts to staff or for consumption at parties. Not only is this conflicting and confusing to pupils, it also does not promote a healthy environment for young people, as alcohol is seen as a normal and positive aspect of life.	Thank you for your comment. The committee were unable to make specific recommendations on school policies as this is out of scope. However, the committee agreed it was important that messages that pupils receive about alcohol are consistent throughout and therefore made a recommendation that alcohol education should be delivered as part of a "whole-school approach": "1.1.1 Plan and deliver alcohol education (universal and targeted interventions) as part of a whole-school approach to relationships education, relationships and sex education (RSE) and health education or personal, social, health and economic education (PSHE). For example : • classroom curriculum activities • pastoral support, school policies (including school ethos) and other actions to support pupils in the wider school environment • activities that involve parents or carers, families and communities (see making it as easy as possible for people to get involved in the NICE guideline on community engagement). " They also added some text to the Rationale for the recommendations in section 1.1 (page 12) as follows

					"It is current practice for schools to use a whole-school approach for alcohol education (universal and targeted) and other health-related topics, as recommended in the original guideline, which has a PSHE component. This helps schools ensure that consistent messages are given about a topic, such as alcohol education, whether taught through health education or PSHE and the national science curriculum. "
Balance	Guideline	4	15 - 21	Our experience has shown that teaching staff are not always aware that some resources / materials have been developed through organisations linked with the alcohol-industry and we would recommend that staff are provided with clear guidance about this. There is evidence to suggest that educational materials developed by the alcohol-industry are not particularly effective and are unlikely to reduce harmful alcohol use.	Thank you for your comment. The committee discussed resources and materials and agreed that schools should be responsible for choosing the appropriate resources to suit their needs. The following text was added to the Rationale section: "The committee also reiterated that it was the school's responsibility to use materials that are free from bias and evidence-based where possible. Also, the committee were mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see the public health burden of alcohol: evidence review). The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)."

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Balance	Guideline	5	5 & 6	Young adults are exposed to alcohol 'influences' from so many places that we do not believe that many (if any) will try alcohol due to curiosity created by what they have learnt in the classroom. The risk of this is far outweighed by the benefits of outlining the risks of alcohol.	Thank you for your comment. The committee noted the evidence provided by expert testimony supporting the need to plan for unintended consequences for all interventions. The committee agreed that education should be planned appropriately to minimise any potential harms.
Balance	Guideline	5	19	As in comment 2 re school policies	Thank you for your comment. The committee were unable to make specific recommendations on school policies as this is out of scope. However, the committee agreed it was important that messages that pupils receive about alcohol are consistent throughout and therefore made a recommendation that alcohol education should be delivered as part of a "whole-school approach": "1.1.1 Plan and deliver alcohol education (universal and targeted interventions) as part of a whole-school approach to relationships education, relationships and sex education (RSE) and health education or personal, social, health and economic education (PSHE). For example : • classroom curriculum activities • pastoral support, school policies (including school ethos) and other actions to support pupils in the wider school environment • activities that involve parents or carers, families and communities (see making it as easy as possible for people to get involved in

					the NICE guideline on community engagement). " They also added some text to the Rationale for the recommendations in section 1.1 (page 12) as follows "It is current practice for schools to use a whole-school approach for alcohol education (universal and targeted) and other health-related topics, as recommended in the original guideline, which has a PSHE component. This helps schools ensure that consistent messages are given about a topic, such as alcohol education, whether taught through health education or PSHE and the national science curriculum. "
Balance	Guideline	6	21	Echoing comment 1 – schools should be guided on which partners are most appropriate (i.e. not those linked with the alcohol industry) to ensure delivery and content is evidence-based, unbiased and most effective.	Thank you for your comment. The committee discussed the use of external providers to support alcohol education. They agree that the content the provider uses must be appropriate for the group they are speaking to and avoid doing harm but could not specify which organisations the providers should come from. As a result, the committee recommended that "1.2.3 If using external providers to supplement alcohol education: • use providers offering content that is consistent with the school's planned alcohol education • follow guidance on quality assurance and

					delivery (see section on Working with external agencies in the Department for Education's draft guidance on relationships education, RSE and health education). "
Balance	Guideline	8	3	We believe it would be really challenging to split out drinkers and non-drinkers. Younger children in the lower age bracket (11) may be starting to 'experiment' whereas others will not yet have tried. Alternatively, most 18 year olds will have tried alcohol, or be consuming it regularly. Children and young people of all ages need the facts and information that is relevant to their age group.	Thank you for your comment. We have now removed the example about drinkers and non-drinkers and the recommendation now says "1.3.7 Avoid normalising unhealthy drinking behaviours when delivering targeted group interventions (for example, by not mixing different age groups)." The committee also added a new recommendation to clarify that this is also considering when selecting pupils for a targeted intervention: "1.3.5 Ensure a targeted group intervention is appropriate for age and maturity of the pupils and aims to minimise the risk of any unintended adverse consequences and stigma (see recommendation 1.3.7)."
Balance	Guideline	12	3-7	Echoing comments 1 and 4 – Balance would recommend that teachers are provided with guidance on which educational resources are most effective and evidence-based and furthermore, that NICE review the resources and training materials that are already available, to ensure they are independent of industry influence and likely to be effective.	Thank you for your comment. The committee discussed resources and materials and agreed that schools should be responsible for choosing the appropriate resources to suit their needs. The following text was added to the Rationale section: "The committee also reiterated that it was the school's responsibility to use materials that are free from bias and evidence-based where possible. Also, the committee were

					mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see the public health burden of alcohol: evidence review). The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)." We will forward your request to review available resources to the Surveillance team for consideration at the next review of this guideline.
Balance	Guideline	12	14 & 15	We would completely endorse the vital importance in schools including alcohol education as a core and mandatory part of their curriculum	Thank you for your comment
Balance	Guideline	13	2, 3, 4, 5	We completely agree that alcohol education needs to be tailored according to age and should not be delivered in mixed age groups, where different behaviours and attitudes are likely.	Thank you for your comment

Balance	Guideline	16	4	Feedback from local Health Related Behaviour (HRB) Surveys suggests that a healthy lifestyle is increasingly important for a lot of young people – particularly when they are shown evidence of how their looks and appearance can be damaged by alcohol. A Teeside University-led piece of research commissioned by Balance, exploring attitudes amongst 11-15 year olds around alcohol, showed that many of them did not actively want to drink, including for health reasons, but that sometimes, parents were giving them alcohol, because they felt that it was the right thing to do.	Thank you for your comment. The committee discussed the influence of parents and carers on their child. They considered it was an important part of the whole-school approach to involve parents and carers in alcohol education to help with giving a consistent message on alcohol and added have text around parental responsibility to the Rationale section which now says "One of the elements of the whole-school approach is to involve parents and carers. The committee acknowledged that parents or carers have an influence on their child's healthy behaviours and therefore there is benefit in involving them in the school's approach to alcohol education. This can also help to improve the consistency of messages that pupils receive." The evidence also showed that there was difficultly in engaging parents with alcohol education. The committee discussed this issue and drafted a research recommendation on the best way to engage parents and carers with alcohol education. See research recommendation 6 "Engaging parents and carers in the whole-school approach to alcohol education" The committee also discussed the need for a positive approach to alcohol discussion. There is text in the rationale section which says that: "education that encourages discussion, for

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					example around healthy lifestyle decisions, is more beneficial than merely giving out information through, for example, leaflets or 'one-way' lectures" We did not include the study cited as it was out of scope and we did not have a question on attitudes to alcohol. However, children and young people's attitudes to alcohol drinking was considered in the committee discussion.
Balance	Guideline	19	11-17	Evidence tells us that more and more young people are choosing not to drink alcohol. This messaging should be embedded within lessons so that positive behaviours around alcohol are normalised and pupils feel supported to choose not to drink. This would also promote inclusivity for children where alcohol is a felt to be a particularly taboo subject e.g. because of religious or cultural beliefs.	Thank you for your comment. The committee have added more detail to the Rationale to highlight that more children are choosing not to drink alcohol and agree that this will promote inclusivity. The text now reads as follows (page 17): "The committee acknowledged that the number of children and young people drinking is decreasing. They considered that this trend will help to frame alcohol education in a positive way by normalising non-drinking behaviours. It will also promote inclusivity for those who choose not to drink or choose, to delay starting to drink, or who do not drink for cultural or religious reasons. " To encourage the use of positive messages in alcohol education the committee made the recommendation "1.2.1 When delivering alcohol education, aim to: • use a positive approach to help pupils to make

					informed, safe, healthy choices • encourage pupils to take part in discussions • avoid unintended consequences (for example, the pupil becoming curious about alcohol and wanting to try it, or substituting it with another substance) • avoid using scare tactics • avoid only giving out information, for example by lectures or leaflets."
Balance	Guideline	20	18	We welcome the update to the guideline in light of these changes.	Thank you for your comment
Community Alcohol Partnership	Guideline	General	General	This supports what Reading Community Alcohol Partnership and Reading Source try to achieve within our Alcohol Awareness Education. It will be good to have a joint up and consistent approach for all providers to be working from, which will in turn help to facilitate an internal/external moderation system. I also use a Needs assessment that I put together to assist with the planning stage, but would be happy to use a more developed version based	Thank you for your comment.

				on schools feedback and consensus from all providers.	
Community Alcohol Partnership	Guideline	4	General	Rec 1.1.3 'Spiral Curriculum' sounds like an interesting recommendation for planning, however this may not be possible for all providers to implement. Certainly in the work we do in schools, we often only see the years groups once per school term. However, that said, if the schools are conscious of this recommendation it may allow us to engage more with them through their needs. It would be good to hear any comments from you as to how you think this could work still, with providers like myself that don't currently have that constant opportunity to reinforce previous lessons, so we could speaks to schools about this at the initial contact stage.	Thank you for your comment. The committee heard from experts that the spiral curriculum is a useful approach to ensure alcohol education is age appropriate in order to minimise harm and builds upon previous learning. They also agreed that it was the schools responsibility to maintain this approach if using external providers and wrote this recommendation with the aim that schools will be more engaging with providers as you suggest: "1.2.3 If using external providers to supplement alcohol education: • use providers offering content that is consistent with the school's planned alcohol education • follow guidance on quality assurance and delivery (see section on Working with external agencies in the Department for Education's draft guidance on relationships education, RSE and health education). "
Community Alcohol Partnership	Guideline	11	24 - 28	I agree it is very important to engage the community, family, parents/guardians/carers. This is something CAP tries to encourage and be a part of, but for obvious reasons find it a difficult and delicate area when it comes to parents. So it would be good to have a plan around the best ways to approach this.	Thank you for your comment. The evidence also showed that there was difficultly in engaging parents with alcohol education. The committee discussed this issue and drafted a research recommendation on the best way to engage parents and carers with alcohol education. See research recommendation 6

					"Engaging parents and carers in the whole-school approach to alcohol education"
Community Alcohol Partnership	Guideline	13	10	Explanation on how the spiral curriculum will work ,so we can discuss at the initial meeting with the school as some times it is hard to reengage with them again, after that initial meeting.	Thank you for your comment. The committee heard from experts that the spiral curriculum is a useful approach to ensure alcohol education is age appropriate in order to minimise harm and builds upon previous learning. They also agreed that it was the schools responsibility to maintain this approach if using external providers and wrote this recommendation with the aim that schools will be more engaging with providers: "1.2.3 If using external providers to supplement alcohol education: • use providers offering content that is consistent with the school's planned alcohol education • follow guidance on quality assurance and delivery (see section on Working with external agencies in the Department for Education's draft guidance on relationships education, RSE and health education). " Please also the "Terms used in this guideline" section for a definition of the spiral curriculum. (Page 9)

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Community Alcohol Partnership	Guideline	15	General	**Delivering Universal alcohol education** I agree, scare tactics aren't the way forward and again a consistent approach through all educators needs to be developed and adopted to ensure the right message is delivered with the right audience.	Thank you for you comment. The aim of these recommendations is to help educators have a more consistent approach to alcohol education.
Mentor UK	Guideline	4	7	We support the recommendation that alcohol education should be delivered as part of a whole-school approach to PSHE. It is important, however, that alcohol education not be seen as a 'tick-box' exercise or 'add-on' in this. Young people in focus groups have stressed to us that part of the problem with the alcohol education they currently receive is that it is not treated as comprehensively as other aspects of the PSHE curriculum and is often delivered in a piecemeal fashion. Alcohol education needs to be delivered consistently and comprehensively as part of a whole-school approach to PSHE, but also as an important element of health education in its own right. Furthermore, schools need to be able to create links between health teaching about alcohol and the lessons that students receive as part of the Science curriculum, particularly at GSCE level. This is especially important, given that many of the students we spoke to considered excessive alcohol consumption to be normalised and even condoned within British society[1].	Thank you for your comment. The committee have added some text to the Rationale for the recommendations in section 1.1 (page 12) as follows "It is current practice for schools to use a whole-school approach for alcohol education (universal and targeted) and other health-related topics, as recommended in the original guideline, which has a PSHE component. This helps schools ensure that consistent messages are given about a topic, such as alcohol education, whether taught through health education or PSHE and the national science curriculum. "

Mentor UK	Guideline	4	10 - 14	We welcome the suggestion that alcohol education should include school activities that involve families and communities. Recent research[2] into effective school-based approaches to alcohol education has shown that programmes that incorporate interventions and information sharing with parents and carers in their models can have consistent positive effects[3][4]. Young people in research focus groups have also told us that they are aware that many young people are first provided with alcohol by their parents and that education work with parents as well as students around alcohol and alcohol harms would therefore be helpful as part of alcohol education generally. They feel that if alcohol education is to be effective in schools there needs to be a non-judgemental awareness among teachers that young people are often encountering alcohol in family environments and some will have already tried alcohol by the time they start to receive alcohol education at secondary school. Not only does this mean that alcohol education should begin before this stage, in primary school, but the recommendation of young people we have worked with is also that teachers need to approach alcohol education in a non-moralising manner.	Thank you for your comment. The committee have added some text to the Rationale for the recommendations in sections 1.1 and 1.2 as follows 1.1: "One of the elements of the whole-school approach is to involve parents and carers. The committee acknowledged that parents or carers have an influence on their child's health behaviours. They considered that involving them in the school's approach to alcohol education is essential to improve the consistency of messages that pupils receive. " 1.2: "Evidence from qualitative studies and expert testimony suggests that negative messages, scare tactics or providing information about alcohol in isolation do not work and may lead to harm, especially when they are not age appropriate. These approaches are not likely to be tailored to pupils' current understanding and perceptions of alcohol and therefore pupils may rebel against such messages. The evidence showed that pupils favour a non-judgemental environment where they can discuss alcohol in the context of real-life situations. "

Mentor UK	Guideline	4	15 - 17	We are concerned that, even with the Department of Education's guidance on RSE and health education, it will be hard for teachers and other staff to access the materials, planning time and training they need "to support, promote and provide alcohol education" in their schools. Mentor UK currently provides the Alcohol and Drug Education and Prevention Information Service (ADEPIS)[12], which points teachers and practitioners in the direction of appropriate and high quality information for planning alcohol education. There needs to be more investment in this and similar services, but also in support for continuing professional development of teachers in schools in this area, but also areas like trauma-informed practice. The current Department of Education guidelines do not go far enough in this respect. Furthermore, alcohol education and PSHE education needs to become a standardised part of teacher training in England and the rest of the UK in order for teachers to feel prepared and confident to deliver this vital component of health education. This is especially true given that we know that partial implementation of alcohol education in schools reduces impact[13][14].	Thank you for your comment. The committee were unable to name specific resources or CPD programmes as these were not evaluated. However, they have signposted to organisations who provide evidence-based resources, including Mentor-ADEPIS in the Rationale and impact section (page 13): " The committee were aware of accredited materials and training resources (although not reviewed by NICE) based on their experience of current practice. These include materials from PSHE Association, Public Health England and Mentor-ADEPIS."

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Mentor UK	Guideline	5	4 - 7	We are concerned that the wording of this guideline, especially that which refers to minimising, "the risk of any unintended adverse consequences" from alcohol education, like, "the pupil becoming curious about alcohol and wanting to try it" will impact on teachers' willingness to engage in open, honest and realistic conversations with students. Young people between the ages of 11 and 18 have been very clear with us that one of the biggest barriers to the effectiveness of alcohol education in their schools is their sense that teachers are unwilling or unable to engage in open and honest discussions around subjects like alcohol (as well as other drugs). It is already hard enough for many teachers to feel confident in delivering effective alcohol education. We do not advocate teachers encouraging or making light of alcohol consumption. They should, however, be supported to understand that whether a young person tries alcohol underage is largely out of their control and usually not the result of the health education they are receiving in school. Furthermore, older young people between the ages of 16 and 18 stressed to us the importance of harm-reduction advice as part of effective alcohol education for their age group. Recent research has shown that this is a crucial part of effective school-based alcohol prevention[18].	Thank you for your comment. The committee acknowledged that this is a key concern for teachers and drafted recommendations to support teachers and schools by highlighting the need to give time and training to those planning and delivering alcohol education as the follows: "1.1.2 Ensure those planning and delivering relationships education, RSE, health education or PSHE have the materials, planning time and training they need to support, promote and provide alcohol education." The committee have also drafted recommendations on the practical steps for planning alcohol education which will help to prevent unintended consequences: "1.1.4 When planning alcohol education: • ensure it is appropriate for age and maturity and aims to minimise the risk of any unintended adverse consequences (see recommendation 1.2.1). • tailor it to take account of each pupil's learning needs and abilities • tailor it to the group's knowledge and perceptions of alcohol and alcohol use • take into account that those aged 18 and over can legally buy alcohol."

				The wording of this guideline may make teachers wary of approaching alcohol education in this way and engaging in open and trusting conversations with their students, even when "age-appropriate".	
Mentor UK	Guideline	6	8 - 15	We are encouraged to see the guidelines including this advice, particularly where they encourage discussion as part of good alcohol education and avoiding scare tactics and information only approaches. This is all best practice for effective alcohol education in schools[19] We would, however, like to see more emphasis in the guidelines on encouraging participatory approaches to developing age-appropriate alcohol education with pupils and an acknowledgement that this is crucial if alcohol education is to be properly tailored "to the group's knowledge and perceptions of alcohol use". It is, of course important that schools understand that in doing this, they not normalise the perceptions of alcohol of any particular group of students. However, young people we spoke to stressed that much of the alcohol education they had received at school had been ineffective because it felt like being "lectured" to by teachers or other providers. It is therefore important that the guidelines include an acknowledgment that part of what allows for effective alcohol education in schools is the creation of a trusting, non-judgemental and interactive approach to fostering	Thank you for your comment. The committee wrote the following recommendations to ensure that the pupils' needs, abilities, knowledge and perceptions are used to tailor the alcohol education both in planning and delivery. These recommendations aim to encourage pupils to participate in the development of alcohol education: "1.2.1 Tailor alcohol education to the group's knowledge and perceptions of alcohol and alcohol use. Aim to: • use a positive approach to help pupils to make informed, safe, healthy choices • encourage pupils to take part in discussions • avoid unintended consequences (for example, the pupil becoming curious about alcohol and wanting to try it, or substituting it with another substance) • avoid using scare tactics • avoid only giving out information, for example by lectures or leaflets 1.1.4 When planning alcohol education: • ensure it is appropriate for age and maturity

				discussion with students without normalising specific students perceptions of alcohol consumption.	and aims to minimise the risk of any unintended adverse consequences (see recommendation 1.2.1). • tailor it to take account of each pupil's learning needs and abilities • tailor it to the group's knowledge and perceptions of alcohol and alcohol use • take into account that those aged 18 and over can legally buy alcohol. "
Mentor UK	Guideline	6	21 - 22	Our research with young people supports the idea that, when using external providers for alcohol education, schools should use providers who's content is consistent with what the school is already delivering. Young people told us that they had found many external providers uninspiring because they appeared to have failed to co-ordinate their messages with those of their teachers and often had no sense of what students had already covered when it came to alcohol education. Furthermore, quite a few young people told us that they found external providers that based their interventions on the testimony of former addicts or those in recovery unhelpful. Young people said this was because the experience of former addicts did not resonate with theirs, given that they are still in high school and very few of them were drinking to the point of addiction at this stage. Several young people also said that since they know that the majority of people who drink	Thank you for your comment. The committee agreed and have written the following text in the Rationale: "The evidence is consistent with current practice that school staff and other providers, including external speakers, can deliver alcohol education. However, there is conflicting evidence on who is best placed to deliver these interventions. Pupils favour a familiar member of school staff, whereas teachers lack confidence in teaching alcohol education. A research recommendation was drafted on the effectiveness of the different components of alcohol education delivery, including providers of the education" They also agreed that the content the provider uses must be appropriate for the group they are speaking to and avoid doing harm but could not specify which organisations the providers should come from. As a result, the committee recommended that "1.2.3 When using external

				alcohol do not become addicts, using the experience of those in recovery was not an effective educational tool[21].	providers to supplement alcohol education: • use providers offering content that is consistent with the school's planned alcohol education • follow guidance on quality assurance and delivery (see the Department offer Education's draft guidance on relationships education, relationships and sex education (RSE) and health education). "
NHS England - CYPMH	Guideline and evidence review	General		Change description form CAMHS to CYPMHS ie children and young people's mental health services as this was the descriptor preferred by CYP and has been used by DHSC and NHSE since 2015	Thank you for your comment. We have now removed the reference to CAMHS from the rationale but will use CYPMHS should they be referenced again.
NHS England - CYPMH	Guideline	6	21 & 22	1.3.1. Selecting pupils for targeted interventions - the guidance would benefit from clarity regarding: a) Who is identifying vulnerable CYP and, b) How will these CYP be identified. This should include recommending listing risk factors identified by research studies as well as training for staff who will be identifying CYP.	Thank you for your comment. The committee agreed that schools will already have processes in place for identifying children and young people (CYP) who are vulnerable for any reason and would expect the staff responsible for this will also be responsible for identifying CYP vulnerable to alcohol misuse e.g. staff with a pastoral role. The scope did not include a question on risk factors so the committee were unable to evaluate evidence on this or make recommendations. However, this will be flagged to surveillance for consideration at the next review of this guideline.

NHS England - CYPMH	Guideline	7	4	1.3.2 Consent should be from the young person and parent/carer where possible to support addressing environmental/social risk factors, unless there is a risk the young person will not engage with the intervention if a parent is informed.	Thank you for your comment. The committee have added a new recommendation (1.3.2) as follows: "1.3.2 When using targeted interventions, always seek to involve the pupils in decisions about them and the interventions offered to them. 1.3.3 Seek consent to include a pupil in a targeted intervention. This should be from the pupil themselves, or the pupil's parent or carer, as appropriate to the situation. "
NHS England - CYPMH	Guideline	7	10 - 24	1.3.3 & 1.3.4 The recommendation regarding the targeted intervention is very broad to put into practice in an effective way without additional recommendations, e.g.: a) What are the key approaches to include in the intervention – i.e. psychoeducation/motivational interviewing and any predictors of good outcomes. b) Who should deliver the intervention and how will this be commissioned as this will require an additional resource. c) Unintended consequences of group delivery - contagion effect and risk of socialised conduct/antisocial behaviour with specific groups. d) Helpful to suggest possible outcome measures for services to evaluate the effectiveness of interventions.	Thank you for your comment. The committee considered these points. It was not possible to ascertain whether individual or group interventions are best or who should deliver them from the evidence in order to make recommendations. However, the committee drafted a research question for targeting interventions on the comparative effectiveness of individual or group targeted interventions that will aim to answer this. Please see research recommendation 2 Targeted school-based interventions. With regards to the unintended consequences of group delivery, the committee made a recommendation which states: "1.3.7 Avoid normalising unhealthy drinking behaviours when delivering targeted group interventions (for example, by not mixing

					different age groups)." Research recommendation 2 will also deal with appropriate measures of effectiveness of targeted interventions.
RCPCH	Guideline	General	General	Thank you for inviting the Royal College of Paediatrics and Child Health to comment on the draft guideline for alcohol: school-based interventions. We have not received any responses for this consultation.	Thank you for your comment
Royal College of Nursing	Guideline	General	General	The Royal College of Nursing (RCN) welcomes the update of the NICE guidelines for Alcohol: school-based interventions.	Thank you for your comment
Royal College of Nursing	Guideline	General	General	We are pleased to note that the role of school nurses in supporting interventions in schools and further education settings is highlighted in the guideline. The RCN has concerns regarding the decreasing number of qualified school nurses following the transfer of commissioning to local authorities – see https://www.rcn.org.uk/professional-development/publications/pdf-007000	Thank you for your comment. The committee included some text in the Rationale section to illustrate this (page 16): "Members advised that it is best practice that schools have clear referral pathways to relevant specialist agencies such as school nursing. The local availability of specialist agencies varies, so the committee suggested examples of services that fulfil this criterion."

				and https://www.rcn.org.uk/professional-development/publications/pub-006200	
Royal College of Nursing	Guideline	General	General	We are pleased to note that children under 11 will be subsequently addressed in the update of another NICE guideline.	Thank you for your comment
Royal College of Nursing	Guideline	4		1.1.1 We note that there is no mention of junior citizenship programmes, yet we are aware that many schools participate and issues such as drugs and alcohol etc. are addressed therein.	Thank you for your comment. The committee were unable to make recommendations about specific interventions as the published literature was inconclusive. However, junior citizenship programmes will be flagged to the surveillance team for consideration at the next review of this guideline.
Royal College of Nursing	Guideline	4		1.1.2 We are pleased to see links to resources and joined up work across health education and social care, as well as links to safeguarding and domestic violence for example.	Thank you for your comment
Royal College of Nursing	Guideline	5		1.1.9 – 1.1.11 We note the mention of referral pathways for pupils. However, we have not noted any mention of potential pathways for a pupil themselves to make a referral for support either for themselves or for one of their peers. Examples of confidential support and access to school nurses such as ChatHealth could be mentioned.	Thank you for your comment. The committee did not evaluate different referral pathways so were unable to recommend specific ones. However, they agreed that pupils should be aware of how they can raise any concerns they have and made the following recommendation: " 1.1.7 Ensure pupils understand: • how they can raise any concerns that they have • that any information or concerns they disclose will be dealt with at an appropriate level of confidentiality

					• how disclosures will be handled where there are safeguarding concerns. "
Royal College of Nursing	Guideline	11 – 12		1.1.1 – 1.1.2 We note that teachers often advise that they do not feel confident or have the necessary knowledge to support pupils with this issue. This is why it is important for schools to involve others such as school nurses and drug and alcohol services within the planning and delivery of interventions, including personal, social, health and economic education (PSHE) programmes.	Thank you for your comment. The committee recommended the use of external providers to supplement alcohol education. "1.2.2 Use school nurses, local public health officers and drug and alcohol services, or other external providers, to provide additional support for alcohol education."
Royal College of Physicians	General	General	General	The RCP is grateful for the opportunity to respond to the above consultation. We have liaised with our Young Adult and Adolescents Steering Group (YAASG) and would like to make the following comments.	Thank you for taking the time to liaise with the Young Adult and Adolescents Steering Group and providing feedback.
Royal College of Physicians	General	General	General	The guideline covers intervention in secondary and further education – the latter could be taken to mean sixth form colleges, or even University. The whole document reads very heavily as though it applied to 'schools' – ie 11-16 year olds – the word 'college ' does not feature. This may be because PHSE is not a requirement for further education, but guidance should suggest that colleges have a duty of care to offer such education to those students who have been identified as at risk.	Thank you for your comment. The guideline covers schools, colleges and sixth forms but does not cover university education. We have now added the term "school" to our glossary to explain what it covers in this guideline: "All schools whether maintained, non-maintained or independent schools (including academies, free schools and alternative provision academies), and pupil referral units (see Department for Education Types of schools) and further education colleges and sixth-form colleges as established under the Further and Higher Education Act 1992 and institutions designated as being within the further education sector. "

				The document sets out as its target audience 'health and social care practitioners working with children and young people' Clarification is needed as to how/why the guidance would be of use, other than those HCP's being aware that such guidance exists. Our experts note that it would be reassuring to know that a similar guidance exists or is planned for alcohol education/intervention within health care, as many young people present to Emergency Departments with alcohol related issues and, in some Trusts, specialist Alcohol Liaison services are not commissioned to deal with young people below the age of 16.	The health and social care practitioners referred to in the guideline are those that specifically work in the education sector. We have now amended the text to say "'Health and social care practitioners working with children and young people in the education sector". NICE have produced guidance on Alcohol-use disorders: prevention and Alcohol-use disorders: diagnosis, assessment and management of harmful drinking and alcohol dependence which are listed on the alcohol page referenced under "Finding more information and resources" (https://www.nice.org.uk/guidance/lifestyle-and-wellbeing/alcohol).

Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	The Royal College of Physicians and Surgeons of Glasgow although based in Glasgow represents Fellows and Members throughout the United Kingdom. While NICE has a remit for England, many of the recommendations are applicable to all devolved nations including Scotland. They should be considered by the relevant Ministers of the devolved governments. The College considers that this an important area to address and supports the general philosophy of the guidance. Alcohol consumption in many parts of the United Kingdom is high and teaching children and young people of the hazards of excessive consumption is part of good health education. The College considers that any educational intervention should be totally independent of the alcohol industry to avoid conflicts of interest.	Thank you for your comment. Although not stated in the guideline, NICE guidelines cover health and care in England. Decisions on how they apply in other UK countries are made by ministers in the Welsh Government, Scottish Government, and Northern Ireland Executive. The committee agreed that the approach to alcohol education should be positive and aim to normalise non-drinking behaviours. They noted in the Rationale section (page 17) that "whilst it is important to highlight the hazards of excessive drinking, education that encourages discussion, for example around healthy lifestyle decisions, is more beneficial than merely giving out information using, for example, leaflets or 'one-way' lectures. " They also made the following recommendation: "1.2.1 When delivering alcohol education, aim to: • use a positive approach to help pupils to make informed, safe, healthy choices • encourage pupils to take part in discussions • avoid unintended consequences (for example, the pupil becoming curious about alcohol and wanting to try it, or substituting it with another substance) • avoid using scare tactics

					• avoid only giving out information, for example by lectures or leaflets" The committee discussed resources and materials and agreed that schools should be responsible for choosing the appropriate resources to suit their needs. The following text was added to the Rationale section: "The committee also reiterated that it was the school's responsibility to use materials that are free from bias and evidence-based where possible. Also, the committee were mindful of a Public Health England 2016 review which noted that the delivery of education messages by the alcohol industry has no public health effects (see the public health burden of alcohol: evidence review). The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for drug abuse prevention from the United Nations Office on Drugs and Crime)."
Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	Our educational reviewer considered the policy is 'generic'. Since all the hyperlink references refer to the PHSE (Personal Social, Health and Economic) policy, it was felt that the document needs to justify why it should be separate policy on its own, from an educational point of view.	Thank you for your comment. The NICE guidance aims to be consistent with the DfE guidance as the forthcoming subjects will be mandatory. However, the guidance does aim to give more recommendations on how schools should plan and deliver alcohol education.

Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	As many of the potential readers are not familiar with NICE documentation, it would be more helpful if hyperlinks were directed to the information referred to, not to documents which contains other hyperlinks. Senior leadership teams in education need to be able to access information efficiently.	Thank you for your comment. There are some instances where we have not directly linked to resources as the they have not been evaluated by NICE but have instead linked to the source that suggests them, such as with the DfE draft guidance. This also ensures that our content remains current.
Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	The guidance is addressed to the 11 – 18-year group (secondary). Our reviewer felt, it needs to be delivered to Year 6 Primary children as well. Our reviewer has had personal experience of alcohol abuse in Year 6 SEND (Special Educational Needs and Disabilities) groups in an inner-city Primary School. Two pupils were often drunk and came from families where there was alcohol and drug abuse. While the scope of the guideline clearly starts at 11 and the document refers to a future guideline. This needs to be cross referenced. The importance of spiral curriculum starting at primary school level is supported	Thank you for your comment. The guideline on social and emotional wellbeing of primary school children is currently being updated and will eventually be cross-referenced in this guideline. In the meantime, we have updated what our guideline covers to say that it is relevant to year 6 pupils also (see guideline landing page).
Royal College of Physicians and Surgeons of Glasgow	Guideline	General	General	The Guidance does not discuss the needs of Black and Minority Ethnic (BME) populations. There are cultural issues for both children and parents where for many, alcohol may either be used in different ways or there may be abstinence. Would for instance Muslim children be excluded from this group of lessons? The content needs to be looked at very carefully in the main document in respect to	Thank you for your comment. The committee acknowledged that children who choose not drink alcohol for any reason should not be excluded from the lessons. They added the following text in the Rationale section: "The committee acknowledged that the number of children and young people drinking is decreasing. The committee considered that this trend is helpful in framing alcohol education in a positive way by normalising non-drinking

				differing cultural attitudes to alcohol. It is noted that this point is referred to in FAQs	behaviours. This will also promote inclusivity for those who choose not to drink, to delay drinking onset or do not drink for cultural or religious reasons. "
Royal College of Physicians and Surgeons of Glasgow	Guideline	6	1	Para 1.1.10 Our reviewer recommends very clear simple pathways. Many programmes in teaching fail for this reason. Our reviewer's experience in C.P. (Child Protection) disclosure training was that staff in schools did not fully understand procedures particularly in relation to SEND leaders. Too often teachers had not been fully briefed as to the key person to go to when a child disclosed sensitive C.P. information. The children themselves often didn't know who to approach for help. It was felt important to skill teachers in the delivery of the programme as they already have the relationship with the children and are more likely to be trusted by them. Teachers can tailor the programme to the needs of their pupils. It is key that the programme is carefully adjusted to meet the needs of SEND pupils and their parents.	Thank you for your comment. The committee agree with using simple referral pathways and made the following recommendation: "1.1.11 Use clear referral pathways, for example into school nursing, school counselling, early help services, voluntary sector services, young people's drugs and alcohol services or to a youth worker, as needed. " The committee agreed that all individuals in alcohol education should be aware of procedures around disclosures and safeguarding, including all pupils. They made the following recommendations: "1.1.6 Ensure all involved in giving the alcohol education sessions are aware of the school's process for handling confidential disclosures. 1.1.7 Ensure pupils understand: • how they can raise any concerns that they have • that any information or concerns they disclose will be dealt with at an appropriate level of confidentiality • how disclosures will be handled where there

					are safeguarding concerns. 1.1.8 Use safeguarding arrangements to refer pupils for extra support if they have: • raised concerns, for example about alcohol-related harm or • had concerns raised about them (see the Department for Education's Keeping children safe in education). " NICE also have related guidance on [Child abuse and neglect (NG76)] which aims to help anyone whose work brings them into contact with children and young people to spot signs of abuse and neglect and to know how to respond. The committee acknowledged that pupils favour a familiar member of staff to deliver alcohol education, but that teacher can lack confidence in teaching it due to not having the appropriate skills. They made a research recommendation that will look at the most effective components of alcohol education including who should provide it. See research recommendation 1 "Components of alcohol education delivery". The committee discussed the applicability of the recommendations to SEND pupils and made the following recommendation on adapting alcohol education for the SEND population. "1.1.5 Think about how to adapt alcohol

					education for pupils with special educational needs and disabilities so that it is tailored to take account of the pupil's learning needs, abilities and maturity (see chapter 6 of the Department for Education's SEND code of practice: 0 to 25 years)."
Royal College of Physicians and Surgeons of Glasgow	Guideline	6	16	Para 1.2.2.-3 Consideration should be given to the use of experience of excessive alcohol consumption including individuals and organisations such as Alcoholics Anonymous or medical services for those with alcohol problems. (however, avoiding normalisation of unhealthy drinking). It is noted that this needs to be tailored to the needs of the individual or group of young people and could in the wrong circumstances be negative (Page 15 Line 25)	Thank you for your comment. The committee discussed the use of external providers to support alcohol education. They agree that the content the provider uses must be appropriate for the group they are speaking to and avoid doing harm but could not specify which organisations the providers should come from. As a result, the committee recommended that "1.2.3 If using external providers to supplement alcohol education: • use providers offering content that is consistent with the school's planned alcohol education • follow guidance on quality assurance and delivery (see section on Working with external agencies in the Department for Education's draft guidance on relationships education, RSE and health education). "

Royal College of Psychiatrists	Guideline	General	General	There is a reference to over 18's able to buy alcohol – there are no references to not needing parental consent for referrals for over 18's or any Children's Safeguarding referral possibility for over 18's – perhaps Adult Safeguarding may be referenced if concerns are severe enough to meet a threshold?	Thank you for your comment. The committee have made the following recommendations which aim to address the different situations (which could include those who are over 18) regarding obtaining consent for interventions and referral: " 1.3.2 When using targeted interventions, always seek to involve the pupils in decisions about them and the interventions offered to them. 1.3.3 Seek consent to include a pupil in a targeted intervention. This should be from the pupil themselves, or the pupil's parent or carer, as appropriate to the situation. " 1.1.12 Involve the pupil and their parents or carers, as appropriate, in any consultation and referral to external services." The committee also agreed not to specify particular safeguarding documents that did not apply to schools and they were mindful of the fact that by using safeguarding arrangements in the stem of the recommendation covered both adult and child safeguarding. The committee have cross-referred to the "Keeping children safe in education" document as this is specific to education setting. Whereas the adult safeguarding documents are not specific to education.

					"1.1.8 Use safeguarding arrangements to refer pupils for extra support if they have: • raised concerns, for example about alcohol-related harm or • had concerns raised about them (see the Department for Education's Keeping children safe in education). "
Royal College of Psychiatrists	Guideline	Gener al	Gener al	The document refers to Social Services throughout – should this not read Children's Social Care?	Thank you for your comment. We have now replaced "social services" with "children's services (including Children's Social Care)" throughout the guideline.
Royal College of Psychiatrists	Guideline	Gener al	Gener al	The document refers to referral to Drug and Alcohol services for young people – there is currently patchy provision of services across the country – the document implies availability nationally. The document also implies CAMHS would offer support for young people with alcohol related needs – this is does not happen in practice – specialist alcohol assessment, support, treatment interventions are not generally available within CAMHS services.	Thank you for your comment. The committee agreed that if children and young people require further support, for example, as a result of something disclosed during alcohol education, schools currently refer to external agencies including specialist drug and alcohol services. We have removed the reference to CAMHS and replaced it with "young people's specialist drug and alcohol services".
Royal College of Psychiatrists	Guideline	Gener al	Gener al	It would be good to see consistent methods of evaluation of interventions to measure effectiveness	Thank you for your comment. The committee have made research recommendations where one of the outcomes specified is process evaluation of interventions.

Royal College of Psychiatrists	Guideline	General	General	Although the document identifies safeguarding as a potential concern, the document avoids discussing vulnerable groups e.g. Children of Problem Drinkers who may require specialist support – this group are generally supported through Young Carers Services – and as such are entitled to a Carers assessment. Perhaps the guidance might include this group specifically?? These children may already be involved with services and receiving support – not merely identified during an alcohol intervention session - however attending these sessions may be impactful for them and is worth bearing in mind? Interventions for these children are specialist and are not the same as routine targeted prevention to those at risk.	Thank you for your comment. The committee have used this group as one of the examples of vulnerable young people in the Rationale section (page 20): "The committee also noted that other groups (for example children who do not drink but are vulnerable to other people's drinking, and those in the criminal justice system) may also be considered to be particularly vulnerable." In addition, the committee acknowledged that there will be groups of vulnerable children that will require more support than targeted prevention interventions and so made a recommendation on referring for further support : "1.1.11 Use clear referral pathways, for example into school nursing, school counselling, early help services, voluntary sector services, young people's drugs and alcohol services or to a youth worker, as needed. "
Royal College of Psychiatrists	Guideline	7	14	Tailoring Targeted Interventions – this is vague – and looks at identifying those most at risk (there are clear indicators for this) but doesn't identify suitable targeted interventions or how these might be delivered.	Thank you for your comment. It was not possible to ascertain whether individual or group interventions are best from the evidence in order to make recommendations. However, the committee drafted a research question for targeting interventions on the comparative effectiveness of individual or group targeted interventions that will aim to answer this. Please see research recommendation 2 Targeted school-based interventions.

South Gloucestershire Council	Guideline	Gener al	Gener al	Research recommendation: Identifying why some yp choose not to drink alcohol and how they manage this within peer groups	Thank you for your comment. The committee were unable to make a research recommendation on this as it was not a question that was asked in the scope. However, we will highlight this as an area for consideration in the next review of this guideline.
South Gloucestershire Council	Guideline	Gener al	Gener al	Good concise document which builds upon existing best practice	Thank you for your comment
South Gloucestershire Council	Guidelines	4	12	More specific examples of effective engagement of parents would be helpful. Guidance on how schools can encourage parents/carers to model good drinking behaviours.	Thank you for your comment. The evidence also showed that there was difficultly in engaging parents with alcohol education. The committee discussed this issue and drafted a research recommendation on the best way to engage parents and carers with alcohol education. See research recommendation 6 "Engaging parents and carers in the whole-school approach to alcohol education"
South Gloucestershire Council	Guidelines	4	15	More specific guidance for schools on how to ensure teachers have the necessary training & resources to provide good quality education	Thank you for your comment. The committee were unable to make recommendations on how to ensure teachers have training and resources for good quality education as this was outside of the scope for this guideline. However, they were aware of resources available and signposted to this in the Rationale section, for example (page 13): "The committee were also aware of international criteria on how to select teaching materials and support resources (see the guidance on school-based education for

					drug abuse prevention from the United Nations Office on Drugs and Crime)."
South Gloucestershire Council	Guidelines	5	3	More guidance around the need for alcohol education to be delivered within each year group	Thank you for your comment. The committee recommended that alcohol education be delivered using a spiral curriculum which builds upon their knowledge each year they are in schools. This also ensures that the content is age appropriate. They made the following recommendations: "1.1.3 Use a ‘spiral curriculum’ when planning and delivering alcohol education. 1.1.4 When planning alcohol education: • ensure it is appropriate for age and maturity and aims to minimise the risk of any unintended adverse consequences (see recommendation 1.2.1). • tailor it to take account of each pupil’s learning needs and abilities • tailor it to the group's knowledge and perceptions of alcohol and alcohol use • take into account that those aged 18 and over can legally buy alcohol."
South Gloucestershire Council	Guidelines	6	4	Suggest a screening tool to ensure yp is involved in conversations around referral	Thank you for your comment. The committee were unable to recommend a screening tool as they were out of scope and therefore not evaluated. However, they agreed that it was important to involve pupils in any decisions around referral to interventions and made the following recommendations: "1.3.2 When using targeted interventions,

					always seek to involve the pupils in decisions about them and the interventions offered to them. 1.3.3 Seek consent to include a pupil in a targeted intervention. This should be from the pupil themselves, or the pupil's parent or carer, as appropriate to the situation. "
Westminster Drug Project	Guideline	General	General	Alcohol education should also focus on the associated risks.	Thank you for your comment. The committee agreed that the approach to alcohol education should be positive and aim to normalise non-drinking behaviours. They noted in the Rationale section (page 17) that "whilst it is important to highlight the hazards of excessive drinking, education that encourages discussion, for example around healthy lifestyle decisions, is more beneficial than merely giving out information using, for example, leaflets or 'one-way' lectures. " They also made the following recommendation: "1.2.1 When delivering alcohol education, aim to: • use a positive approach to help pupils to make informed, safe, healthy choices • encourage pupils to take part in discussions • avoid unintended consequences (for example, the pupil becoming curious about alcohol and wanting to try it, or substituting it with another substance) • avoid using scare tactics

					• avoid only giving out information, for example by lectures or leaflets"
Westminster Drug Project	Guideline	6	17	We feel that although local drug and alcohol services (adult or YP services) have much experience and expertise in alcohol misuse and can provide tangible benefits, they may not necessarily have the required resources to adequately provide universal alcohol education to schools in their local area. We suggest where school leaders require universal alcohol education in schools, this should be detailed and resourced through the local authority commissioning process. This will allow for more effective and better-resourced interventions to be designed and carried out by local services; and further foster important relationships between local services and schools. WDP is happy to meet and suggest how this might be achievable.	Thank you for your comment. The committee made recommendations that would be able to be used in all localities and avoided recommending processes that might not be available to all areas.

Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how recommendations are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its officers or advisory committees