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2 **NATIONAL INSTITUTE FOR HEALTH AND CARE**
3 **EXCELLENCE**

4 # Guideline

5 # Alcohol interventions in secondary and further
6 education

7 ## Draft for consultation, February 2019

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This guideline covers interventions in secondary and further education to prevent and reduce alcohol use among children and young people aged 11 to 18. It also covers people aged 11 to 25 with special educational needs or disabilities in full-time education. It aims to encourage children and young people not to drink, to delay the age at which they start drinking, and to reduce the harm to those who do drink.

Who is it for?

- Local authorities responsible for education and public health
- Teachers, school governors and others (including school and public health nurses and healthy school leads) in schools and further education settings
- Health and social care practitioners working with children and young people
- Providers of alcohol education
- Members of the public, including parents or carers of children and young people in full-time education
- People working with children and young people in the voluntary sector

This guideline will update and replace NICE guideline PH7 (published 2007). Unlike PH7, the guideline will cover children and young people aged 18 to 25 with special educational needs or disabilities who remain in education and will not cover children under 11. However, children under 11 will be covered in the next

update of our guideline on social and emotional wellbeing in primary education (NICE guideline PH12).

This draft guideline contains:

- the draft recommendations
- recommendations for research
- rationale and impact sections that explain why the committee made the recommendations and how they might affect practice
- the guideline context.

Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

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Contents

Recommendations

People have the right to be involved in discussions and make informed decisions about their care, as described in your care.

Making decisions using NICE guidelines explains how we use words to show the strength (or certainty) of our recommendations, and has information about prescribing medicines (including off-label use), professional guidelines, standards and laws (including on consent and mental capacity), and safeguarding.

1.1 Planning alcohol education

These recommendations are for school leaders, head teachers and governing bodies.

Organising alcohol education

1.1.1 Plan and deliver alcohol education (universal and targeted interventions) as part of a whole-school approach to 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 families and communities (see the section on making it as easy as possible for people to get involved, in the NICE guideline on community engagement).

1.1.2 Ensure those planning and delivering PSHE have the materials, planning time and training they need to support, promote and provide alcohol education.

Be aware that there are resources available that can be used for planning and delivering alcohol education (see the Department of Education's draft guidance on relationships education, relationships and sex education, and health education).

Planning alcohol education content

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. For example, the pupil becoming curious about alcohol and wanting to try it, or substituting it with another substance (see recommendation 1.2.1).
- Tailor it to take account of each pupil's learning needs and abilities.
- Take into account that those aged 18 and over can legally buy alcohol.

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).

Confidentiality

1.1.6 Ensure all involved in giving the alcohol education sessions are aware of the process for handling confidential disclosures.

1.1.7 Ensure pupils understand that any information or concerns they disclose can be kept private unless there are safeguarding concerns.

1.1.8 Use existing school policies to deal with problems (such as bullying) that may arise if a pupil's disclosures are inappropriately shared by other pupils.

Referral for further support

1.1.9 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).

1.1.10 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.

1.1.11 Involve the pupil and their parents or carers, as appropriate, in any consultation and referral to external services.

> To find out why the committee made the recommendations on planning alcohol education and how they might affect practice, see rationale and impact.

1.2 Delivering universal alcohol education

Structuring 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 encourage pupils to make safe, healthy choices
- encourage discussion
- avoid scare tactics
- avoid only giving out information, for example by lectures or leaflets.

Providers of 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.

1.2.3 When 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 the Department of Education's draft guidance on relationships education, relationships and sex education, and health education).

To find out why the committee made the recommendations on universal alcohol education and how they might affect practice, see rationale and impact.

1.3 Targeted interventions

Selecting pupils for targeted interventions

1.3.1 When selecting pupils to offer a targeted intervention to, avoid treating them in a way that could stigmatise them or that would encourage them to see themselves as likely to use alcohol or see it as normal behaviour.

1.3.2 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.

1.3.3 Offer a targeted individual or group intervention (for example counselling or a brief intervention) to pupils who are assessed as vulnerable to alcohol misuse.

Tailoring targeted interventions

1.3.4 For each person or group offered an intervention, identify their specific risk factors and any concerns about their behaviour so that the intervention can be tailored to their needs. Use information from sources such as:

- level of needs assessment
- formal sources of information about risk factors (for example. information provided by social services or through the whole-school approach)
- informal sources of information about pupils' behaviour (for example a member of the community informing the school after witnessing pupils drinking alcohol).

Avoiding unintended consequences of group interventions

1.3.5 Avoid normalising unhealthy drinking behaviours when delivering targeted group interventions (for example, by not having drinkers and non-drinkers in the same group).

To find out why the committee made the recommendations on targeted interventions and how they might affect practice, see rationale and impact.

Terms used in this guideline

Level of needs assessment

An agreed threshold document from the local children's safeguarding board (LSCB)[1] or safeguarding partnership that sets out risks factors and considerations for what to do when worried about a child.

Spiral curriculum

A course of study in which pupils study the same topics in ever-increasing complexity throughout their time at school to reinforce previous lessons.

Targeted intervention

Interventions for children and young people who are not necessarily seeking help but are identified as being vulnerable to alcohol misuse because of risk factors that they have.

Universal alcohol education

Education that addresses all pupils in the school. It is delivered to groups of pupils without assessing for risk.

Vulnerable to alcohol misuse

This may include children and young people:

- whose personal circumstances put them at increased risk

[1] From September 2019, all local authority areas in England should have completed their transition from LSCBs to safeguarding partnerships.

- who may already be drinking alcohol
- who may already be regularly using another harmful substance, such as cannabis.

Whole-school approach

An ethos and environment that supports learning and promotes the health and wellbeing of everyone in the school community. The aim is to ensure pupils feel safe, happy and prepared for life beyond school. It covers:

- curriculum subjects
- general school policies on social, moral and spiritual wellbeing
- cultural awareness.

It also promotes a partnership between the school, children, young people and their parents or carers, and the wider community.

Recommendations for research

The guideline committee has made the following recommendations for research.

Key recommendations for research

1 Components of alcohol education delivery

What components of alcohol education delivery contribute to its effectiveness for children and young people aged 11 to 18 in full-time education, including those with special educational needs and disabilities (SEND)?

To find out why the committee made the research recommendation on the impact of statutory health education on alcohol see the rationale and impact section for planning alcohol education.

2 Targeted school-based interventions

How effective and cost-effective are individual, compared with group, school-based interventions for children and young people aged 11 to 18 in full-time education who are thought to be vulnerable to alcohol misuse?

To find out why the committee made the research recommendation on targeted school-based interventions see the rationale and impact section for targeted interventions.

3 Universal interventions for people aged 11 to 25 with special educational needs and disabilities

How effective and cost-effective are universal, school-based alcohol interventions for children and young people aged 11 to 25 with SEND?

To find out why the committee made the research recommendation on universal school-based interventions for those aged 11 to 25 with SEND see the rationale and impact section for planning alcohol education.

4 Targeted interventions for people aged 11 to 25 with SEND

How effective and cost-effective are school-based alcohol interventions targeted at young people aged 11 to 25 with SEND who are thought to be vulnerable to alcohol misuse?

To find out why the committee made the research recommendation on targeted interventions for those aged 11 to 25 with SEND see the rationale and impact sections for planning alcohol education and targeted interventions.

5 Engaging parents and carers in the whole-school approach to alcohol education

What methods and techniques help secondary schools to effectively engage with parents and carers as part of a whole-school approach to promote and support alcohol education?

To find out why the committee made the research recommendation on engaging parents in the whole-school approach to alcohol education see the rationale and impact section for delivering universal alcohol education.

6 Prevention interventions for people aged 11 to 25 with SEND

How effective are school-based alcohol prevention interventions (universal or targeted) for people aged 11 to 25 with SEND in full-time education?

To find out why the committee made the research recommendation on prevention interventions for those aged 11 to 25 with SEND see the rationale and impact sections for planning alcohol education and targeted interventions.

Rationale and impact

These sections briefly explain why the committee made the recommendations and how they might affect practice. They link to details of the evidence and a full description of the committee's discussion.

Planning alcohol education

Organising alcohol education

Recommendations 1.1.1 to 1.1.2

Why the committee made the recommendations

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. In England, universal alcohol education forms part of the usual curriculum through the health component of PSHE, which will be compulsory in all schools from 2020.

Evidence was identified on delivering universal alcohol-specific education programmes in a mix of approaches and components (for example, in or outside of the classroom, on its own, or in combination with family, the community, or both). This evidence showed that effectiveness of specific universal alcohol education programmes is no better than usual alcohol education. In England usual alcohol education is delivered as part of PSHE, so the committee thought that alcohol education can continue to be delivered through PSHE.

One of the elements of the whole-school approach is to involve parents and carers. Evidence was identified on universal alcohol programmes that involved parents, but it was inconclusive. The committee believed that limitations in study design, such as short follow-up, might explain this. The evidence also showed that it can be difficult to engage parents successfully (for example, to attend family education activities at

school) and so the committee made a research recommendation to evaluate the different ways to engage with parents (research recommendation 5).

Evidence from qualitative studies showed that teachers may lack confidence in teaching alcohol education and don't know the best materials to use. The committee was 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, Mentor-ADEPIS, and OFSTED.

The committee discussed that schools should adopt existing examples of good practice in alcohol education to suit local needs. But it also pointed out that there was no evidence to recommend this practice and there was also a concern that adapting examples of good practice for local needs may alter the effectiveness.

Evidence from qualitative studies shows that many schools find it difficult to prioritise alcohol education because of the demands of a crowded curriculum. But, given that health education will be compulsory from 2020, the committee thought it important that schools find time to plan for alcohol education in the curriculum.

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following and will become mandatory. However, the statutory changes may mean that schools need to make changes in how they prioritise health education to give it equal status to other subjects in the curriculum.

Full details of the evidence and the committee's discussion are in evidence review 1: universal school-based alcohol interventions.

Return to recommendations

Planning alcohol education content

Recommendations 1.1.3 to 1.1.5

Why the committee made the recommendations

Evidence from qualitative studies showed that pupils and their teachers believe that the content of alcohol education needs to be age appropriate and should not be taught to a group of mixed ages. Pupils and teachers also believe that it should be tailored to the levels of need and maturity. Evidence from expert testimony highlighted that accounting for these factors will help avoid unintended consequences. For example, a pupil who has not started drinking alcohol may want to try it once they start to learn more about it. Or when they learn that they should not drink alcohol or cannot buy it, they may choose another substance instead.

Experts told the committee that making alcohol education age appropriate can be achieved using a 'spiral curriculum' approach. Taking into consideration the need for alcohol education to be age appropriate to minimise harm, the committee agreed that the spiral curriculum concept is a logical approach to do this.

No evidence was identified for alcohol education specific to pupils with special educational needs and disabilities (SEND), and intervention studies carried out in schools often exclude pupils with SEND. Therefore the committee could not recommend any specific alcohol education adaptations for SEND pupils. But they thought it was important for schools to consider adapting alcohol education to the needs of their SEND pupils. The SEND code of practice sets out how schools can ensure equality of access to the curriculum and inclusion in all school activities for SEND pupils. Therefore research is needed to evaluate the effectiveness of such interventions for this group and of alcohol education (research recommendations 1, 3, 4 and 6).

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following. Schools should already be considering adapting education for their SEND pupils so it is not anticipated that there will be any resource impact. Full details of the evidence and the committee's discussion are in evidence review 1: universal school-based alcohol interventions.

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Confidentiality

Recommendations 1.1.6 to 1.1.8

Why the committee made the recommendations

Alcohol education can touch on personal experiences or issues that could be sensitive or confidential in nature and may also involve a safeguarding issue. The evidence from qualitative studies suggested that pupils would be more comfortable discussing alcohol-related concerns if they were reassured that they could speak in confidence. Therefore the committee thought that it should be made clear to pupils how any concerns they raise will be dealt with. To make this possible, those in a position to hear these concerns must be aware of how to handle confidential disclosures. Expert testimony also suggested that schools should be prepared to deal with unintended consequences and so the committee made a recommendation that this should be planned for and anticipated.

The evidence from qualitative studies also showed that some pupils may be reluctant to share information in a group setting for fear of the information being shared, and of being teased or bullied by their peers. The committee wanted schools to be aware of this and suggested that following existing school policies, for example on bullying, should help to minimise this.

It is current practice for schools to have a process in place so that pupils know that they can speak confidentially, and to allow for concerns to be raised and local safeguarding processes to be followed. (For example, see Public Health England guidance on Safeguarding and promoting the welfare of children affected by parental alcohol and drug use: a guide for local authorities.)

Referral for further support

Recommendations 1.1.9 to 1.1.10

Alcohol education may bring to light some matters that may lead to safeguarding issues. 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. The committee wanted to reinforce the need for all

those providing alcohol education to be aware of safeguarding and of the referral pathways in place. This would help to provide as much support for pupils as possible. For example, the Early Help Assessment is designed to help ensure a pupil is offered the right support at an early stage. If these external specialist interventions are needed, the school needs to involve the pupil and their parents or carers. The committee thought that this would be a way of increasing the chances of success of any intervention by allowing them to consult and agree on the best approach for referral to these services.

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following. However, statutory changes may mean that schools need to make changes in how they prioritise health education to give it equal status to other subjects in the curriculum. Schools currently refer to school nursing, school counsellors or external specialist services such as child and adolescent mental health services (CAMHS). There may be some resource implications depending on who delivers the interventions if the number of referrals increases.

Full details of the evidence and the committee's discussion are in evidence review 1: universal school-based alcohol interventions.

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Delivering universal alcohol education

Structuring alcohol education

Recommendation 1.2.1

Why the committee made the recommendations

Evidence from qualitative studies and expert testimony suggest that negative messages, scare tactics or providing information on 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 an environment where pupils can discuss alcohol in the context of real-life situations is favoured by pupils. Taking all this into consideration, the committee agreed 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.

Providers of alcohol education

Recommendations 1.2.2 to 1.2.3

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 (see research recommendation 1).

Evidence suggests that using trained external providers to supplement alcohol education may benefit pupils, as well as offering a solution to teachers who are not confident in teaching the subject. However, evidence also supported the committee's experience that some external providers may be unsuccessful in getting the right message across and their approach may be potentially harmful. Experts on the committee said that negative approaches and scare tactics from police officers or recovering alcoholics, for example, could either scare pupils or inadvertently glamorise alcohol misuse. The committee agreed that if schools use external providers, they should ensure that the providers 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. The committee also heard from expert testimony that these sources are listed on the Department for Education website.

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following. The use of external providers (such as school nurses, local public health officers and drug and alcohol

services) to support alcohol education varies, and there may be a cost associated with this provision. This may then have an impact on staff workload in terms of planning or delivering the alcohol education, or both.

Full details of the evidence and the committee's discussion are in evidence review 1: universal school-based alcohol interventions.

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Targeted interventions

Selecting pupils for targeted interventions

Recommendations 1.3.1 to 1.3.3

Why the committee made the recommendations

Evidence suggests that targeted interventions for pupils who are vulnerable to alcohol misuse may be effective. These studies included individual or group brief interventions or counselling that are delivered over 1 to 5 sessions. The committee was unable to recommend specific details for these interventions because they thought this would be dependent on the pupil's specific needs. For example, one pupil may benefit from a one-off session whereas another pupil may need follow-up sessions or further support. It was not possible to determine the comparative effectiveness of individual interventions compared with group interventions, so the committee made a research recommendation (see research recommendations 2 and 4).

Experts told the committee that when planning an intervention, it is important to consider any potential unintended consequences. This supported the committee's view that care should be taken to avoid 'labelling' or stigmatising pupils when selecting vulnerable pupils for a targeted intervention. For example, if a pupil needs to leave lessons for a counselling session, classmates or teachers might treat them differently, and they could be at increased risk of bullying. They may become withdrawn or defiant as a result, and increase the behaviour that the intervention is intended to prevent.

The committee was clear that seeking consent from the pupil or their guardian when offering any intervention is best practice. Also, for alcohol education to be successful the pupil must be a willing participant and seeking consent from them (or their families and carers) is an important part of following a whole-school approach.

How the recommendations might affect practice

The recommendations will reinforce best practice because they are based on existing processes and on guidance on individual sessions for vulnerable people. Potentially, group intervention will lead to savings but it is not clear how often these would be used.

Full details of the evidence and the committee's discussion are in evidence review 2: targeted school-based alcohol interventions.

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Tailoring targeted interventions

Recommendation 1.3.4

Why the committee made the recommendations

The identified studies used varying risk factors to determine if a pupil was vulnerable to alcohol misuse, for example drinking in a risky way, use of other substances, or showing challenging behaviour at school. This is consistent with how schools might consider whether a pupil is vulnerable to alcohol misuse. How best to identify those who may benefit from targeted interventions was not included in the scope and so the committee was not able to make a recommendation on this issue.

As schools might use several factors to determine whether a pupil is vulnerable to alcohol misuse and to ensure the alcohol intervention is tailored to the pupil's needs, the committee agreed that there should be an assessment of the pupil's individual risk factors and needs. The committee suggested using existing processes, for example, by using information from a level of needs assessment. Other sources include information derived from the whole-school approach or social services, as well as more informal sources such as reports from members of the community.

How the recommendations might affect practice

The recommendations will reinforce current practice because they are based on existing processes. These sources of information should be readily available to all concerned so there should not be any additional resource impact.

Full details of the evidence and the committee's discussion are in evidence review 2: targeted school-based alcohol interventions.

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Avoiding unintended consequences of group interventions

Recommendation 1.3.5

Why the committee made the recommendations

There could be many reasons why someone is vulnerable to alcohol misuse, and including them in a targeted group intervention may lead to unintended consequences. For example, if the group includes several young people who are already drinking, this may lead to the non-drinkers trying alcohol because they begin to see it as 'normal'. The committee agreed with expert testimony that planning for unintended consequences of interventions should be taken into account when deciding on the best approach for group interventions.

How the recommendations might affect practice

The recommendations will reinforce best practice because they are based on existing processes and existing guidance. But splitting groups based on vulnerabilities may result in additional resource impact depending on who is delivering these interventions and how frequently they might be run.

Full details of the evidence and the committee's discussion are in evidence review 2: targeted school-based alcohol interventions.

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Context

Children and young people risk disease, poisoning, injury, violence, depression and damage to their development from drinking alcohol, especially those who drink

heavily (Statistics on alcohol, England, 2018, NHS Digital). Drinking at an early age is also associated with a higher likelihood of alcohol dependence.

The statistics on alcohol also show that:

- 44% of 11- to 15-year-olds had tried alcohol
- 10% of 11- to 15-year-olds had drunk alcohol in the past week
- pupils who drank alcohol in the past week consumed an average (mean) of 9.6 units
- girls (11%) were more likely than boys (7%) to report having been drunk in the past 4 weeks.

Since publication of NICE's guideline on alcohol and school-based interventions in 2007 (PH7), both the public health and education sectors have changed a great deal. For example, academies and free schools have been introduced, leading to a reduction in local authority governance of schools. Some of the barriers and facilitators for implementing the previous NICE guidance have also changed.

In addition, the Chief Medical Officer's Guidance on the consumption of alcohol by children and young people was published in 2009. This advises parents and children that an alcohol-free childhood is the healthiest and best option.

In light of all these changes, we decided to update the guideline.

The Youth alcohol action plan (Department of Health and Social Care) acknowledges that alcohol education in schools is crucial. In England, personal, social, health and economic education (PSHE) is the most common way to deliver this. Currently PSHE is not statutory (Personal, social, health and economic education, Department for Education). But from 2020 the health aspects will be compulsory in all schools.

This guideline covers children and young people aged 11 to 18 in full-time education and young people aged 18 to 25 with special educational needs and disabilities in full-time education. The latter group has been added to the groups covered by NICE's public health guideline PH7, in line with the Children and Families Act 2014.

Unlike PH7, this guideline does not cover alcohol education for children of primary school age. Children under 11 will be covered in the next update of our guideline on social and emotional wellbeing in primary education.

Finding more information and resources

To find out what NICE has said on topics related to this guideline, see our web page on alcohol.

Update information

February 2019

This guideline is a draft update of NICE PH7 (published November 2007).