National Institute for Health and Care Excellence

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Alcohol interventions in secondary and further education

[C] Evidence review of the acceptability of universal school-based alcohol interventions

NICE guideline NG135

Evidence reviews

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Final

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Contents

Acceptability of universal school based-interventions 6
Review questions 6
Introduction 6
PICO table... 6
Methods and process 7
Public Health evidence 7
Summary of public health studies included in the evidence review 9
Evidence statements 22
Appendices.. 24
Appendix A: Review protocols 24
A.1 Review 1: Protocols for school based alcohol intervention programmes for children and young people aged 11 to 18 years.. 24
1.1 Effectiveness and cost effectiveness of universal classroom-based alcohol programmes 24
1.2 Effectiveness and cost effectiveness of universal school-based alcohol programmes outside of the classroom 31
1.3 Effectiveness and cost effectiveness of school-based multicomponent alcohol programmes that include additional components such as family and community activities 38
A.2 Review 2: Protocols for school based alcohol intervention programmes for children and young people aged 11 to 18 years.. 46
2.1 Effectiveness and cost effectiveness of school-based targeted alcohol programmes and pastoral support for children and young people at risk or already using alcohol aged 11 to 18? 46
A.3 Review 3: Protocols for School or college based alcohol intervention programmes for young people aged 18 to 25 years with special educational needs and disabilities (SEND) 53
3.1 Effectiveness and cost effectiveness of universal classroom-based alcohol programmes for young people aged 18 to 25 with SEND 53
3.2 Effectiveness and cost effectiveness of universal school-based (outside of the classroom) alcohol interventions for young people aged 18 to 25 with SEND...... 60
3.3 Effectiveness and cost effectiveness of school-based multicomponent alcohol interventions that include additional components such as family and community activities for young people aged 18 to 25 with SEND 67
A.4 Review 4: Protocols for School or college based alcohol intervention programmes for young people aged 18 to 25 years with special educational needs and disabilities (SEND) 74
4.1 Effectiveness and cost effectiveness of school-based targeted alcohol interventions and pastoral support for young people aged 18 to 25 with SEND considered 'at risk'... 74
Appendix B: Literature search strategies 81
Appendix C: Public Health evidence study selection 82

Appendix D: Public Health evidence tables ... 83
D.1.1 Coombes 2009 ... 83
D.1.2 Davies 2016 ... 88
D.1.3 Hawkins 2016 ... 94
D.1.4 Milliken-Tull 2017 ... 100
D.1.5 Ogenchuk 2012 ... 105
D.1.6 Sumnall 2017 ... 110
Appendix E: GRADE CERQual tables ... 121
E.1.1 Table 5: Acceptability of interventions ... 121
Appendix F: Excluded studies ... 126
Table 6: Public Health studies ... 126

Acceptability of universal school based-interventions

Review questions

RQ 1.1 What universal classroom-based alcohol interventions are effective and cost effective in children and young people aged 11 up to and including 18 years?

RQ 1.2 What universal alcohol interventions based outside of the classroom are effective and cost effective in children and young people aged 11 up to and including 18 years?

RQ 1.3 What universal multicomponent alcohol interventions are effective and cost effective in children and young people aged 11 up to and including 18 years?

RQ 3.1: What universal classroom-based alcohol interventions are effective and cost effective among young people aged 18 to 25 years with (special educational needs and disabilities) SEND?

RQ 3.2 What universal school-based (outside the classroom) alcohol interventions are effective and cost effective among young people aged 18 up to and including 25 years with SEND?

RQ 3.3 What universal school-based multi-component alcohol interventions that include additional components such as family and community activities are effective and cost effective among young people aged 18 up to and including 25 years with SEND?

Sub-question for all review question. What factors influence the acceptability of interventions and do they differ between groups or settings?

Introduction

Children and young people who drink alcohol increase their risk of injury, poisoning, violence, depression, sexually-transmitted diseases and damage to their development. This is especially true for children and young people who drink heavily. Drinking at an early age is also associated with a higher likelihood of alcohol dependence.

This review covers the qualitative findings for acceptability of the interventions evaluated in the effectiveness reviews.

PICO table

Table 1: PICO inclusion criteria for universal school-based interventions

Population	Children and young people aged 11 up to and including 18 years in full time education receiving the interventions Parents/caregivers of children and young people receiving the interventions People who deliver the interventions
Interventions	• Universal classroom based alcohol interventions delivered by a teacher, peer, other school staff or external provider

Population	Children and young people aged 11 up to and including 18 years in full time education receiving the interventions Parents/caregivers of children and young people receiving the interventions People who deliver the interventions
	• Universal school-based multicomponent interventions delivered in conjunction with other components such as family, community or media • Universal school-based alcohol interventions delivered outside the classroom
Comparator	The intervention of interest against a control group
Outcomes	Views and experiences of: • teachers and practitioners delivering interventions (UK or countries similar to UK) • children and young people receiving interventions. (UK or countries similar to UK) • parents/carers of children and young people receiving the interventions (UK or countries similar to UK)

Methods and process

This evidence review was developed using the methods and process described in Developing NICE guidelines: the manual. Methods specific to this review question are described in the review protocol in appendix A.

Declarations of interest were recorded according to NICE's 2018 conflicts of interest policy.

Public Health evidence

Included studies

In total 9900 references were identified through systematic searches and 79 references were taken from the previous guideline. 1 additional reference was identified through another source. Of these references, 333 were ordered. Of these, 7 of the papers were unavailable. A total of 125 references were included across all reviews and 201 were excluded. Some studies were relevant for more than one review.

Table 2: Summary of study selection across guideline

Stage of selection	Number of papers
Screened	9980 papers
Ordered	333 papers
Excluded	208 papers (7 full texts were unavailable)
Included (guideline-wide)	125 papers
RQ 1.1 Universal classroom (11-18 years)	54 papers (32 RCTs)
RQ 1.2 Universal outside the classroom (11-18 years)	7 papers (6 RCTs)
RQ 1.3 Universal multicomponent (11-18 years)	43 papers (19 RCTs)
Universal qualitative review	9 papers (6 studies)
RQ 2.1 Targeted (11-18 years)	24 papers (16 RCTs; 1 qualitative study)
RQ 3.1 Universal classroom (18-25 years SEND)	0 papers
RQ 3.2 Universal outside the classroom (18-25 years SEND)	0 papers
RQ 3.3 Universal multicomponent (18-25 years SEND)	0 papers
RQ 4.1 Targeted (18-25 years SEND)	0 papers

A total of 9 articles incorporating 6 qualitative studies were identified and included (see Table 3 for a summary of included studies). From these studies 5 themes were identified. (See Table 4 for a summary of key themes). Full evidence tables are in Appendix D: No studies were identified for questions 3.1, 3.2 or 3.3 which cover the SEND population.

Summary of public health studies included in the evidence review

Table 3: Summary of studies included in the review

Author [Year]	Country	Setting	Population(s)	Intervention	Method	Themes
Coombes 2009	UK	School	Young people Parents/caregivers	SFP 10-14[a]	Interviews and focus groups. Thematic analysis	Impact of family component of intervention
Davies 2016	UK	School	Teachers	PSHE[b]	Semi-structured interviews Thematic analysis	Challenges/barriers to implementation Providers Content
Hawkins 2016	UK	School	Young people Teachers	PSE[c]	Semi-structured interviews and focus groups Thematic analysis	Challenges/barriers to implementation Content Method of delivery Providers
Milliken-Tull 2017	UK	School	Young people Teachers	PSHE Other drug and alcohol education	Online survey, interviews and focus groups. Thematic analysis.	Challenges/barriers to implementation Providers Content Method of delivery
Ogenchuk 2012	Canada	School	Young people Teachers	Other drug and alcohol education	Semi-structured interviews and focus groups Thematic analysis	Challenges/barriers to implementation Content Method of delivery
Sumnall 2017	UK	School	Young people Teachers	STAMMP	Focus groups Thematic analysis	Challenges/barriers to implementation

a Strengthening Families Programme (see Evidence review on universal multi-component interventions)
b Personal, Social, Health and Economic education
c Personal Social Education

Author [Year]	Country	Setting	Population(s)	Intervention	Method	Themes
				Classroom curriculum plus a parent component of a presentation on the Chief Medical Officer's 2009 guidelines		Providers Content Method of delivery

Table 4: Summary of key themes

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
Challenges/barriers to implementation				
Lesson time priority and availability	Ogenchuk 2012, Davies 2016, Hawkins 2016, Sumnall 2017, Milliken-Tull 2017	Young people People delivering the intervention	The most common challenge for teachers delivering alcohol prevention education was that there was just not enough time delegated to it within the curriculum due to conflicting priorities with other subjects. This is further reflected in the student's experiences. There is also difficulty in knowing what exactly was taught to students about alcohol and how it should fit into the curriculum alongside other subjects. The low priority of these lessons leads to a lack of structure that results in a lack of motivation for both students and teachers.	*"Time constraints can be an issues – [we only have] 1 period per week [for personal development (PD) classes] and we have other core modules to cover." (Provider) [Sumnall 2017]* *"The content was dealt with in a 'couple of hours over two days'" (Provider) [Ogenchuk 2012]* *"I enjoy leading on PSHE and it's a very important area but not everyone sees it that way and I get very little time for planning our lessons. It is also the class that get … I teach across two other subject areas, so I don't have a lot of time for finding good resources." (Provider) [Milliken-Tull 2017]* *"We've not had any drugs or alcohol education in Year 7. We were supposed to be doing something, but the teacher changed her mind and did something else instead." (Student) [Milliken-Tull 2017]* *"I suppose they probably do some in science, but I don't know when. I worry sometimes that there isn't someone with a master plan of all the actual knowledge that they need and the information." (Provider) [Davies 2016]*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
				"Some teachers don't really bother with it, they just say what they've been told to say, and they don't really chat to you about the problems and stuff about it…" (Student) [Hawkins 2016] *"I remember having to teach about careers and I had no interest in it at all. So I would skip through that and think 'yeah, well you know just read that paragraph, ok?'" (Provider) [Hawkins 2016]*
Planning and resources	Milliken-Tull 2017	People delivering the intervention	Further challenges relate to reduced funding and lack of support from external agencies that are available to provide interventions for students.	*"Until 2016 we had a qualified counsellor in school two days per week and we would refer students to him. The process was quick and effective, and in most cases the students benefited from this and were able to stay in school. Following budget cuts, we lost the counsellor and the pastoral lead now manages referrals to the local drugs service, but exclusions have increased." (Provider) [Milliken-Tull 2017]* *"There's no support from our local authority unless we pay for it, and that's mainly for specialist interventions" (Provider) [Milliken-Tull 2017]* *"I was head of student services and PSHE lead for 6 years, and it was my job to make referrals and deal with safeguarding along with the deputy head. The process got increasingly difficult with waiting times for intervention increasing, especially if CAMHS were involved." (Provider) [Milliken-Tull 2017]*
Available resources	Sumnall 2017, Milliken-Tull 2017	People delivering the intervention	Some schools have taken it upon themselves to provide their own, unstructured, materials from multiple external sources, however it appears that it may be more of lack of awareness of resources and support available to schools and their staff. Due to the	*"It would have been just resources that you would have obtained out of various books that you'd have put together, to create a unit of work for teachers to deliver in the PD class." (Provider) [Sumnall 2017]* *"This (Mentor-ADEPIS website and resources) would be really useful to us. Could it be part included in the Healthy*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
			perceived lack of priority for alcohol and drug education there is also less consideration for quality assurance of the teaching.	*Schools website, so we have regular reminders?" (Provider) [Milliken-Tull 2017]* *"I would have used the lesson plans, they could have enhanced some of the work we did with KS3, especially the social norms project with year 9" [Milliken-Tull 2017]* *"I'm always looking for new ideas, this would have saved so much time!" (Provider) [Milliken-Tull 2017]* *"I was not aware of ADEPIS, possibly more publicity." (Provider) [Milliken-Tull 2017]* *"If my tutors are delivering the material and the students are involved in the lessons we can assume that the quality is ok. We try to make sure we cover at least most of what is on the PSHE programme of study" (Provider) [Milliken-Tull 2017]* *"We haven't really thought about quality assurance when it comes to PSHE, because it's not statutory and we don t do any assessment so quality assurance hasn't hit the radar" (Provider) [Milliken-Tull 2017]*
Training	Sumnall 2017, Milliken-Tull 2017	People delivering the intervention	There is general concern over the training available to teachers to deliver PSHE with just over a third reporting they received some CPD training within the last 3 years. The changes that have occurred across alcohol and drug support from local authorities has impacted on the availability and quality of CPD. There are concerns that inexperienced teacher will lack confidence to teach these topics and/or may deliver inappropriate messages.	*". . . we're supposed to be so-called experts in all the different fields, but I know from personal experience . . . that a lot of teachers will kind of stick to what they're confident in, and if they're not confident, they'll avoid it or they'll just skim through it." (Provider) [Sumnall 2017]* *"A few years ago, we were able to regularly invite our local drug service into school to deliver lessons, the students enjoyed the sessions and got to know the team. Now, we can refer students with problems to the service, but there is no support or information provided more generally." (Provider) [Milliken-Tull 2017]* *"Our local authority provided very good CPD on everything from eating disorders, to self-harm and of course drugs and alcohol. I think there are still safeguarding course but*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
				everything else has stopped." (Provider) [Milliken-Tull 2017] *"We don't even have a healthy schools team anymore and that was always the main way we heard about local training courses." (Provider) [Milliken-Tull 2017]*
Content				
Age appropriateness	Ogenchuk 2012, Sumnall 2017	Young people People delivering the intervention	It was felt that the content of alcohol interventions are required to be more age appropriate as well as targeting the delivery at the right time. The content needs to reflect realistic drinking habits of the target audience but also target the age groups that are likely to at least be thinking about drinking.	*" in grades 7 and 8 no one really cares….then in grade 9, they say I'll never do it, and bam, everyone who didn't drink, drinks" (Student) [Ogenchuk 2012]* *"I know they cover when you drink when you're older, but underage drinking, they could, kind of, cover in that, because there's not much about that." (Student; intervention group) [Sumnall 2017]* *"It was well extreme. Like, no one our age is going to drink to that extent, like. The one on the video, like, had probably about a litre of vodka." (Student; control group) [Sumnall 2017]* *"I think if it was done maybe end of year 10, we would already have known most, well, quite a lot of the stuff that was already in the book, which would have made it, kind of, pointless, most of that section." (Student)[Sumnall 2017]* *"Seemed a bit advanced for some of the pupils in my class who could not relate to some of the activities. The video for example on the Night Out featured people in their 20s." (Provider)[Sumnall 2017]*
Negative alcohol messages	Ogenchuk 2012, Davies 2016, Hawkins 2016, Sumnall	Young people People delivering the intervention	Students' experience of alcohol education is that it is usually combined with drug education. However, they feel that as alcohol is more socially acceptable, the two should not be taught together. The	*"if you pile alcohol, drugs, heroin in one presentation, alcohol sort of gets lost…alcohol is overshadowed" (Student) [Ogenchuk 2012]*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
	2017, Milliken-Tull-2017		scare tactics and negative alcohol messages are reported as to not work. These negative messages are less effective due to the repetitive nature of them and can be met with resistance.	*"Give accurate information- don't tell kids that if they drink they are going to become an alcoholic" (Student) [Ogenchuk 2012]* *"It's really repetitive. We get it a lot every year, and it's basically just the same information every single year, and it's all negative views." (Student) [Sumnall 2017]* *". . they basically teach us don't do it at this age because it will have consequences, extreme consequences that will come back at you in the future . . ." [Sumnall 2017]* *"Yeah, 'cause it's wrong to say to kids, 'oh, don't drink, it's bad for you', 'cause that's gonna make us drink more, we're obviously gonna drink at some point in our lives, so you might as well tell us which way's the best way to drink, more sensibly, then it'd give us something to think about" (Student) [Hawkins 2016]* *"We want to know more about how normal, average, students are feeling and how many are using drugs and alcohol and why. Scare stories where someone dies are upsetting, but everyone soon forgets about it and thinks it won't happen to them." (Student) [Milliken-Tull 2017]* *"The whole day was about the effects of alcohol on your future and how much it could be a problem." (Student) [Milliken-Tull 2017]* *"… I just happen to think that alcohol is one of those things that all sorts of young people get involved in, but I'm trying very hard to steer away from the 'monster of the month' approach" (Provider) [Davies 2016]*
Resilience	Ogenchuk 2012, Davies 2016. Sumnall 2017	Young people	Students and teachers believe that the aim of alcohol education is to equip young people with the skills that will help them make decisions that they felt were sensible. Students like to explore real-life	*"We do look at the dangers of drugs and alcohol but it's more about the choices that young people make cause it's about choices and consequences more than the actual substance itself" (Provider) [Davies 2016]*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
		People delivering the intervention	situations about peer-pressure and how individuals have dealt with this. Those already drinking suggested that approaches where they can imagine themselves in these situations would help them to stop and think.	*"It's like saying 'no' yourself maybe helping, looking out for, your friends and trying to encourage them and say 'maybe you've had a little too much here, why don't we just walk outside'" (Provider) [Davies 2016]* *"they would like to hear about 'how people did not give into peer pressure' including 'the bonuses that they got out of not drinking'" (Student) [Ogenchuk 2012]* *'then the actual person comes to talk to you, about how it affected their life, then it really hits home because they're like an everyday person' (Student) [Ogenchuk 2012]* *"Plus, like, for later in life, it's giving them information of alcohol and they can decide, because they know the facts about it. So they're able to decide…whether they want to drink or not, they know the facts and the consequences it's going to have on them." (Student) [Ogenchuk 2012]* *"I quite liked the bit about the real-life situations because then you could, like, put it into real-life context. And then if you were ever put in a situation like that, you could know how to deal with it, and all." (Student) [Sumnall 2017]* *"…they should make you write an essay on what would happen if you got in an accident, and make you really think about how it would change your life" (Student) [Ogenchuk 2012]*
Knowledge on units	Davies 2016, Sumnall 2017	Young people People delivering the intervention	A consistent finding across teachers and young people was that knowledge of alcohol units was important especially in regards to differences in drinking in a pub where the units are measured compared to drinking at home.	*"I think they need to understand what the units and measures are and how it can affect people differently" (Provider) [Davies 2016]* *"We talk about the strengths of alcohol and what a unit is because that is a misnomer amongst adults, a glass of wine is not one unit anymore because people drink with great big fishbowls don't they" (Provider) [Davies 2016]*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
				"It, sort of, gave you an insight into the units of alcohol, like, in each drink and shows how they can vary and affect your system differently." (Student) [Sumnall 2017]
Materials	Sumnall 2017, Hawkins 2016	Young people People delivering the intervention	Students who received the SHAHRP intervention generally accepted the two workbooks (phase 1 and 2) and they were delivered in the appropriate order and at the appropriate times. Teachers liked the approach that one workbook was factual and the other was about consequences. The students who favoured the workbooks helped them to learn but the students workbooks in the education as normal groups were negatively received. In general, lessons delivered as a set of instructions or repetition of what has been done before does not stimulate participation. It was noted that the materials might need to be updated to maintain currency which was seen with videos used in the education as normal group.	*"Because this one [workbook for phase 1] was more like a teaching one, like this one explained it and, kind of, like, gave you answers and your teacher went through with you and, kind of, explained the facts and everything on you. So when that book came along [workbook for phase 2], you were able to think of the stuff you had learned, like, beforehand and you could put that, like, to the test and make sure you knew everything." (Student) [Sumnall 2017]* *"I think it's better when you're, like, writing out in a book because you take it in more, as opposed to sitting there and, like, reading it." (Student) [Sumnall 2017]* *"We're so used to books, you, kind of, just ignore them now."(Student) [Sumnall 2017]* *"She just tells us what to do, and we all have this booklet, so it's a page of that and then we do a poster for the rest of the lesson, I dunno why. We just do posters, every lesson!" (Student) [Hawkins 2016]* *"I liked the overall approach. I feel that it is a very planned approach to alcohol education. I think that there is a great deal of depth in the materials, without giving the pupils information overload." (Provider) [Sumnall 2017]* *"It was easy to access. Pitched at the correct level and the pupils engaged with the materials." (Provider) [Sumnall 2017]* *"Very good [phase 2 materials], I like that it takes a different approach. It is less factual than the [phase 1] book. Which is important, as it could easily get very repetitive. I like the way that the book focuses on the*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
				consequences, but without being preaching to the pupils about alcohol." (Provider) [Sumnall 2017] *"Yeah, they're all pretty old, so, you know, the messages back then would have been, kind of, different because obviously people can learn different things..." (Student) [Sumnall 2017]*
Method of delivery				
Individual vs group	Sumnall 2017, Milliken-Tull 2017. Hawkins 2016	Young people	Young people generally favour an approach for alcohol and drug education that is delivered as a group and allows for more discussion and activities. Many favoured the option to discuss views and opinions with their peers and in particular would prefer if it was delivered in small groups with their friends. However, they were mindful of confidentiality and some young people shy away from discussion with their peers for fear of being judged. Others preferred a one-to-one approach.	*"Well, firstly, we used to do, like, our whole class did a class discussion of it. So it was helpful that everyone got to share their opinions and views, and everyone gets to see where they're coming from." (Student) [Sumnall 2017]* *"Well, in a way, you know, there could have been, like, more physical activities instead of, like, always doing it in the book." (Student; intervention group) [Sumnall 2017]* *"No, it's not difficult to speak with your friends around you, because they're people you can trust, even if the form teacher's in the room, you still have friends who you'd hang around with just in the school". (Student) [Sumnall 2017]* *"You might even be comfortable to open up and say something you'd really been worrying about, because everyone else has had a story, and you think, 'well, they're quite bad too, so I might as well say what I've been worrying about', and then you open up and everyone's just like, 'yeah, that's totally normal', and then they can help with that, and you can talk about it in a group." (student) [Hawkins 2016]* *"I think there always is, like, that fear that you're going to be judged in the group discussions when you know all the people and you see them every day. If you say something like if you did drink, you think some people might be really scared to actually say that because they could get really*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
				badly judged for it and they could be teased about it." (Student) [Sumnall 2017] *"The only thing is, if someone does open up, you have to make sure that nobody's going to leave that room and go tell everyone what that person has said, 'cause that can lead to things like bullying" (Student) [Hawkins 2016]* *"One to one is much better but hard to access unless you're caught with drugs." (Student) [Milliken-Tull 2017]* *"We worked in friendship groups, so it was basically a day of mucking around." (Student) [Milliken-Tull 2017]*
Lesson time vs one-off sessions	Milliken-Tull 2017	People delivering the intervention	It is common practice to deliver alcohol and drug education in a variety of different methods which is generally either in lesson time, 'drop-down' days (off-timetable sessions) or themed assemblies.	*"We tend to use lots of different ways to deliver PSHE, but try to avoid drop down days" (Provider) [Milliken-Tull 2017]* *"Tutor time is used, but there's not much time to get your teeth into anything. We also have themed assemblies throughout the year where external speakers come along. These are well received by students but there is never enough time for any effective follow up" (Provider) [Milliken-Tull 2017]*
Providers				
Teachers vs external speakers	Davies 2016, Sumnall 2017, Milliken-Tull 2017; Hawkins 2016	Young people People delivering the intervention	The majority of teachers reported a strong preference for inviting external speakers to speak with students about alcohol. The feeling here is that external speakers would be more engaging and have more experience. Another reason is that some teachers are uncomfortable teaching these lessons and often refuse. However, some teachers note that the real impact of these speakers was unknown due to some experiencing external people who were poor public speakers or unable to engage with children and that due to the	*"That's why we tend to try and get so many external speakers because they seem to have more impact than what teachers would necessarily deliver in a lesson" (Provider) [Davies 2016]* *"Engaging lessons are key as otherwise they (the students) will switch off. This is where external speakers can help. I think they are often more credible than us." (Provider) [Milliken-Tull 2017]* *"The tutors point blank refuse to deliver some lessons, mainly the sexual health ones, but some won't deliver drugs education either. We want the right people to deliver good quality lessons and feel comfortable, but there*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
			'one-off' nature of the talk, there was less opportunity to follow up any important issues raised. In contrast, students preferred to discuss these issues with their teachers, providing they had a good relationship with them or that the teacher had a good personality and could empathise with the pressures young people face. They particularly wanted someone who was committed to what they were teaching and who could create an empathic and respectful atmosphere where students can speak freely. They also favoured the continuity teachers provided as opposed to a 'one-off' session. Students also disliked the 'one-sided' nature of some of the interventions where the external providers did not ask their views.	*doesn't seem to be enough of them. I've suggested some CPD but that hasn't been received well either, it's very frustrating." (Provider) [Milliken-Tull 2017]* *"I have been in really tricky situations where speakers have been organised for different things but they haven't been very good quality and if anything they have possibly done some damage to either the reputation of the children, by encouraging disclosures, or you know actually giving out slightly inaccurate information or using shock and scare tactics which are not evidence-based, so yes I've seen some interesting things in my time" (Provider) [Davies 2016]* *"Didn't ask us for our views we were talked at by the trainers." (Student) [Milliken-Tull 2017]* *". . . quite easy to discuss it with our form teacher, like, because he's quite laid back . . ." (Student; intervention group) [Sumnall 2017]* *"It, kind of, depends on the teacher . . . the younger ones are, kind of, more understanding about it . . ." (Student; Control group) [Sumnall 2017]* *"But if you had someone who was just stubborn in the mornings and wouldn't talk to youse, it would make it far harder." [Sumnall 2017]* *"It's the way they speak to you, if they say 'oh, so you like this, how do you feel about that?' If they just asked you questions about what you're talking about, at least you'd feel like they're interested, and they want to talk to you, and that they're like, engaging with you" (Student) [Hawkins 2016]* *"If they wanna talk to us about mature things, they should treat us like we want to be treated, and as we treat them*

Review theme and subthemes	Studies contributing	Population	Summary	Supporting statements
				as well, and be equal, it makes us feel comfortable" Student) [Hawkins 2016]
Impact of family component of the intervention				
Wellbeing	Coombes 2009	Young people Parents/care givers	Parents and young people reported improvements in the young person's emotional health and wellbeing during the course of SPF-10-14 and that they were dealing with emotional issues more constructively.	*"I learned how to deal with stress, talk things through sensibly and how to get out of tricky situations" (Student) [Coombes 2009]* *"I have learned that my mum loves me and wants what's best for me" (Student) [Coombes 2009]* *"I learned how to talk to him without shouting and to listen more without arguing" (Parent) [Coombes 2009]* *"I learned how to deal with stressful situations in a different way" (Parent) [Coombes 2009]*
Behaviour	Coombes 2009	Young people Parents/care givers	Young people reported that improved behavioural management had brought benefits to family relationships and functioning. Some parents commented that it was hard to set limits and to remember to consistently maintain boundaries but that it was an important way of expressing love and care for young people and that setting limits provided a form of security.	*"We use the points chart and I get to go to the swimming pool… for not losing my temper…" (Student) [Coombes 2009]* *"Because that is what I think – especially all that is going on out there at the moment. Kids need to know that there is security…"(Parent) [Coombes 2009]*
Substance use	Coombes 2009	Young people Parents/care givers	Young people and parents reported that the way they were dealing with drug and alcohol use had changed significantly during the period of SFP 10-14, including the improvement of peer resistance skills.	"Whenever anyone asks you to do something you don't want to I know the process" *(Student) [Coombes 2009]*

See Appendix D: for full evidence tables.

Excluded studies

See Appendix F: for a list of excluded studies.

Evidence statements

Challenges/barriers to implementation

Evidence of high confidence from 5 studies (4 UK; 1 Canada) used a combination of semi-structured interviews (4 studies), focus groups (3 studies), questionnaires (2 studies) and an online survey (1 study) to gain the views and perspectives of teachers and young people delivering and receiving school-based alcohol interventions, respectively. The findings were consistent between studies in that there are clear barriers to implementing alcohol education due to lack of delegated time within the curriculum due to conflicting priorities with other subjects, reduced funding, lack of awareness of resources available and lack of support from external agencies. Limited or poor quality training available leads to inexperienced or unconfident teachers refusing to deliver these interventions or if they do there are concerns over inappropriate messages being delivered.

Content

Evidence of high confidence from 5 studies (4 UK; 1 Canada) used a combination of semi-structured interviews (4 studies), focus groups (3 studies), questionnaires (2 studies) and an online survey (1 study) to gain the views and perspectives of teachers and young people delivering and receiving school-based alcohol interventions, respectively. The key findings were that alcohol education needs to be age appropriate and delivered at the right time in terms of age. Students did not feel that alcohol should be taught with other drug education because alcohol was perceived to be more socially acceptable. It was consistent across both teachers and young people that scare tactics and negative alcohol messages are not effective and that skills training and application to real-life situations was preferred. There were mixed views on the use of workbooks with some students find them repetitive and other finding them more useful for learning. Knowledge of units of alcohol was considered important by both groups.

Method of delivery

Evidence of high confidence from 3 UK studies used a combination of semi-structured interviews (2 studies), focus groups (3 studies), questionnaires (1 study) and an online survey (1 study) to gain the views and perspectives of teachers and young people delivering and receiving school-based alcohol interventions, respectively. Teachers reported that it was common practice to deliver alcohol interventions in different formats, namely, through lessons, ‘drop-down’ days (off-timetable sessions) or themed assemblies. The majority of young people preferred for alcohol education to be delivered in group format as it allows for discussion with peers and group activities. Although some students preferred a one-to-one approach for fear of being judged by peers and value confidentiality as a key component.

Providers

Evidence of high confidence from 4 UK studies used a combination of semi-structured interviews (3 studies), focus groups (3 studies), questionnaires (1 study) and an online survey (1 study) to gain the views and perspectives of teachers and young people delivering and receiving school-based alcohol interventions, respectively. The majority of teachers reported a strong preference for inviting external speakers to speak with students about

alcohol as they felt they would be more engaging and have more experience compared to teachers who are uncomfortable teaching these topics. However, they acknowledged that these sessions offer less opportunity to follow up any issues. In contrast, young people preferred someone who would create an empathic and respectful atmosphere where they could speak freely. They felt they could discuss these issues with their teachers providing they had a good relationship with them and felt that they were more likely to be asked for their views compared to sessions with external speakers.

Impact of family component of intervention

Evidence of moderate confidence from 1 UK study used focus groups to gain the views of young people and their parents/caregivers on their experiences of the SPF-10-14 intervention. Young people and their parents reported improvements in the young person's emotional health and wellbeing, improved behavioural management, improved family functioning and a significant change in how the family was dealing with alcohol use through improved peer resistance skills.

Appendices

Appendix A: Review protocols

A.1 Review 1: Protocols for school based alcohol intervention programmes for children and young people aged 11 to 18 years.

1.1 Effectiveness and cost effectiveness of universal classroom-based alcohol programmes

Field	Content
Review question	What universal[d] classroom-based alcohol interventions are effective and cost effective in children and young people aged 11 up to and including 18 years?
Type of review question	Intervention and qualitative
Objective of the review	To identify which universal classroom-based alcohol interventions are effective and cost effective for those children and young people aged between 11 and 18 years in delaying, reducing or stopping alcohol use. The purpose of this review is to identify which interventions work rather than which interventions work best. The review question will examine the effectiveness and cost effectiveness of universal classroom-based alcohol interventions and whether effectiveness varies according to a range of factors including the person delivering the intervention, programme fidelity, the population receiving the intervention, population subgroups e.g gender, age, socioeconomic group, ethnicity, geographical area, children and young people with special educational needs and disabilities (SEND)
Eligibility criteria – population	Children and young people aged 11 up to and including 18 years in full time education.

[d] Universal refers to the whole population-approach, school based alcohol intervention programmes aimed at preventing alcohol use and are offered to all children who meet the programme criteria for inclusion (such as age). See the ACMD report on The prevention of drug and alcohol dependence 2015.

Field	Content
Eligibility criteria – intervention(s)	Universal classroom based alcohol interventions delivered by a teacher, peer, other school staff or external provider
Eligibility criteria – comparator(s)/ control	The intervention of interest against a control group
Outcomes and prioritisation	• age at first whole drink of alcohol (for those who have never drunk alcohol) where reported • age at first experience of drunkenness[e] where reported • amount and frequency of alcohol use • school attendance. • alcohol related risky behaviour: ○ unprotected or regretted sex ○ violence and other antisocial behaviour ○ criminal activity • mental health and wellbeing • Adverse or unintended effects: ○ an increased interest in trying alcohol. **Qualitative outcome measures** Views and experiences of: • teachers and practitioners delivering interventions (UK or countries similar to UK) • children and young people receiving interventions. (UK or countries similar to UK) • parents/carers of children and young people receiving the interventions (UK or countries similar to UK) The qualitative outcome measures will be limited to UK or similar countries due to the varying contexts surrounding alcohol education/legislation in the different countries which may impact the generalisability of the interventions Outcomes reported at 12 months will be prioritised over shorter outcomes, e.g. amount and frequency of alcohol use at 12 months will be prioritised over alcohol use at 3 months. However, outcomes reported at less than a year will only be reported if 12 month data is not available, being mindful that an academic year is divided into terms (around 3 months long).
Eligibility criteria – study design	• Studies of effectiveness and cost effectiveness: ○ Systematic reviews ○ Randomised controlled trials (RCTs) including cluster RCTs.

[e] Recent evidence suggests it is the age at which a young person first gets drunk that is a more important predictor of subsequent harmful drinking than age of first drink

<table>
<tr><th>Field</th><th>Content</th></tr>
<tr><td></td><td>UK based qualitative studies of interventions shown to be effective
Economic studies:
Economic evaluations
Cost-utility (cost per QALY)
Cost benefit (i.e. Net benefit)
Cost-effectiveness (Cost per unit of effect)
Cost minimization
Cost-consequence</td></tr>
<tr><td>Other inclusion exclusion criteria</td><td>Included studies

There will be a scoping search carried out to identify any recent systematic reviews that directly relate to one or more of the scope questions and have been published since 1st December 2015. Any systematic reviews identified will be used as a source of primary studies or as a source of data.

A full development search for individual studies will be carried out.

As this is an update of existing guidance (PH7), the studies included in the evidence reviews supporting the recommendations being updated will be assessed against the new inclusion criteria. Studies will be included if they meet the new inclusion criteria.

Full economic analyses and costing studies will be included. Included costing studies reporting any health outcomes will be noted in EPPI/the evidence tables and forwarded on for economic modelling and not for the purposes of this review.

Only papers published in the English language will be included.
Only studies carried out in OECD countries will be included.

Population
Populations that cover a broad age range will be included if the data for the age group of interest are reported separately.
<u>Note:</u> In the UK or similar countries, school based interventions aimed at year 6 pupils (ages 10-11) through to sixth form (ages 16-18) will be included.
<u>Note:</u> In the USA or similar countries, school-based interventions aimed at grades 6 to 12 (ages 11 to 18 years) will be included.
Interventions
Statutory drug education that is part of the national science curriculum (see National Curriculum in England: science programmes of study Department of Education) will be excluded.</td></tr>
</table>

Field	Content

	• Interventions that are more broadly focussed e.g. substance misuse prevention will be included only if they report alcohol outcomes.
	• Individual decisions will be taken on interventions that are stated as school based, but conducted off site. For example a school nurse employed by a local authority may be responsible for a number of schools or there may be schools that are part of a federation and share a school nurse or counsellor who may conduct the intervention with pupils from a number of schools away from school premises
	Comparators
	
	• Control groups to be defined as described in the studies.
	• Studies with comparators within and between schools will be included.
	Settings
	
	• Schools and colleges (See DfE *Types of School)* including:
	  ○ Academies
	  ○ Free schools
	  ○ Faith schools
	  ○ City technology colleges
	  ○ State boarding schools
	  ○ Private schools
	  ○ Special schools
	  ○ Alternative provisions e.g. pupil referral units (PRUs)
	  ○ Post 16-18 education provisions e.g sixth form
	• Local authority secure children's homes
	• Secure training centres
	
	The following settings are excluded:
	• Home
	• Higher education institutions
	• Young offender institutions (YOI) (and similar in other countries).

Proposed sensitivity/sub-group analysis, or meta-regression	Where evidence allows subgroup analyses and/or meta-regression will be conducted.
	Depending on the evidence available some or all of the following will be explored.
	
	Subgroups of interest include:
	
	• Baseline characteristics of the children and young people receiving the intervention
	  ○ age (11-15, 16-18)
	  ○ gender
	  ○ socioeconomic status

Field	Content
	○ ethnicity ○ geographical area ○ children and young people with special educational needs and disabilities (SEND) ○ type of school setting e.g. mainstream, alternative provision, secure settings • People delivering the intervention • Teacher • Peer • Other school staff • External provider • People who have been trained to deliver the intervention • Method of delivery • Theories underlying the intervention If the evidence allows for intervention "variables or conditions" to be identified, a qualitative comparative analysis (QCA) may be conducted as well as a pairwise review. A QCA analysis allows the different causal contributions of the interventions to be explored.
Selection process – duplicate screening/selection/analysis	10% of the search results will be blind-screened by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. If the initial level of agreement is below 90%, a second round of blind-screening will be considered. 10% of data extraction and critical appraisal will be checked by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. Only 10% of the search results will be checked as this is an intervention and qualitative review and there is confidence that RCTs, controlled studies or related qualitative studies are unlikely to be missed at the sifting stage. The inclusion list will be checked with PHAC to ensure no studies are excluded inappropriately.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to store extracted data. If meta-analysis is undertaken, Cochrane Review Manager 5 will be used to perform the analysis. Qualitative data will be analysed using EPPI Reviewer. Qualitative data will be summarised using an appropriate qualitative synthesis approach, for example, narrative synthesis.
Information sources –	A date cut off of the year 2006 will be used. This is because this is an update of existing guidance published in 2007 and searches for the original guideline were

Field	Content
databases and dates	completed in 2006. Citation search of studies included in the original guideline will be undertaken. The Medline strategy will be translated for use within the following databases: **Primary Databases** • Medline and Medline in Process (OVID) • Embase (OVID) • CENTRAL (Wiley)) • Cochrane Database of Systematic Reviews (Wiley) • DARE (records up to March 2014 only) (Wiley) • NHS EED (records up to March 2014 only) (Wiley) • Econlit (Ovid) • PsycINFO (Ovid) • Social Policy and Practice (OVID) • HMIC (OVID) • ERIC (Proquest) **Secondary Databases** • ASSIA (Proquest) • CINAHL (EBSCO) • Econ Papers (RePEc) • National Guidelines Clearinghouse (US Dept. of Health and Human Services) • Bibliomap (eppicentre) • Dopher (eppicentre) • Trophi (epicentre) • Alcohol Studies Database Web searches will also be conducted. NICE Evidence Search , Google and Google Scholar will be searched for key terms and the first 50 results examined to identify any UK reports or publications relevant to the review that have not already been identified. Relevant results will be added to the Endnote database. Searches will also be conducted on the following key websites for relevant UK reports or publications: **Websites** • PSHE association • Public Health England • Department of Health • Department for Education • Alcohol Research UK • Public Health Institute • Mentor-Adepis • OFSTED

Field	Content
	• National Foundation for Educational Research • Research in Practice • Education Endowment Foundation • Office for Children's Commissioner • Council for disabled children A study filter will not be applied. Citation searching of included studies will be undertaken. Results will be saved to an EndNote database and de-duplicated. Results will be provided to the Public Health team as RIS files, suitable for import into EPPI Reviewer. A record will be kept of number of records found from each database and of the strategy used in each database. A record will be kept of total number of duplicates found and of total results provided to the Public Health team.
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual For intervention studies the Cochrane Risk of Bias 2 tool will be used and for qualitative studies, the Cochrane qualitative checklist will be used. Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE-CERQUAL will be used for qualitative findings. When performing GRADE and where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality.
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual The outcomes of interest are likely to be reported in the studies as continuous data. Where appropriate the data will be dichotomised to enable the committee to make recommendations.
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that the studies included will be heterogeneous with respect to participants and interventions. Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested will be tested with a fixed effects model.

Field	Content
	Data from different studies will be meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes. Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Unexplained heterogeneity will be examined where appropriate with a sensitivity analysis. If the studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual

1.2 Effectiveness and cost effectiveness of universal school-based alcohol programmes outside of the classroom

Field	Content
Review question	What universal[f] school-based (outside of the classroom) alcohol interventions are effective and cost effective in children and young people aged 11 up to and including 18 years?
Type of review question	Intervention and qualitative
Objective of the review	To identify which universal school-based (outside of the classroom) alcohol interventions are effective and cost effective for those children and young people aged between 11 and 18 years in delaying, reducing or stopping alcohol use. The purpose of this review is to identify which interventions work rather than which interventions work best. The review question will examine the effectiveness and cost effectiveness of universal school-based (outside of the classroom) alcohol interventions and whether effectiveness varies according to a range of factors including the person delivering the intervention, programme fidelity, the population receiving the intervention, population subgroups e.g gender, age, socioeconomic group, ethnicity, geographical area, children and young people with special educational needs and disabilities (SEND)

[f] Universal refers to the whole population-approach, school based alcohol intervention programmes aimed at preventing alcohol use and are offered to all children who meet the programme criteria for inclusion (such as age). See the ACMD report on The prevention of drug and alcohol dependence 2015.

Field	Content
Eligibility criteria – population	Children and young people aged 11 up to and including 18 years in full time education.
Eligibility criteria – intervention(s)	Universal school-based alcohol interventions delivered outside the classroom. For example: Whole school approaches, health promotion information and advice provided as part of the Healthy Schools Programme (UK) or school policies on alcohol. Other approaches that do not involve classroom based teaching can include peer-led approaches, school assemblies, Theatre in Education,.
Eligibility criteria – comparator(s)/ control	The intervention of interest against a control group

Outcomes and prioritisation	• age at first whole drink of alcohol (for those who have never drunk alcohol) where reported
	• age at first experience of drunkenness[g] where reported
	• amount and frequency of alcohol use
	• school attendance
	• alcohol related risky behaviour:
	    o unprotected or regretted sex
	    o violence and other antisocial behaviour
	    o criminal activity
	• mental health and wellbeing
	• Adverse or unintended effects:
	    o an increased interest in trying alcohol.
	
	Qualitative outcome measures
	
	Views and experiences of:
	• teachers and practitioners delivering interventions (UK or countries similar to UK)
	• children and young people receiving interventions. (UK or countries similar to UK)

[g] Recent evidence suggests it is the age at which a young person first gets drunk that is a more important predictor of subsequent harmful drinking than age of first drink

Field	Content
	• parents/carers of children and young people receiving the interventions (UK or countries similar to UK) The qualitative outcome measures will be limited to UK or similar countries due to the varying contexts surrounding alcohol education/legislation in the different countries which may impact the generalisability of the interventions. Outcomes reported at 12 months will be prioritised over shorter outcomes, e.g. amount and frequency of alcohol use at 12 months will be prioritised over alcohol use at 3 months. However, outcomes reported at less than a year will only be reported if 12 month data is not available, being mindful that an academic year is divided into terms (around 3 months long).
Eligibility criteria – study design	• Studies of effectiveness and cost effectiveness: ○ Systematic reviews ○ Randomised controlled trials (RCTs) including cluster RCTs. • UK based qualitative studies of interventions shown to be effective • • Economic studies: ○ Economic evaluations ○ Cost-utility (cost per QALY) ○ Cost benefit (i.e. Net benefit) ○ Cost-effectiveness (Cost per unit of effect) ○ Cost minimization ○ Cost-consequence
Other inclusion exclusion criteria	**Included studies** There will be a scoping search carried out to identify any recent systematic reviews that directly relate to one or more of the scope questions and have been published since 1st December 2015. Any systematic reviews identified will be used as a source of primary studies or as a source of data. A full development search for individual studies will be carried out. As this is an update of existing guidance (PH7), the studies included in the evidence reviews supporting the recommendations being updated will be assessed against the new inclusion criteria. Studies will be included if they meet the new inclusion criteria. Full economic analyses and costing studies will be included. Included costing studies reporting any health outcomes will be noted in EPPI/the evidence tables and forwarded on for economic modelling and not for the purposes of this review. Only papers published in the English language will be included

<table>
<tr><th>Field</th><th>Content</th></tr>
<tr><td></td><td>Only studies carried out in OECD countries will be included.

Population

• Note: Populations that cover a broad age range will be included if the data for the age group of interest are reported separately.
• Note: In the UK or similar countries, school based interventions aimed at year 6 pupils (ages 10-11) through to sixth form (ages 16-18) will be included.
• Note: In the US or similar countries, school-based interventions aimed at grades 6 to 12 (ages 11 to 18 years) will be included.

Interventions

• Statutory drug education that is part of the national science curriculum (see National Curriculum in England: science programmes of study Department of Education) will be excluded.
• Interventions that are more broadly focussed e.g. substance misuse prevention will be included only if they report alcohol outcomes.
• Individual decisions will be taken on interventions that are stated as school based, but conducted off site. For example a school nurse employed by a local authority may be responsible for a number of schools or there may be schools that are part of a federation and share a school nurse or counsellor who may conduct the intervention with pupils from a number of schools away from school premises

Comparators

• Controls to be defined as described in the studies.
• Studies with comparators within and between schools will be included.

Settings

• Schools and colleges (See DfE Types of School) including:
    ○ Academies
    ○ Free schools
    ○ Faith schools
    ○ City technology colleges
    ○ State boarding schools
    ○ Private schools
    ○ Alternative provisions e.g. pupil referral units (PRUs)
    ○ Post 16-18 education provisions e.g. sixth form
• Local authority secure children's homes
• Secure training centres

The following settings are excluded:
• Home.</td></tr>
</table>

Field	Content
	• Higher education institutions • Young offender institutions (YOI) (and similar in other countries). .
Proposed sensitivity/sub-group analysis, or meta-regression	Where evidence allows subgroup analyses and/or meta-regression will be conducted. Depending on the evidence available some or all of the following will be explored. Subgroups of interest include: • Baseline characteristics of the children and young people receiving the intervention ○ age (11-15, 16-18) ○ gender ○ socioeconomic status ○ ethnicity ○ geographical area ○ children and young people with special educational needs and disabilities (SEND) • type of school setting e.g. mainstream, alternative provision, secure settings • People delivering the intervention ○ Teacher ○ Peer ○ Other school staff ○ External provider ○ People who have been trained to deliver the intervention • Method of delivery • Theories underlying the intervention If the evidence allows for intervention "variables or conditions" to be identified, a qualitative comparative analysis (QCA) may be conducted as well as a pairwise review. A QCA analysis allows the different causal contributions of the interventions to be explored.
Selection process – duplicate screening/selection/analysis	10% of the search results will be blind-screened by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. If the initial level of agreement is below 90%, a second round of blind-screening will be considered. 10% of data extraction and critical appraisal will be checked by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached.

Field	Content
	Only 10% of the search results will be checked as this is an intervention and qualitative review and there is confidence that RCTs, controlled studies or related qualitative studies are unlikely to be missed at the sifting stage. The inclusion list will be checked with PHAC to ensure no studies are excluded inappropriately.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to store extracted data. If meta-analysis is undertaken, Cochrane Review Manager 5 will be used to perform the analysis. Qualitative data will be analysed using EPPI Reviewer. Qualitative data will be summarised using an appropriate qualitative synthesis approach, for example, narrative synthesis.
Information sources – databases and dates	A date cut off of the year 2006 will be used. This is because this is an update of existing guidance published in 2007 and searches for the original guideline were completed in 2006. Citation search of studies included in the original guideline will be undertaken. The Medline strategy will be translated for use within the following databases: **Primary Databases** • Medline and Medline in Process (OVID) • Embase (OVID) • CENTRAL (Wiley)) • Cochrane Database of Systematic Reviews (Wiley) • DARE (records up to March 2014 only) (Wiley) • NHS EED (records up to March 2014 only) (Wiley) • Econlit (Ovid) • PsycINFO (Ovid) • Social Policy and Practice (OVID) • HMIC (OVID) ERIC (Proquest) **Secondary Databases** • ASSIA (Proquest) • CINAHL (EBSCO) • Econ Papers (RePEc) • National Guidelines Clearinghouse (US Dept. of Health and Human Services) • Bibliomap (eppicentre) • Dopher (eppicentre) • Trophi (epicentre) • Alcohol Studies Database Web searches will also be conducted. NICE Evidence Search , Google and Google Scholar will be searched for key terms and the first 50 results examined to

Field	Content
	identify any UK reports or publications relevant to the review that have not already been identified. Relevant results will be added to the Endnote database. Searches will also be conducted on the following key websites for relevant UK reports or publications: **Websites** • PSHE association • Public Health England • Department of Health • Department for Education • Alcohol Research UK • Public Health Institute • Mentor-Adepis • OFSTED • National Foundation for Educational Research • Research in Practice • Education Endowment Foundation • Office for Children's Commissioner • Council for disabled children A study filter will not be applied. Citation searching of included studies will be undertaken. Results will be saved to an EndNote database and de-duplicated. Results will be provided to the Public Health team as RIS files, suitable for import into EPPI Reviewer. A record will be kept of number of records found from each database and of the strategy used in each database. A record will be kept of total number of duplicates found and of total results provided to the Public Health team.
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual For intervention studies the Cochrane Risk of Bias 2 tool will be used and for qualitative studies, the Cochrane qualitative checklist will be used. Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE-CERQUAL will be used for qualitative findings. When performing GRADE and where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality.

Field	Content
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual The outcomes of interest are likely to be reported in the studies as continuous data. Where appropriate the data will be dichotomised to enable the committee to make recommendations.
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that the studies included will be heterogeneous with respect to participants and interventions. Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested will be tested with a fixed effects model. Data from different studies will be meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes. Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Unexplained heterogeneity will be examined where appropriate with a sensitivity analysis. If the studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual

1.3 Effectiveness and cost effectiveness of school-based multicomponent alcohol programmes that include additional components such as family and community activities

Field	Content
Review question	What universal[h] school-based multi-component alcohol interventions that include additional components such as family and community activities are effective and cost effective in children and young people aged 11 up to and including and 18 years?

[h] Universal refers to the whole population-approach, school based alcohol intervention programmes aimed at preventing alcohol use and are offered to all children who meet the programme criteria for inclusion (such as age). See the ACMD report on The prevention of drug and alcohol dependence 2015.

Field	Content
Type of review question	Intervention and qualitative
Objective of the review	To identify which school-based multi-component alcohol interventions are effective and cost effective for those children and young people aged between 11 and 18 years in delaying, reducing or stopping alcohol use. The purpose of this review is to identify which interventions work rather than which interventions work best. The review question will examine the effectiveness and cost effectiveness of universal school-based multi-component alcohol interventions and whether effectiveness varies according to a range of factors including the person delivering the intervention, programme fidelity, the population receiving the intervention, population subgroups e.g gender, age, socioeconomic group, ethnicity, geographical area, children and young people with special educational needs and disabilities (SEND).
Eligibility criteria – population	Children and young people aged 11 up to and including 18 years in full time education.
Eligibility criteria – intervention(s)	Universal school-based multi-component interventions These are school-based alcohol programmes delivered in conjunction with other components such as family, community or media based intervention components
Eligibility criteria – comparator(s)/ control	The intervention of interest against a control group

Outcomes and prioritisation	• age at first whole drink of alcohol (for those who have never drunk alcohol) where reported
	• age at first experience of drunkenness[i] where reported
	• amount and frequency of alcohol use
	• school attendance
	• alcohol related risky behaviour:
	  o unprotected or regretted sex
	  o violence and other antisocial behaviour
	  o criminal activity

[i] Recent evidence suggests it is the age at which a young person first gets drunk that is a more important predictor of subsequent harmful drinking than age of first drink

Field	Content
	• mental health and wellbeing • Adverse or unintended effects: o an increased interest in trying alcohol. **Qualitative outcome measures** Views and experiences of: • teachers and practitioners delivering interventions (UK or countries similar to UK) • children and young people receiving interventions. (UK or countries similar to UK) • parents/carers of children and young people receiving the interventions (UK or countries similar to UK) The qualitative outcome measures will be limited to UK or similar countries due to the varying contexts surrounding alcohol education/legislation in the different countries which may impact the generalisability of the interventions Outcomes reported at 12 months will be prioritised over shorter outcomes, e.g. amount and frequency of alcohol use at 12 months will be prioritised over alcohol use at 3 months. However, outcomes reported at less than a year will only be reported if 12 month data is not available, being mindful that an academic year is divided into terms (around 3 months long).

Eligibility criteria – study design	• Studies of effectiveness and cost effectiveness:
	
	  o Systematic reviews
	  o Randomised controlled trials (RCTs) including cluster RCTs.
	
	• UK based qualitative studies of interventions shown to be effective
	
	• Economic studies:
	  o Economic evaluations
	  o Cost-utility (cost per QALY)
	  o Cost benefit (i.e. Net benefit)
	  o Cost-effectiveness (Cost per unit of effect)
	  o Cost minimization
	  o Cost-consequence

Other inclusion exclusion criteria	**Included studies** There will be a scoping search carried out to identify any recent systematic reviews that directly relate to one or more of the scope questions and have been published since 1st December 2015. Any systematic reviews identified will be used as a source of primary studies or as a source of data. A full development search for individual studies will be carried out..

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<tr><td></td><td>As this is an update of existing guidance (PH7), the studies included in the evidence reviews supporting the recommendations being updated will be assessed against the new inclusion criteria. Studies will be included if they meet the new inclusion criteria.

Full economic analyses and costing studies will be included. Included costing studies reporting any health outcomes will be noted in EPPI/the evidence tables and forwarded on for economic modelling and not for the purposes of this review.

Only papers published in the English language will be included
Only studies carried out in OECD countries will be included.

Population

• Note:Populations that cover a broad age range will be included if the data for the age group of interest are reported separately.
• Note: In the UK or similar countries, school based interventions aimed at year 6 pupils (ages 10-11) through to sixth form (ages 16-18) will be included.
• Note: In the USA or similar countries, school-based interventions aimed at grades 6 to 12 (ages 11 to 18 years) will be included.
Interventions

• Statutory drug education that is part of the national science curriculum (see National Curriculum in England: science programmes of study Department of Education) will be excluded.
• Interventions that are more broadly focussed e.g. substance misuse prevention will be included only if they report alcohol outcomes.
• Individual decisions will be taken on interventions that are stated as school based, but conducted off site. For example a school nurse employed by a local authority may be responsible for a number of schools or there may be schools that are part of a federation and share a school nurse or counsellor who may conduct the intervention with pupils from a number of schools away from school premises

Comparators

• Controls to be defined as described in the studies.
• Studies with comparators within and between schools will be included.

Settings

• Schools and colleges (See DfE Types of School) including:
o Academies
o Free schools
o Faith schools
o City technology colleges
o State boarding schools
o Private schools</td></tr>
</table>

Field	Content
	◦ Alternative provisions e.g. pupil referral units (PRUs) ◦ Post 16-18 education provisions e.g. sixth form • Local authority secure children's homes • Secure training centres *The following settings are excluded:* • Home. • Higher education institutions • Young offender institutions (YOI) (and similar in other countries).
Proposed sensitivity/sub-group analysis, or meta-regression	Where evidence allows subgroup analyses and/or meta-regression will be conducted. Depending on the evidence available some or all of the following will be explored. Subgroups of interest include: • Baseline characteristics of the children and young people receiving the intervention ◦ age (11-15, 16-18) ◦ gender ◦ socioeconomic status ◦ ethnicity ◦ geographical area ◦ children and young people with special educational needs and disabilities (SEND) ◦ type of school setting e.g. mainstream, alternative provision, secure settings • People delivering the intervention ◦ Teacher ◦ Peer ◦ Other school staff ◦ External provider ◦ Deliverers who have been trained to deliver the intervention • Method of delivery • Theories underlying the intervention If the evidence allows for intervention "variables or conditions" to be identified, a qualitative comparative analysis (QCA) may be conducted as well as a pairwise review. A QCA analysis allows the different causal contributions of the interventions to be explored.

Field	Content
Selection process – duplicate screening/selection/analysis	10% of the search results will be blind-screened by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. If the initial level of agreement is below 90%, a second round of blind-screening will be considered. 10% of data extraction and critical appraisal will be checked by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. Only 10% of the search results will be checked as this is an intervention review and there is confidence that RCTs or controlled studies are unlikely to be missed at the sifting stage. The inclusion list will be checked with PHAC to ensure no studies are excluded inappropriately.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to store extracted data. If meta-analysis is undertaken, Cochrane Review Manager 5 will be used to perform the analysis. Qualitative data will be analysed using EPPI Reviewer. Qualitative data will be summarised using an appropriate qualitative synthesis approach, for example, narrative synthesis.
Information sources – databases and dates	A date cut off of the year 2006 will be used. This is because this is an update of existing guidance published in 2007 and searches for the original guideline were completed in 2006. Citation search of studies included in the original guideline will be undertaken. The Medline strategy will be translated for use within the following databases: **Primary Databases** • Medline and Medline in Process (OVID) • Embase (OVID) • CENTRAL (Wiley)) • Cochrane Database of Systematic Reviews (Wiley) • DARE (records up to March 2014 only) (Wiley) • NHS EED (records up to March 2014 only) (Wiley) • Econlit (Ovid) • PsycINFO (Ovid) • Social Policy and Practice (OVID) • HMIC (OVID) ERIC (Proquest) **Secondary Databases** • ASSIA (Proquest)

Field	Content
	• CINAHL (EBSCO) • Econ Papers (RePEc) • National Guidelines Clearinghouse (US Dept. of Health and Human Services) • Bibliomap (eppicentre) • Dopher (eppicentre) • Trophi (epicentre) • Alcohol Studies Database Web searches will also be conducted. NICE Evidence Search , Google and Google Scholar will be searched for key terms and the first 50 results examined to identify any UK reports or publications relevant to the review that have not already been identified. Relevant results will be added to the Endnote database. Searches will also be conducted on the following key websites for relevant UK reports or publications: **Websites** • PSHE association • Public Health England • Department of Health • Department for Education • Alcohol Research UK • Public Health Institute • Mentor-Adepis • OFSTED • National Foundation for Educational Research • Research in Practice • Education Endowment Foundation • Office for Children's Commissioner • Council for disabled children A study filter will not be applied. Citation searching of included studies will be undertaken. Results will be saved to an EndNote database and de-duplicated. Results will be provided to the Public Health team as RIS files, suitable for import into EPPI Reviewer. A record will be kept of number of records found from each database and of the strategy used in each database. A record will be kept of total number of duplicates found and of total results provided to the Public Health team.
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual For intervention studies the Cochrane Risk of Bias 2 tool will be used and for qualitative studies, the Cochrane qualitative checklist will be used. Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations

Field	Content
	Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE-CERQUAL will be used for qualitative findings. When performing GRADE and where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality.
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual The outcomes of interest are likely to be reported in the studies as continuous data. Where appropriate the data will be dichotomised to enable the committee to make recommendations.
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that the studies included will be heterogeneous with respect to participants and interventions. Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested will be tested with a fixed effects model. Data from different studies will be meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes. Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Unexplained heterogeneity will be examined where appropriate with a sensitivity analysis. If the studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual

A.2 Review 2: Protocols for school based alcohol intervention programmes for children and young people aged 11 to 18 years.

2.1 Effectiveness and cost effectiveness of school-based targeted alcohol programmes and pastoral support for children and young people at risk or already using alcohol aged 11 to 18?

Field	Content
Review question	What school-based targeted[j] alcohol interventions and pastoral support are effective and cost effective in children and young people aged 11 up to and including 18 years?
Type of review question	Intervention and qualitative
Objective of the review	To identify which school-based targeted alcohol interventions and pastoral support are effective and cost effective for those children and young people aged between 11 and 18 years in delaying, reducing or stopping alcohol use. The purpose of this review is to identify which interventions work rather than which interventions work best. The review question will examine the effectiveness and cost effectiveness school-based selected/indicated alcohol interventions and whether effectiveness varies according to a range of factors including the person delivering the intervention, programme fidelity, the population receiving the intervention, population subgroups e.g gender, age, socioeconomic group, ethnicity, geographical area, children and young people with special educational needs and disabilities (SEND).
Eligibility criteria – population	Children and young people aged 11 up to and including 18 years in full time education considered ‘at risk’.

[j] Targeted services and programmes: For young people who are not necessarily seeking help but are identified as being at ‘risk on the basis of characteristics they themselves have, or on the basis of the group to which they belong.’

Field	Content
Eligibility criteria – intervention(s)	Targeted school-based programmes or pastoral support such as brief interventions or counselling
Eligibility criteria – comparator(s)/ control	The intervention of interest against a control group

Outcomes and prioritisation	• age at first whole drink of alcohol (for those who have never drunk alcohol) where reported
	• age at first experience of drunkenness[k] where reported
	• amount and frequency of alcohol use
	• school attendance.
	• alcohol related risky behaviour:
	    ○ unprotected or regretted sex
	    ○ violence and other antisocial behaviour
	    ○ criminal activity
	• mental health and wellbeing
	• Adverse or unintended effects:
	    ○ an increased interest in trying alcohol.
	
	Qualitative outcome measures
	
	Views and experiences of:
	• teachers and practitioners delivering interventions (UK or countries similar to UK)
	• children and young people receiving interventions. (UK or countries similar to UK)
	• parents/carers of children and young people receiving the interventions (UK or countries similar to UK)
	
	The qualitative outcome measures will be limited to UK or similar countries due to the varying contexts surrounding alcohol education/legislation in the different countries which may impact the generalisability of the interventions.
	
	Outcomes reported at 12 months will be prioritised over shorter outcomes, e.g. amount and frequency of alcohol use at 12 months will be prioritised over alcohol use at 3 months. However, outcomes reported at less than a year will only be reported if 12 month data is not available, being mindful that an academic year is divided into terms (around 3 months long).

Eligibility criteria – study design	• Studies of effectiveness and cost effectiveness: ○ Systematic reviews ○ Randomised controlled trials (RCTs) including cluster RCTs.

[k] Recent evidence suggests it is the age at which a young person first gets drunk that is a more important predictor of subsequent harmful drinking than age of first drink

<table>
<tr><th>Field</th><th>Content</th></tr>
<tr><td></td><td>
• UK based qualitative studies of interventions shown to be effective
•
• Economic studies:
○ Economic evaluations
○ Cost-utility (cost per QALY)
○ Cost benefit (i.e. Net benefit)
○ Cost-effectiveness (Cost per unit of effect)
○ Cost minimization
○ Cost-consequence
</td></tr>
<tr><td>Other inclusion exclusion criteria</td><td>
Included studies

There will be a scoping search carried out to identify any recent systematic reviews that directly relate to one or more of the scope questions and have been published since 1st December 2015. Any systematic reviews identified will be used as a source of primary studies or as a source of data.

A full development search for individual studies will be carried out.

As this is an update of existing guidance (PH7), the studies included in the evidence reviews supporting the recommendations being updated will be assessed against the new inclusion criteria. Studies will be included if they meet the new inclusion criteria.

Full economic analyses and costing studies will be included. Included costing studies reporting any health outcomes will be noted in EPPI/the evidence tables and forwarded on for economic modelling and not for the purposes of this review.

Only papers published in the English language will be included
Only studies carried out in OECD countries will be included.

Population

• Note: At risk' populations will be defined as per study definitions.
• Note: Populations that cover a broad age range will be included if the data for the age group of interest are reported separately.
• Note: In the UK or similar countries, school based interventions aimed at year 6 pupils (aged 10-11) through to sixth form (16 to 18) will be included.
• Note: In the US or similar countries, school-based interventions aimed at grades 6 to 12 (11 to 18 years) will be included.
Interventions

• Statutory drug education that is part of the national science curriculum (see National Curriculum in England: science programmes of study Department of Education) will be excluded.
</td></tr>
</table>

Field	Content

	• Interventions that are more broadly focussed e.g. substance misuse prevention will be included if they report alcohol outcomes.
	• Individual decisions will be taken on interventions that are stated as school based, but conducted off site. For example a school nurse employed by a local authority may be responsible for a number of schools or there may be schools that are part of a federation and share a school nurse or counsellor who may conduct the intervention with pupils from a number of schools away from school premises
	
	Comparators
	
	Controls to be defined as described in the studies.
	
	Studies with comparators within and between schools will be included.
	
	Settings
	
	• Schools and colleges (See DfE *Types of School)* including:
	  ○ Academies
	  ○ Free schools
	  ○ Faith schools
	  ○ City technology colleges
	  ○ State boarding schools
	  ○ Private schools
	  ○ Alternative provisions e.g. pupil referral units (PRUs)
	  ○ Post 16-18 education provisions e.g. sixth form
	• Local authority secure children's homes
	• Secure training centres
	
	The following settings are excluded:
	• Home.
	• Higher education institutions
	• Young offender institutions (YOI) (and similar in other countries).
	
	.

Proposed sensitivity/sub-group analysis, or meta-regression	Where evidence allows subgroup analyses and/or meta-regression will be conducted. Depending on the evidence available some or all of the following will be explored.
	
	Subgroups of interest include:
	
	• Baseline characteristics of the children and young people receiving the intervention
	  ○ age (11-15, 16-18)
	  ○ gender
	  ○ socioeconomic status

Field	Content
	○ ethnicity ○ geographical area ○ children and young people with special educational needs and disabilities (SEND) ○ type of school setting e.g. mainstream, alternative provision, secure settings • People delivering the intervention e.g. teacher, peer, other school staff or external provider ○ Teacher ○ Peer ○ Other school staff ○ External provider e.g school nurse ○ People who have been trained to deliver the intervention • Method of delivery • Single component or multi-component • Theories underlying the intervention If the evidence allows for intervention “variables or conditions” to be identified, a qualitative comparative analysis (QCA) may be conducted as well as a pairwise review. A QCA analysis allows the different causal contributions of the interventions to be explored.
Selection process – duplicate screening/selection/analysis	10% of the search results will be blind-screened by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. If the initial level of agreement is below 90%, a second round of blind-screening will be considered. 10% of data extraction and critical appraisal will be checked by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. Only 10% of the search results will be checked as this is an intervention and qualitative review and there is confidence that RCTs, controlled studies or related qualitative studies are unlikely to be missed at the sifting stage. The inclusion list will be checked with PHAC to ensure no studies are excluded inappropriately.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to store extracted data. If meta-analysis is undertaken, Cochrane Review Manager 5 will be used to perform the analysis.

Field	Content
	Qualitative data will be analysed using EPPI Reviewer. Qualitative data will be summarised using an appropriate qualitative synthesis approach, for example, narrative synthesis.
Information sources – databases and dates	A date cut off of the year 2006 will be used. This is because this is an update of existing guidance published in 2007 and searches for the original guideline were completed in 2006. Citation search of studies included in the original guideline will be undertaken. The Medline strategy will be translated for use within the following databases: **Primary Databases** • Medline and Medline in Process (OVID) • Embase (OVID) • CENTRAL (Wiley)) • Cochrane Database of Systematic Reviews (Wiley) • DARE (records up to March 2014 only) (Wiley) • NHS EED (records up to March 2014 only) (Wiley) • Econlit (Ovid) • PsycINFO (Ovid) • Social Policy and Practice (OVID) • HMIC (OVID) ERIC (Proquest) **Secondary Databases** • ASSIA (Proquest) • CINAHL (EBSCO) • Econ Papers (RePEc) • National Guidelines Clearinghouse (US Dept. of Health and Human Services) • Bibliomap (eppicentre) • Dopher (eppicentre) • Trophi (epicentre) • Alcohol Studies Database Web searches will also be conducted. NICE Evidence Search , Google and Google Scholar will be searched for key terms and the first 50 results examined to identify any UK reports or publications relevant to the review that have not already been identified. Relevant results will be added to the Endnote database. Searches will also be conducted on the following key websites for relevant UK reports or publications: **Websites** • PSHE association • Public Health England • Department of Health • Department for Education • Alcohol Research UK • Public Health Institute

Field	Content
	• Mentor-Adepis • OFSTED • National Foundation for Educational Research • Research in Practice • Education Endowment Foundation • Office for Children's Commissioner • Council for disabled children A study filter will not be applied. Citation searching of included studies will be undertaken. Results will be saved to an EndNote database and de-duplicated. Results will be provided to the Public Health team as RIS files, suitable for import into EPPI Reviewer. A record will be kept of number of records found from each database and of the strategy used in each database. A record will be kept of total number of duplicates found and of total results provided to the Public Health team.
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual For intervention studies the Cochrane Risk of Bias 2 tool will be used and for qualitative studies, the Cochrane qualitative checklist will be used. Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE-CERQUAL will be used for qualitative findings. When performing GRADE and where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality.
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual The outcomes of interest are likely to be reported in the studies as continuous data. Where appropriate the data will be dichotomised to enable the committee to make recommendations..
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that the studies included will be heterogeneous with respect to participants and interventions.

Field	Content
	Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested will be tested with a fixed effects model. Data from different studies will be meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes. Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Unexplained heterogeneity will be examined where appropriate with a sensitivity analysis. If the studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual

A.3 Review 3: Protocols for School or college based alcohol intervention programmes for young people aged 18 to 25 years with special educational needs and disabilities (SEND)

3.1 Effectiveness and cost effectiveness of universal classroom-based alcohol programmes for young people aged 18 to 25 with SEND

Field	Content
Review question	What universal[l] classroom-based alcohol programmes are effective and cost effective among young people aged 18 up to and including 25 years with SEND?
Type of review question	Intervention and qualitative
Objective of the review	To identify which universal classroom based alcohol programmes are effective and cost effective harm reduction approaches among young people aged 18 to 25

[l] Universal refers to the whole population-approach, school based alcohol intervention programmes aimed at preventing alcohol use and are offered to all children who meet the programme criteria for inclusion (such as age). See the ACMD report on The prevention of drug and alcohol dependence 2015

Field	Content
	years with SEND. . The purpose of this review is to identify which interventions work rather than which interventions work best. The review question will examine the effectiveness and cost effectiveness of universal classroom-based alcohol programmes and whether effectiveness varies according to a range of factors including the person delivering the intervention, programme fidelity, the population receiving the intervention, population subgroups e.g. gender, age, socioeconomic group, ethnicity, geographical area.
Eligibility criteria – population	Young people aged 18 up to and including 25 years with an Education, health and care (EHC) plan.
Eligibility criteria – intervention(s)	Universal classroom based alcohol interventions delivered by a teacher, peer, other school staff or external provider
Eligibility criteria – comparator(s)/control	The intervention of interest against a control group

Outcomes and prioritisation	• age at first whole drink of alcohol (for those who have never drunk alcohol) where reported
	• age at first experience of drunkenness[m] where reported
	• amount and frequency of alcohol use
	• school attendance.
	• alcohol related risky behaviour:
	  o unprotected or regretted sex
	  o violence and other antisocial behaviour
	  o criminal activity
	• mental health and wellbeing
	• Adverse or unintended effects:
	  o an increased interest in trying alcohol.
	
	Qualitative outcome measures
	
	Views and experiences of:
	• teachers and practitioners delivering interventions (UK or countries similar to UK)
	• young people receiving interventions. (UK or countries similar to UK)
	• parents/carers of young people receiving the interventions (UK or countries similar to UK)

[m] Recent evidence suggests it is the age at which a young person first gets drunk that is a more important predictor of subsequent harmful drinking than age of first drink

Field	Content
	The qualitative outcome measures will be limited to UK or similar countries due to the varying contexts surrounding alcohol education/legislation in the different countries which may impact the generalisability of the interventions Outcomes reported at 12 months will be prioritised over shorter outcomes, e.g. amount and frequency of alcohol use at 12 months will be prioritised over alcohol use at 3 months. However, outcomes reported at less than a year will be considered if 12 month data is not available being mindful that an academic year is divided into terms (around 3 months long).
Eligibility criteria – study design	• Studies of effectiveness and cost effectiveness: o Systematic reviews o Randomised controlled trials (RCTs) including cluster RCTs. • Should the evidence from systematic reviews and RCTs be limited, the following study designs will be sought in descending priority: o Quasi-experimental studies, such as non-randomised controlled trials and controlled before and after studies. • UK based qualitative studies linked to included studies of effectiveness. • Economic studies: o Economic evaluations o Cost-utility (cost per QALY) o Cost benefit (i.e. Net benefit) o Cost-effectiveness (Cost per unit of effect) o Cost minimization o Cost-consequence
Other inclusion exclusion criteria	**Included studies** There will be a scoping search carried out to identify any recent systematic reviews that directly relate to one or more of the scope questions and have been published since 1st December 2015. Any systematic reviews identified will be used as a source of primary studies or as a source of data. A full development search for individual studies will be carried out. Full economic analyses and costing studies will be included. Included costing studies reporting any health outcomes will be noted in EPPI/the evidence tables and forwarded on for economic modelling and not for the purposes of this review.

Field	Content
	Only papers published in the English language will be included Only studies carried out in OECD countries will be included. If it is clear from the full paper includes that there is no or virtually no evidence available to populate this review, a discussion will take place with the committee to determine which other approaches such as expert testimony, call for evidence and case studies should be considered. **Population** • Populations that cover a broad age range will be included if the data for the age group of interest are reported separately • To note that this group are considered separately to SEND 11 to 18 as education likely to be provided in different settings and as 18 and over are also eligible to drink alcohol **Interventions** • Statutory drug education that is part of the national science curriculum (see National Curriculum in England: science programmes of study Department of Education) will be excluded • Interventions that are more broadly focussed e.g. substance misuse prevention will be included if they report alcohol outcomes. • Individual decisions will be taken on interventions that are stated as school based, but conducted off site. For example a school nurse employed by a local authority may be responsible for a number of schools or there may be schools that are part of a federation and share a school nurse or counsellor who may conduct the intervention with pupils from a number of schools away from school premises **Comparators** • Controls to be defined as described in the studies • Studies with comparators within and between schools will be included. **Settings** Further education colleges Specialist colleges *The following settings are excluded:* Higher education institutions

Field	Content

Proposed sensitivity/sub-group analysis, or meta-regression	Where evidence allows subgroup analyses and/or meta-regression will be conducted. Depending on the evidence available some or all of the following will be explored.
	
	Subgroups of interest include:
	
	• Baseline characteristics of the young people receiving the intervention
	  ○ gender
	  ○ socioeconomic status
	  ○ ethnicity
	  ○ geographical area
	• People delivering the intervention
	  ○ Teacher
	  ○ Peer
	  ○ Other school staff
	  ○ External provider
	  ○ People who have been trained to deliver the intervention
	• Method of delivery
	• Theories underlying the intervention
	
	If the evidence allows for intervention “variables or conditions” to be identified, a qualitative comparative analysis (QCA) may be conducted as well as a pairwise review. A QCA analysis allows the different causal contributions of the interventions to be explored.

Selection process – duplicate screening/selection/analysis	10% of the search results will be blind-screened by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. If the initial level of agreement is below 90%, a second round of blind-screening will be considered. 10% of data extraction and critical appraisal will be checked by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. Only 10% of the search results will be checked as this is an intervention and qualitative review and there is confidence that RCTs, controlled studies or related qualitative studies are unlikely to be missed at the sifting stage. The inclusion list will be checked with PHAC to ensure no studies are excluded inappropriately.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to store extracted data.

Field	Content
	If meta-analysis is undertaken, Cochrane Review Manager 5 will be used to perform the analysis. Qualitative data will be analysed using EPPI Reviewer. Qualitative data will be summarised using an appropriate qualitative synthesis approach, for example, narrative synthesis.
Information sources – databases and dates	The Medline strategy will be translated for use within the following databases: **Primary Databases** • Medline and Medline in Process (OVID) • Embase (OVID) • CENTRAL (Wiley)) • Cochrane Database of Systematic Reviews (Wiley) • DARE (records up to March 2014 only) (Wiley) • NHS EED (records up to March 2014 only) (Wiley) • Econlit (Ovid) • PsycINFO (Ovid) • Social Policy and Practice (OVID) • HMIC (OVID) ERIC (Proquest) **Secondary Databases** • ASSIA (Proquest) • CINAHL (EBSCO) • Econ Papers (RePEc) • National Guidelines Clearinghouse (US Dept. of Health and Human Services) • Bibliomap (eppicentre) • Dopher (eppicentre) • Trophi (epicentre) • Alcohol Studies Database Web searches will also be conducted. NICE Evidence Search , Google and Google Scholar will be searched for key terms and the first 50 results examined to identify any UK reports or publications relevant to the review that have not already been identified. Relevant results will be added to the Endnote database. Searches will also be conducted on the following key websites for relevant UK reports or publications: **Websites** • PSHE association • Public Health England • Department of Health • Department for Education • Alcohol Research UK • Public Health Institute • Mentor-Adepis • OFSTED • National Foundation for Educational Research • Research in Practice

Field	Content
	• Education Endowment Foundation • Office for Children's Commissioner • Council for disabled children A study filter will not be applied. Citation searching of included studies will be undertaken. Results will be saved to an EndNote database and de-duplicated. Results will be provided to the Public Health team as RIS files, suitable for import into EPPI Reviewer. A record will be kept of number of records found from each database and of the strategy used in each database. A record will be kept of total number of duplicates found and of total results provided to the Public Health team.
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual For intervention studies the Cochrane Risk of Bias 2 tool will be used and for qualitative studies, the Cochrane qualitative checklist will be used.Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE-CERQUAL will be used for qualitative findings. When performing GRADE and where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality.
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual The outcomes of interest are likely to be reported in the studies as continuous data. Where appropriate the data will be dichotomised to enable the committee to make recommendations.
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that the studies included will be heterogeneous with respect to participants and interventions. Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested will be tested with a fixed effects model. Data from different studies will be meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes.

Field	Content
	Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Unexplained heterogeneity will be examined where appropriate with a sensitivity analysis. If the studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual

3.2 Effectiveness and cost effectiveness of universal school-based (outside of the classroom) alcohol interventions for young people aged 18 to 25 with SEND

Field	Content
Review question	What universal[n] school-based (outside the classroom) alcohol interventions are effective and cost effective among young people aged 18 up to and including 25 years with SEND?
Type of review question	Intervention and qualitative
Objective of the review	To identify which school-based (outside the classroom) alcohol programmes are effective and cost effective harm reduction approaches among young people aged 18 to 25 years with SEND. The purpose of this review is to identify which interventions work rather than which interventions work best. The review question will examine the effectiveness and cost effectiveness of universal classroom-based alcohol programmes and whether effectiveness varies according to a range of factors including the person delivering the intervention, programme fidelity, the population receiving the intervention, population subgroups e.g. gender, age, socioeconomic group, ethnicity, geographical area.
Eligibility criteria – population	Young people aged 18 up to and including 25 years with an Education, health and care (EHC) plan.

[n] Universal refers to the whole population-approach, school based alcohol intervention programmes aimed at preventing alcohol use and are offered to all children who meet the programme criteria for inclusion (such as age). See the ACMD report on The prevention of drug and alcohol dependence 2015

Field	Content
Eligibility criteria – intervention(s)	School-based (outside the classroom) interventions For example: Whole school approaches, health promotion information and advice provided as part of the Healthy Schools Programme (UK) or school policies on alcohol. Other approaches that do not involve classroom based teaching can include peer-led approaches, school assemblies, Theatre in Education
Eligibility criteria – comparator(s)/control	The intervention of interest against a control group

Outcomes and prioritisation	• age at first whole drink of alcohol (for those who have never drunk alcohol) where reported
	• age at first experience of drunkenness[o] where reported
	• amount and frequency of alcohol use
	• school attendance
	• alcohol related risky behaviour:
	  ○ unprotected or regretted sex
	  ○ violence and other antisocial behaviour
	  ○ criminal activity
	
	• mental health and wellbeing
	• Adverse or unintended effects:
	  ○ an increased interest in trying alcohol.
	
	Qualitative outcome measures
	
	Views and experiences of:
	• teachers and practitioners delivering interventions (UK or countries similar to UK)
	• young people receiving interventions. (UK or countries similar to UK)
	• parents/carers of young people receiving the interventions (UK or countries similar to UK)
	
	The qualitative outcome measures will be limited to UK or similar countries due to the varying contexts surrounding alcohol education/legislation in the different countries which may impact the generalisability of the interventions

[o] Recent evidence suggests it is the age at which a young person first gets drunk that is a more important predictor of subsequent harmful drinking than age of first drink

<table>
<tr><th>Field</th><th>Content</th></tr>
<tr><td></td><td>Outcomes reported at 12 months will be prioritised over shorter outcomes, e.g. amount and frequency of alcohol use at 12 months will be prioritised over alcohol use at 3 months. However, outcomes reported at less than a year will only be reported if 12 month data is not available, being mindful that an academic year is divided into terms (around 3 months long).</td></tr>
<tr><td>Eligibility criteria – study design</td><td>• Studies of effectiveness and cost effectiveness:
  o Systematic reviews
  o Randomised controlled trials (RCTs) including cluster RCTs.
• Should the evidence from systematic reviews and RCTs be limited, the following study designs will be sought in descending priority:
  o Quasi-experimental studies, such as non-randomised controlled trials and controlled before and after studies.
• UK based qualitative studies linked to included studies of effectiveness.
• Economic studies:
  o Economic evaluations
  o Cost-utility (cost per QALY)
  o Cost benefit (i.e. Net benefit)
  o Cost-effectiveness (Cost per unit of effect)
  o Cost minimization
  o Cost-consequence</td></tr>
<tr><td>Other inclusion exclusion criteria</td><td>Included studies

There will be a scoping search carried out to identify any recent systematic reviews that directly relate to one or more of the scope questions and have been published since 1st December 2015. Any systematic reviews identified will be used as a source of primary studies or as a source of data.

A full development search for individual studies will be carried out..

Full economic analyses and costing studies will be included. Included costing studies reporting any health outcomes will be noted in EPPI/the evidence tables and forwarded on for economic modelling and not for the purposes of this review.

Only papers published in the English language will be included
Only studies carried out in OECD countries will be included.

The purpose of this review is to identify which interventions work rather than which interventions work best.</td></tr>
</table>

<table>
<tr><th>Field</th><th>Content</th></tr>
<tr><td></td><td>If it is clear from the full paper includes that there is no or virtually no evidence available to populate this review, a discussion will take place with the committee to determine which other approaches such as expert testimony, call for evidence and case studies should be considered.

Population

Populations that cover a broad age range will be included if the data for the age group of interest are reported separately

To note that this group are considered separately to SEND 11 to 18 as education likely to be provided in different settings and as 18 and over are also eligible to drink alcohol

Interventions

• Statutory drug education that is part of the national science curriculum (see National Curriculum in England: science programmes of study Department of Education) will be exluded
• Interventions that are more broadly focussed e.g. substance misuse prevention will be included if they report alcohol outcomes.
• Individual decisions will be taken on interventions that are stated as school based, but conducted off site. For example a school nurse employed by a local authority may be responsible for a number of schools or there may be schools that are part of a federation and share a school nurse or counsellor who may conduct the intervention with pupils from a number of schools away from school premises

Comparators

• Controls to be defined as described in the studies
• Studies with comparators within and between schools will be included.

Settings

Further education colleges

Specialist colleges

The following settings are excluded:

Higher education institutions</td></tr>
</table>

Field	Content

Proposed sensitivity/sub-group analysis, or meta-regression	Where evidence allows subgroup analyses and/or meta-regression will be conducted. Depending on the evidence available some or all of the following will be explored.
	
	Subgroups of interest include:
	
	• Baseline characteristics of the young people receiving the intervention
	  ○ gender
	  ○ socioeconomic status
	  ○ ethnicity
	  ○ geographical area
	• People delivering the intervention
	  ○ Teacher
	  ○ Peer
	  ○ Other school staff
	  ○ External provider
	  ○ People who have been trained to deliver intervention
	• Method of delivery
	• Theories underlying the intervention
	
	If the evidence allows for intervention "variables or conditions" to be identified, a qualitative comparative analysis (QCA) may be conducted as well as a pairwise review. A QCA analysis allows the different causal contributions of the interventions to be explored.

Selection process – duplicate screening/selection/analysis	10% of the search results will be blind-screened by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. If the initial level of agreement is below 90%, a second round of blind-screening will be considered. 10% of data extraction and critical appraisal will be checked by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. Only 10% of the search results will be checked as this is an intervention and qualitative studies review and there is confidence that RCTs, controlled studies or related qualitative studies are unlikely to be missed at the sifting stage. The inclusion list will be checked with PHAC to ensure no studies are excluded inappropriately.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to store extracted data.

Field	Content
	If meta-analysis is undertaken, Cochrane Review Manager 5 will be used to perform the analysis. Qualitative data will be analysed using EPPI Reviewer. Qualitative data will be summarised using an appropriate qualitative synthesis approach, for example, narrative synthesis.
Information sources – databases and dates	The Medline strategy will be translated for use within the following databases: **Primary Databases** • Medline and Medline in Process (OVID) • Embase (OVID) • CENTRAL (Wiley)) • Cochrane Database of Systematic Reviews (Wiley) • DARE (records up to March 2014 only) (Wiley) • NHS EED (records up to March 2014 only) (Wiley) • Econlit (Ovid) • PsycINFO (Ovid) • Social Policy and Practice (OVID) • HMIC (OVID) ERIC (Proquest) **Secondary Databases** • ASSIA (Proquest) • CINAHL (EBSCO) • Econ Papers (RePEc) • National Guidelines Clearinghouse (US Dept. of Health and Human Services) • Bibliomap (eppicentre) • Dopher (eppicentre) • Trophi (epicentre) • Alcohol Studies Database Web searches will also be conducted. NICE Evidence Search , Google and Google Scholar will be searched for key terms and the first 50 results examined to identify any UK reports or publications relevant to the review that have not already been identified. Relevant results will be added to the Endnote database. Searches will also be conducted on the following key websites for relevant UK reports or publications: **Websites** • PSHE association • Public Health England • Department of Health • Department for Education • Alcohol Research UK • Public Health Institute • Mentor-Adepis • OFSTED • National Foundation for Educational Research • Research in Practice • Education Endowment Foundation

Field	Content
	• Office for Children's Commissioner • Council for disabled children A study filter will not be applied. Citation searching of included studies will be undertaken. Results will be saved to an EndNote database and de-duplicated. Results will be provided to the Public Health team as RIS files, suitable for import into EPPI Reviewer. A record will be kept of number of records found from each database and of the strategy used in each database. A record will be kept of total number of duplicates found and of total results provided to the Public Health team.
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual For intervention studies the Cochrane Risk of Bias 2 tool will be used and for qualitative studies, the Cochrane qualitative checklist will be used. Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE-CERQUAL will be used for qualitative findings. When performing GRADE and where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality.
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual The outcomes of interest are likely to be reported in the studies as continuous data. Where appropriate the data will be dichotomised to enable the committee to make recommendations.
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that the studies included will be heterogeneous with respect to participants and interventions. Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested will be tested with a fixed effects model. Data from different studies will be meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes.

Field	Content
	Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Unexplained heterogeneity will be examined where appropriate with a sensitivity analysis. If the studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual

3.3 Effectiveness and cost effectiveness of school-based multicomponent alcohol interventions that include additional components such as family and community activities for young people aged 18 to 25 with SEND

Field	Content
Review question	What universal[p] school-based multi-component alcohol interventions that include additional components such as family and community activities are effective and cost effective among young people aged 18 up to and including 25 years with SEND?
Type of review question	Intervention and qualitative
Objective of the review	To identify which universal school-based multi-component alcohol interventions are effective and cost effective harm reduction approaches among young people aged 18 to 25 years with SEND. The purpose of this review is to identify which interventions work rather than which interventions work best. The review question will examine the effectiveness and cost effectiveness of universal school-based multi-component alcohol interventions and whether effectiveness varies according to a range of factors including the person delivering the intervention, programme fidelity, the population receiving the intervention, population subgroups e.g. gender, age, socioeconomic group, ethnicity, geographical area.

[p] Universal refers to the whole population-approach, school based alcohol intervention programmes aimed at preventing alcohol use and are offered to all children who meet the programme criteria for inclusion (such as age). See the ACMD report on The prevention of drug and alcohol dependence 2015

Field	Content
Eligibility criteria – population	Young people aged 18 up to and including 25 years with an Education, health and care (EHC) plan.
Eligibility criteria – intervention(s)	Universal school-based multi-component alcohol interventions These are school-based alcohol programmes delivered in conjunction with other components such as family, community or media based intervention components.
Eligibility criteria – comparator(s)/control	The intervention of interest against a control group

Outcomes and prioritisation	• age at first whole drink of alcohol (for those who have never drunk alcohol) where reported
	• age at first experience of drunkenness[q] where reported
	• amount and frequency of alcohol use
	• school attendance
	• alcohol related risky behaviour:
	  ○ unprotected or regretted sex
	  ○ violence and other antisocial behaviour
	  ○ criminal activity
	• mental health and wellbeing
	• Adverse or unintended effects
	  ○ an increased interest in trying alcohol.
	
	Qualitative outcome measures
	
	Views and experiences of:
	• teachers and practitioners delivering interventions (UKor countries similar to UK)
	• young people receiving interventions. (UK or countries similar to UK)
	• parents/carers of young people receiving the interventions (UK or countries similar to UK)
	
	The qualitative outcome measures will be limited to UK or similar countries due to the varying contexts surrounding alcohol education/legislation in the different countries which may impact the generalisability of the interventions
	
	Outcomes reported at 12 months will be prioritised over shorter outcomes, e.g. amount and frequency of alcohol use at 12 months will be prioritised over alcohol use at 3 months. However, outcomes reported less than a year will be considered if 12 month data is not available being mindful that an academic year is divided into terms (around 3 months long).

[q] Recent evidence suggests it is the age at which a young person first gets drunk that is a more important predictor of subsequent harmful drinking than age of first drink

<table>
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<tr><td></td><td></td></tr>
<tr><td>Eligibility criteria – study design</td><td>Studies of effectiveness and cost effectiveness:
Systematic reviews
Randomised controlled trials (RCTs) including cluster RCTs.
Should the evidence from systematic reviews and RCTs be limited, the following study designs will be sought in descending priority:
Quasi-experimental studies, such as non-randomised controlled trials and controlled before and after studies.
UK based qualitative studies linked to included studies of effectiveness.
Economic studies:
Economic evaluations
Cost-utility (cost per QALY)
Cost benefit (i.e. Net benefit)
Cost-effectiveness (Cost per unit of effect)
Cost minimization
Cost-consequence</td></tr>
<tr><td>Other inclusion exclusion criteria</td><td>Included studies

There will be a scoping search carried out to identify any recent systematic reviews that directly relate to one or more of the scope questions and have been published since 1st December 2015. Any systematic reviews identified will be used as a source of primary studies or as a source of data.

A full development search for individual studies will be carried out..

Full economic analyses and costing studies will be included. Included costing studies reporting any health outcomes will be noted in EPPI/the evidence tables and forwarded on for economic modelling and not for the purposes of this review.

Only papers published in the English language will be included
Only studies carried out in OECD countries will be included.

Population</td></tr>
</table>

<table>
<tr><th>Field</th><th>Content</th></tr>
<tr><td></td><td>Populations that cover a broad age range will be included if the data for the age group of interest are reported separately

To note that this group are considered separately to SEND 11 to 18 as education likely to be provided in different settings and as 18 and over are also eligible to drink alcohol

Interventions

• Statutory drug education that is part of the national science curriculum (see National Curriculum in England: science programmes of study Department of Education) will be excluded.
• Interventions that are more broadly focussed e.g. substance misuse prevention will be included if they report alcohol outcomes.
• Individual decisions will be taken on interventions that are stated as school based, but conducted off site. For example a school nurse employed by a local authority may be responsible for a number of schools or there may be schools that are part of a federation and share a school nurse or counsellor who may conduct the intervention with pupils from a number of schools away from school premises

Comparators

• Controls to be defined as described in the studies
• Studies with comparators within and between schools will be included.

Settings

Further education colleges

Specialist colleges

The following settings are excluded:

Higher education institutions</td></tr>
<tr><td>Proposed sensitivity/sub-group analysis, or meta-regression</td><td>Where evidence allows subgroup analyses and/or meta-regression will be conducted. Depending on the evidence available some or all of the following will be explored

Subgroups of interest include:

• Baseline characteristics of the young people receiving the intervention
○ gender</td></tr>
</table>

Field	Content
	○ socioeconomic status ○ ethnicity ○ geographical area • People delivering the intervention ○ Teacher ○ Peer ○ Other school staff ○ External provider ○ People who have been trained to deliver the intervention • Method of delivery • Theories underlying the intervention If the evidence allows for intervention "variables or conditions" to be identified, a qualitative comparative analysis (QCA) may be conducted as well as a pairwise review. A QCA analysis allows the different causal contributions of the interventions to be explored.
Selection process – duplicate screening/selection/analysis	10% of the search results will be blind-screened by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. If the initial level of agreement is below 90%, a second round of blind-screening will be considered. 10% of data extraction and critical appraisal will be checked by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. Only 10% of the search results will be checked as this is an intervention and qualitative review and there is confidence that RCTs, controlled studies or related qualitative studies are unlikely to be missed at the sifting stage. The inclusion list will be checked with PHAC to ensure no studies are excluded inappropriately.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to store extracted data. If meta-analysis is undertaken, Cochrane Review Manager 5 will be used to perform the analysis. Qualitative data will be analysed using EPPI Reviewer. Qualitative data will be summarised using an appropriate qualitative synthesis approach, for example, narrative synthesis.
Information sources – databases and dates	The Medline strategy will be translated for use within the following databases: **Primary Databases** • Medline and Medline in Process (OVID) • Embase (OVID)

Field	Content
	• CENTRAL (Wiley)) • Cochrane Database of Systematic Reviews (Wiley) • DARE (records up to March 2014 only) (Wiley) • NHS EED (records up to March 2014 only) (Wiley) • Econlit (Ovid) • PsycINFO (Ovid) • Social Policy and Practice (OVID) • HMIC (OVID) • ERIC (Proquest) **Secondary Databases** • ASSIA (Proquest) • CINAHL (EBSCO) • Econ Papers (RePEc) • National Guidelines Clearinghouse (US Dept. of Health and Human Services) • Bibliomap (eppicentre) • Dopher (eppicentre) • Trophi (epicentre) • Alcohol Studies Database Web searches will also be conducted. NICE Evidence Search , Google and Google Scholar will be searched for key terms and the first 50 results examined to identify any UK reports or publications relevant to the review that have not already been identified. Relevant results will be added to the Endnote database. Searches will also be conducted on the following key websites for relevant UK reports or publications: **Websites** • PSHE association • Public Health England • Department of Health • Department for Education • Alcohol Research UK • Public Health Institute • Mentor-Adepis • OFSTED • National Foundation for Educational Research • Research in Practice • Education Endowment Foundation • Office for Children's Commissioner • Council for disabled children A study filter will not be applied. Citation searching of included studies will be undertaken. Results will be saved to an EndNote database and de-duplicated. Results will be provided to the Public Health team as RIS files, suitable for import into EPPI Reviewer.

Field	Content
	A record will be kept of number of records found from each database and of the strategy used in each database. A record will be kept of total number of duplicates found and of total results provided to the Public Health team.
Methods for assessing bias at outcome/study level	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual For intervention studies the Cochrane Risk of Bias 2 tool will be used and for qualitative studies, the Cochrane qualitative checklist will be used. Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE-CERQUAL will be used for qualitative findings. When performing GRADE and where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality.
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual The outcomes of interest are likely to be reported in the studies as continuous data. Where appropriate the data will be dichotomised to enable the committee to make recommendations.
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that the studies included will be heterogeneous with respect to participants and interventions. Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested will be tested with a fixed effects model. Data from different studies will be meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes. Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Unexplained heterogeneity will be examined where appropriate with a sensitivity analysis. If the studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.

Field	Content
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual

A.4 Review 4: Protocols for School or college based alcohol intervention programmes for young people aged 18 to 25 years with special educational needs and disabilities (SEND)

4.1 Effectiveness and cost effectiveness of school-based targeted alcohol interventions and pastoral support for young people aged 18 to 25 with SEND considered 'at risk'.

Field	Content
Review question	What school-based targeted[r] alcohol interventions and pastoral support are effective and cost effective among young people aged 18 up to and including 25 years with SEND?
Type of review question	Intervention and qualitative
Objective of the review	To identify which school-based targeted alcohol interventions and pastoral support are effective and cost effective harm reduction approaches among young people aged 18 up to and including 25 years with SEND. The purpose of this review is to identify which interventions work rather than which interventions work best. The review question will examine the effectiveness and cost effectiveness of universal classroom-based alcohol programmes and whether effectiveness varies according to a range of factors including the person delivering the intervention, programme fidelity, the population receiving the intervention, population subgroups e.g. gender, age, socioeconomic group, ethnicity, geographical area.
Eligibility criteria – population	Young people aged 18 up to and including 25 years with an Education, health and care (EHC) plan considered 'at risk'.

[r] Targeted services and programmes: For young people who are not necessarily seeking help but are identified as being at 'risk on the basis of characteristics they themselves have, or on the basis of the group to which they belong

Field	Content
Eligibility criteria – intervention(s)	Targeted school-based programmes and pastoral support such as brief interventions or counselling
Eligibility criteria – comparator(s)/control	The intervention of interest against a control group

Outcomes and prioritisation	• age at first whole drink of alcohol (for those who have never drunk alcohol) where reported
	• age at first experience of drunkenness[s] where reported
	• amount and frequency of alcohol use
	• school attendance
	• alcohol related risky behaviour:
	  ○ unprotected or regretted sex
	  ○ violence and other antisocial behaviour
	  ○ criminal activity
	
	• mental health and wellbeing
	• Adverse or unintended effects, such as an increased interest in trying alcohol.
	
	Qualitative outcome measures
	
	Views and experiences of:
	• teachers and practitioners delivering interventions (UK or countries similar to UK)
	• young people receiving interventions. (UK or countries similar to UK)
	• parents/carers of young people receiving the interventions (UK or countries similar to UK)
	
	The qualitative outcome measures will be limited to UK or similar countries due to the varying contexts surrounding alcohol education/legislation in the different countries which may impact the generalisability of the interventions
	
	Outcomes reported at 12 months will be prioritised over shorter outcomes, e.g. amount and frequency of alcohol use at 12 months will be prioritised over alcohol use at 3 months. However, outcomes reported at less than a year will only be reported if 12 month data is not available, being mindful that an academic year is divided into terms (around 3 months long).

Eligibility criteria – study design	• Studies of effectiveness and cost effectiveness: ○ Systematic reviews ○ Randomised controlled trials (RCTs) including cluster RCTs.

[s] Recent evidence suggests it is the age at which a young person first gets drunk that is a more important predictor of subsequent harmful drinking than age of first drink

Field	Content

	• Should the evidence from systematic reviews and RCTs be limited, the following study designs will be sought in descending priority:
	  ○ Quasi-experimental studies, such as non-randomised controlled trials and controlled before and after studies.
	
	• UK based qualitative studies linked to included studies of effectiveness.
	
	• Economic studies:
	  ○ Economic evaluations
	  ○ Cost-utility (cost per QALY)
	  ○ Cost benefit (i.e. Net benefit)
	  ○ Cost-effectiveness (Cost per unit of effect)
	  ○ Cost minimization
	  ○ Cost-consequence

Other inclusion exclusion criteria	**Included studies** There will be a scoping search carried out to identify any recent systematic reviews that directly relate to one or more of the scope questions and have been published since 1st December 2015. Any systematic reviews identified will be used as a source of primary studies or as a source of data. A full development search for individual studies will be carried out. Full economic analyses and costing studies will be included. Included costing studies reporting any health outcomes will be noted in EPPI/the evidence tables and forwarded on for economic modelling and not for the purposes of this review. Only papers published in the English language will be included Only studies carried out in OECD countries will be included. If it is clear from the full paper includes that there is no or virtually no evidence available to populate this review, a discussion will take place with the committee to determine which other approaches such as expert testimony, call for evidence and case studies should be considered. **Population** • At risk' populations will be defined as per study definitions. • Populations that cover a broad age range will be included if the data for the age group of interest are reported separately • To note that this group are considered separately to SEND 11 to 18 as education likely to be provided in different settings and as 18 and over are also eligible to drink alcohol **Interventions**

<table>
<tr><th>Field</th><th>Content</th></tr>
<tr><td></td><td>

Statutory drug education that is part of the national science curriculum (see National Curriculum in England: science programmes of study Department of Education)
Interventions that are more broadly focussed e.g. substance misuse prevention will be included if they report alcohol outcomes.
Individual decisions will be taken on interventions that are stated as school based, but conducted off site. For example a school nurse employed by a local authority may be responsible for a number of schools or there may be schools that are part of a federation and share a school nurse or counsellor who may conduct the intervention with pupils from a number of schools away from school premises

Comparators

Controls to be defined as described in the studies
Studies with comparators within and between schools will be included.

Settings
Further education colleges
Specialist colleges
The following settings are excluded:
Higher education institutions
</td></tr>
<tr><td>Proposed sensitivity/sub-group analysis, or meta-regression</td><td>
Where evidence allows subgroup analyses and/or meta-regression will be conducted. Depending on the evidence available some or all of the following will be explored.
Where evidence allows subgroup analyses and/or meta-regression will be conducted.
Subgroups of interest include:

Baseline characteristics of the young people receiving the intervention
gender
socioeconomic status
ethnicity
geographical area
People delivering the intervention
Teacher
Peer
Other school staff

</td></tr>
</table>

Field	Content
	○ External provider ○ People who have been trained to deliver the intervention • Method of delivery • Single component or multicomponent • Theories underlying the intervention If the evidence allows for intervention "variables or conditions" to be identified, a qualitative comparative analysis (QCA) may be conducted as well as a pairwise review. A QCA analysis allows the different causal contributions of the interventions to be explored.
Selection process – duplicate screening/selection/analysis	10% of the search results will be blind-screened by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. If the initial level of agreement is below 90%, a second round of blind-screening will be considered. 10% of data extraction and critical appraisal will be checked by a second reviewer. Any disagreements will be resolved by the two reviewers, and escalated to a third reviewer if agreement cannot be reached. Only 10% of the search results will be checked as this is an intervention and qualitative review and there is confidence that RCTs, controlled studies or related qualitative studies are unlikely to be missed at the sifting stage. The inclusion list will be checked with PHAC to ensure no studies are excluded inappropriately.
Data management (software)	EPPI Reviewer will be used: • to store lists of citations • to sift studies based on title and abstract • to record decisions about full text papers • to store extracted data. If meta-analysis is undertaken, Cochrane Review Manager 5 will be used to perform the analysis. Qualitative data will be analysed using EPPI Reviewer. Qualitative data will be summarised using an appropriate qualitative synthesis approach, for example, narrative synthesis.
Information sources – databases and dates	The Medline strategy will be translated for use within the following databases: **Primary Databases** • Medline and Medline in Process (OVID) • Embase (OVID) • CENTRAL (Wiley)) • Cochrane Database of Systematic Reviews (Wiley) • DARE (records up to March 2014 only) (Wiley) • NHS EED (records up to March 2014 only) (Wiley) • Econlit (Ovid) • PsycINFO (Ovid)

Field	Content
	• Social Policy and Practice (OVID) • HMIC (OVID) • ERIC (Proquest) **Secondary Databases** • ASSIA (Proquest) • CINAHL (EBSCO) • Econ Papers (RePEc) • National Guidelines Clearinghouse (US Dept. of Health and Human Services) • Bibliomap (eppicentre) • Dopher (eppicentre) • Trophi (epicentre) • Alcohol Studies Database Web searches will also be conducted. NICE Evidence Search , Google and Google Scholar will be searched for key terms and the first 50 results examined to identify any UK reports or publications relevant to the review that have not already been identified. Relevant results will be added to the Endnote database. Searches will also be conducted on the following key websites for relevant UK reports or publications: **Websites** • PSHE association • Public Health England • Department of Health • Department for Education • Alcohol Research UK • Public Health Institute • Mentor-Adepis • OFSTED • National Foundation for Educational Research • Research in Practice • Education Endowment Foundation • Office for Children's Commissioner • Council for disabled children A study filter will not be applied. Citation searching of included studies will be undertaken. Results will be saved to an EndNote database and de-duplicated. Results will be provided to the Public Health team as RIS files, suitable for import into EPPI Reviewer. A record will be kept of number of records found from each database and of the strategy used in each database. A record will be kept of total number of duplicates found and of total results provided to the Public Health team.
Methods for assessing bias at	Standard study checklists will be used to critically appraise individual studies. For details please see section 6.2 of Developing NICE guidelines: the manual

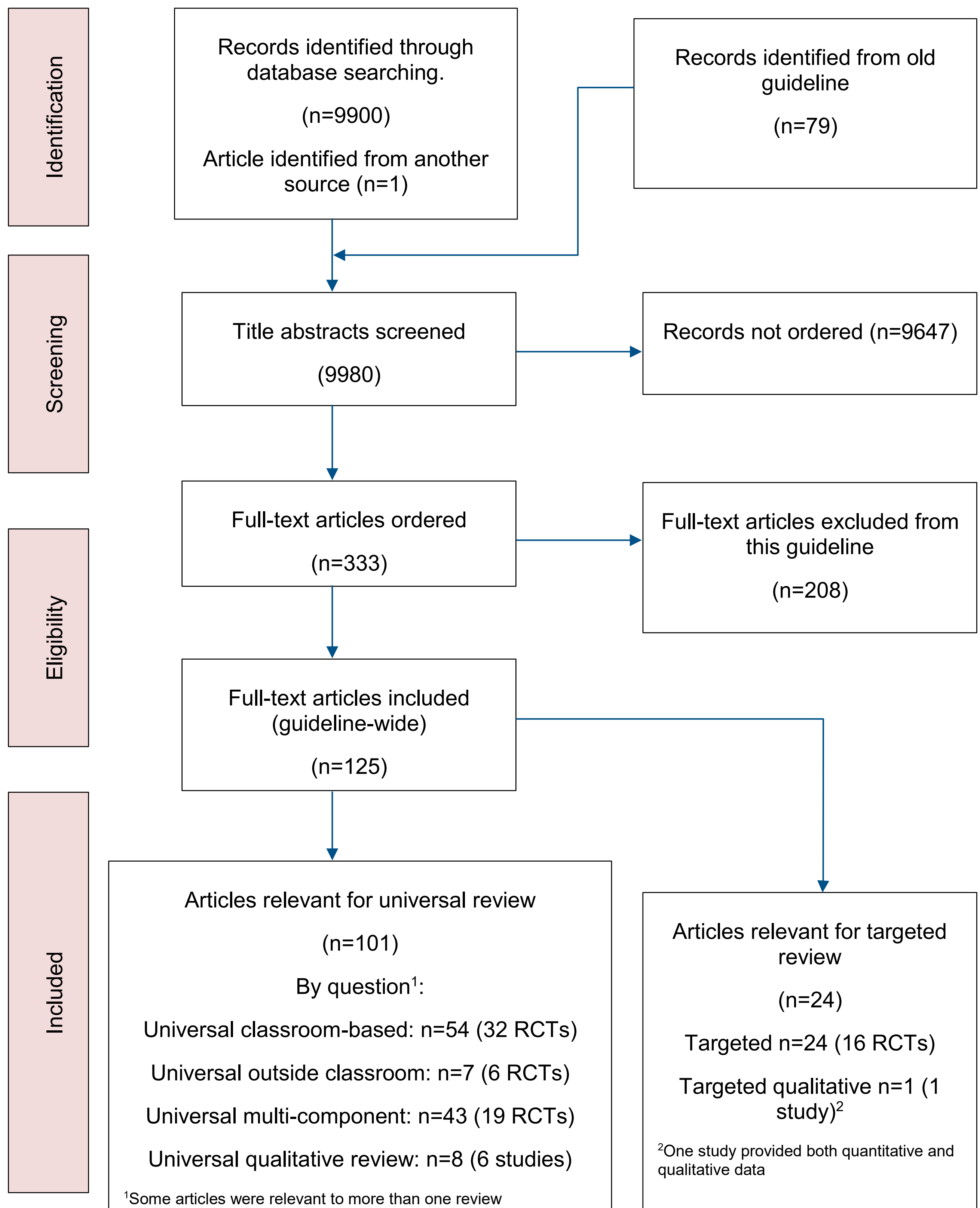
Field	Content
outcome/study level	For intervention studies the Cochrane Risk of Bias 2 tool will be used and for qualitative studies, the Cochrane qualitative checklist will be used. Where appropriate, the risk of bias across all available evidence will be evaluated for each outcome using an adaptation of the 'Grading of Recommendations Assessment, Development and Evaluation (GRADE) toolbox' developed by the international GRADE working group http://www.gradeworkinggroup.org/ GRADE-CERQUAL will be used for qualitative findings. When performing GRADE and where RCTs are considered the best available evidence for the question and outcome in question, they will start as high quality evidence. Where RCTs are not the most appropriate study design for a particular question or outcome, GRADE will be modified to allow for the study design considered most appropriate to start as high quality.
Criteria for quantitative synthesis	Studies will be grouped according to the type of intervention as appropriate. For details please see section 6.4 of Developing NICE guidelines: the manual The outcomes of interest are likely to be reported in the studies as continuous data. This will be discussed with the committee as to how the data will be reported for this review to enable them to make recommendations. This will most likely involve dichotomising the data.
Methods for quantitative analysis – combining studies and exploring (in)consistency	It is anticipated that the studies included will be heterogeneous with respect to participants and interventions. Where meta-analysis is appropriate, a random effects model will be used to allow for the anticipated heterogeneity. This assumption will be tested will be tested with a fixed effects model. Data from different studies will be meta-analysed if the studies are similar enough in terms of population, interventions, comparators and outcomes. Methods for pooling cluster and individual randomised controlled trials will be considered where appropriate. Unexplained heterogeneity will be examined where appropriate with a sensitivity analysis. If the studies are found to be too heterogeneous to be pooled statistically, a narrative synthesis will be conducted.
Meta-bias assessment – publication bias, selective reporting bias	For details please see section 6.2 of Developing NICE guidelines: the manual.

Field	Content
Confidence in cumulative evidence	For details please see sections 6.4 and 9.1 of Developing NICE guidelines: the manual

Appendix B: Literature search strategies

See Search Strategies document

Appendix C: Public Health evidence study selection



Appendix D: Public Health evidence tables

D.1.1 Coombes 2009

Bibliographic reference	**Coombes L, Allen D, Marsh M et al (2009) The Strengthening Families Programme (SFP) 10-14 and Substance Misuse in Barnsley: The perspectives of facilitators and families. Child Abuse Review 18: 41-59**		
Trial registration	None		
Study type	Mixed methods (quantitative and qualitative)		
Study dates	2005 (over a 9 month period)		
Aim	To evaluate the Strengthening Families Programme for young people age 10-14 and their parents		
Country/geographical location	UK (Barnsley)		
Setting/School type	Schools		
Inclusion criteria	Families must have: at least one young person aged 10-14 years completed SFP 10-14 between 2002-2005 both parents/caregivers gave consent to participate able to read/write in English not hospitalised		
Exclusion criteria	None		
Intervention	TIDieR Checklist criteria	Paper/Location	Details
	Brief Name	P45	The SFP 10-14 curriculum
	Rationale/theory/Goal	-	Not reported
	Materials used	P45	Highly structured with detailed manuals, videos and activities.

Bibliographic reference	Coombes L, Allen D, Marsh M et al (2009) The Strengthening Families Programme (SFP) 10-14 and Substance Misuse in Barnsley: The perspectives of facilitators and families. Child Abuse Review 18: 41-59		
	Procedures used	P45	For the first hour, parallel groups of children and parents from 4 to 14 families develop their understanding and skills led by the facilitators. In the second hour parents and children come together in family units to practice the principles they have learned. The remaining time is spent in logistics, meals and enjoyable family activities.
	Provider	P45	Two parent and two child group facilitators
	Method of delivery	P45	Group
	Location	-	Not reported
	Duration	P45	2 to 3 hours per week
	Intensity	P45	7 consecutive weeks
	Tailoring/adaptation	-	Not reported
	Modifications	-	Not reported
	Planned treatment fidelity	-	Not reported
	Actual treatment fidelity	-	Not reported
	Other details	-	Not reported
Comparison	TIDieR Checklist criteria	Paper/Location	Details
	Brief Name	-	None
	Rationale/theory/Goal	-	Not applicable
	Materials used	-	Not applicable
	Procedures used	-	Not applicable
	Provider	-	Not applicable
	Method of delivery	-	Not applicable

Bibliographic reference	Coombes L, Allen D, Marsh M et al (2009) The Strengthening Families Programme (SFP) 10-14 and Substance Misuse in Barnsley: The perspectives of facilitators and families. Child Abuse Review 18: 41-59		
	Location	-	Not applicable
	Duration	-	Not applicable
	Intensity	-	Not applicable
	Tailoring/adaptation	-	Not applicable
	Modifications	-	Not applicable
	Planned treatment fidelity	-	Not applicable
	Actual treatment fidelity	-	Not applicable
	Other details	-	Not applicable
Follow up	Not applicable		
Qualitative methods	Research question(s)	The participants' experiences of the SFP 10-14 materials and approach	
	Theoretical approach	Not reported	
	Data collection	Two tape-recorded focus group interviews lasting approximately 60 minutes with parents and young people. Three tape-recorded focus group interviews with the facilitators.	
	Method and process of analysis	Audiotapes of focus group interviews were transcribed and content analysis of transcriptions was undertaken. Responses were categorised into themes.	
	Population and sample collection	10 parents/caregivers and young people 15 facilitators	
Results	Outcome	Acceptability of intervention	
	Population	Key themes	
	Young people	Emotional health and wellbeing	Reported improvements in their emotional health and well-being during the course of the programme and that they were dealing with emotional issues more constructively.

Bibliographic reference	Coombes L, Allen D, Marsh M et al (2009) The Strengthening Families Programme (SFP) 10-14 and Substance Misuse in Barnsley: The perspectives of facilitators and families. Child Abuse Review 18: 41-59		
			"I learned how to deal with stress, talk things through sensibly and how to get out of tricky situations" The emotional aspects of relationships between parents and young people was also improved. "I have learned that my mum loves me and wants what's best for me"
		Change in young people's behaviour	Young people reported that improved behavioural management had brought benefits to family relationships and functioning. "We use the points chart and I get to go to the swimming pool… for not losing my temper…"
		Young people's substance use	Reported that the way they were dealing with drug and alcohol use had changed significantly during the period of SFP 10-14, including the improvement of peer resistance skills. "Whenever anyone asks you to do something you don't want to I know the process"
		Family functioning	Reported that the programme had improved family functioning. "We have family meetings now and we talk about what we are doing. We have less arguments".
	Parents/ Carers	Emotional health and wellbeing	Reported improvements in their emotional health and well-being during the course of the programme and that they were dealing with emotional issues more constructively. "I learned how to talk to him without shouting and to listen more without arguing" "I learned how to deal with stressful situations in a different way" The emotional aspects of relationships between parents and young people was also improved. "I tell my child my feelings now – I didn't do this before"
		Change in young people's behaviour	Some parents commented that it was hard to set limits and to remember to consistently maintain boundaries but that it was an important way of expressing love and care for young people and that setting limits provided a form of security. "Because that is what I think – especially all that is going on out there at the moment. Kids need to know that there is security…"

Bibliographic reference	**Coombes L, Allen D, Marsh M et al (2009) The Strengthening Families Programme (SFP) 10-14 and Substance Misuse in Barnsley: The perspectives of facilitators and families. Child Abuse Review 18: 41-59**		
		Young people's substance use	Reported that the way they were dealing with drug and alcohol use had changed significantly during the period of SFP 10-14 (no quotes from parents)
		Family functioning	Reported that the programme had improved family functioning. (no quotes from parents)
	People delivering the intervention		No reported
Risk of bias	Item	Yes/No/Can't tell	Comments
	1. Was there a clear statement of the aim of the research?	Yes	To evaluate the SFP based on the experiences for facilitators and their families
	2. Is a qualitative methodology appropriate?	Yes	Focus group interviews were conducted with the participants
	3. Was the research design appropriate to address the aims of the research?	Yes	Interviews were sufficient to obtain views and experiences
	4. Was the recruitment strategy appropriate to the aims of the research?	Yes	Had specific inclusion and exclusion criteria appropriate for the study aim
	5. Was the data collected in a way that addressed the research issue?	Yes	Focus groups were audio-recorded and transcribed
	6. Has the relationship between researcher and participants been adequately considered?	Can't tell	No information
	7. Have ethical issues been taken into consideration?	Yes	The School of Health and Social Care Research Ethics Committee, Oxford Brookes University and Barnsley Local Research Ethics Committee approved the study.
	8. Was the data analysis sufficiently rigorous?	No	Only positive views were reported for each theme. Although the facilitators' views were obtained, these were not discussed in the paper.

Bibliographic reference	Coombes L, Allen D, Marsh M et al (2009) The Strengthening Families Programme (SFP) 10-14 and Substance Misuse in Barnsley: The perspectives of facilitators and families. Child Abuse Review 18: 41-59		
	9. Is there a clear statement of findings?	No	Statement of findings does not reflect the detail in the reported findings.
	10. How valuable is the research?	Can't tell	Insufficient information due to unbalanced reporting and lack of data.
Source of funding	Alcohol Education and Research Council		
Comments	Does not report the views and perspectives of the facilitators or any negative views of the intervention. No information on views on how the intervention was delivered and implemented.		

D.1.2 Davies 2016

Bibliographic reference	Davies EL (2016)"The monster of the month": teachers' views about alcohol within personal, social, health and economic education (PSHE) in schools. Drugs and Alcohol today 16 (4) p279-288		
Trial registration	None		
Study type	Qualitative		
Study dates	Not reported		
Aim	Explore secondary school teachers' views on the quality and content of alcohol education delivered in PSHE		
Country/geographical location	England (over 3 English counties)		
Setting/School type	School		
Inclusion criteria	Not reported		
Exclusion criteria	Not reported		
Intervention	TIDieR Checklist criteria	Paper/Location	Details

Bibliographic reference	**Davies EL (2016)“The monster of the month”: teachers’ views about alcohol within personal, social, health and economic education (PSHE) in schools. Drugs and Alcohol today 16 (4) p279-288**		
	Brief Name	P280	PSHE
	Rationale/theory/Goal	-	Not reported
	Materials used	-	Not reported
	Procedures used	-	Not reported
	Provider	-	Not reported
	Method of delivery	-	Not reported
	Location	-	Not reported
	Duration	-	Not reported
	Intensity	-	Not reported
	Tailoring/adaptation	-	Not reported
	Modifications	-	Not reported
	Planned treatment fidelity	-	Not reported
	Actual treatment fidelity	-	Not reported
	Other details		
Comparison	TIDieR Checklist criteria	Paper/Location	Details
	Brief Name	-	None
	Rationale/theory/Goal	-	Not applicable
	Materials used	-	Not applicable
	Procedures used	-	Not applicable

Bibliographic reference	Davies EL (2016)"The monster of the month": teachers' views about alcohol within personal, social, health and economic education (PSHE) in schools. Drugs and Alcohol today 16 (4) p279-288		
	Provider	-	Not applicable
	Method of delivery	-	Not applicable
	Location	-	Not applicable
	Duration	-	Not applicable
	Intensity	-	Not applicable
	Tailoring/adaptation	-	Not applicable
	Modifications	-	Not applicable
	Planned treatment fidelity	-	Not applicable
	Actual treatment fidelity	-	Not applicable
	Other details	-	Not applicable
Follow up	Not applicable		
Qualitative methods	Research question(s)	Participants were asked their overall opinions about alcohol education	
	Theoretical approach	Not reported	
	Data collection	Semi-structured interviews	
	Method and process of analysis	Thematic analysis	
	Population and sample collection	9 participants: 1 was a school nurse who had responsibility for teaching health topics, 5 were head of PSHE or well-being at their school, 3 were responsible for talking about PSHE topics with tutor groups.	
Results	Outcome	Acceptability of intervention	
	Population	Key categories	

Bibliographic reference	Davies EL (2016)"The monster of the month": teachers' views about alcohol within personal, social, health and economic education (PSHE) in schools. Drugs and Alcohol today 16 (4) p279-288		
	Young people	Not applicable	
	Parents/Caregivers	Not applicable	
	People delivering the intervention	Challenges of delivering PSHE	Teachers reported many challenges in ensuring good quality provision of PSHE. There were concerns over teachers not being given enough time to cover important issues and that the topics in PSHE were too disjointed. "Schemes of work and lessons still kind of tend to lead to the sort of compartmentalising of PSHE and I'm very much in favour of it being positive, I just happen to think that alcohol is one of those things that all sorts of young people get involved in, but I'm trying very hard to steer away from the 'monster of the month' approach" Research and government funding were limiting factors in the development of a wide ranging curriculum. Felt that PSHE was a low priority in comparison to other subjects. Concerns about the training available for teachers to deliver PSHE and that inexperienced colleagues may lack confidence or deliver inappropriate messages. There is a challenge in knowing what exactly was taught to students about alcohol and other drugs, and where it might fit into the curriculum. "I suppose they probably do some in science, but I don't know when. I worry sometimes that there isn't someone with a master plan of all the actual knowledge that they need and the information. Sometimes, the different departments in this school are quite insular and there's no one with the overall view of the things they really need to know"
		PSHE facilitation (outside speakers)	Many teachers reported a strong preference for inviting outside agencies or speakers to their school to talk to students about alcohol and drugs with the idea that the power of an external speaker can be engaging and interesting in contrast to a normal lesson. "That's why we tend to try and get so many external speakers because they seem to have more impact than what teachers would necessarily deliver in a lesson" In contrast it was acknowledged that the real impact of external speakers was unknown and could be detrimental. "I have been in really tricky situations where speakers have been organised for different things but they haven't been very good quality and if anything they have possibly done

Bibliographic reference	Davies EL (2016)"The monster of the month": teachers' views about alcohol within personal, social, health and economic education (PSHE) in schools. Drugs and Alcohol today 16 (4) p279-288		
			some damage to either the reputation of the children, by encouraging disclosures, or you know actually giving out slightly inaccurate information or using shock and scare tactics which are not evidence-based, so yes I've seen some interesting things in my time" Some teachers were positive about these type of sessions being delivered during special days of the year whereas other were concerned that this method of teaching meant that there was less opportunity to follow up important issues. "It was kind of like a one man show where he talked about himself as entering secondary school and then went through all these pitfalls and one of them was getting horribly drunk and how that upset his friend because her dad was an alcoholic, and his good friend then didn't speak to him for ages, and he'd made idiot of her and you know so it was a talking point I suppose. So they were kind of exposed to it, but I don't know that they particularly then got to think it over with someone directing their discussion at all"
		Units and quantity	Most teachers talked about alcohol units as being an important knowledge for adolescents especially in regards to differences in drinking in a pub where the units are measured compared to drinking at home. "I think they need to understand what the units and measures are and how it can affect people differently" "We talk about the strengths of alcohol and what a unit is because that is a misnomer amongst adults, a glass of wine is not one unit anymore because people drink with great big fishbowls don't they"
		Making decisions	The teachers' aim within alcohol education was to equip their students with the skills to make the decisions that they felt were sensible and would reduce the most risk, mainly reducing the harms that might occur as a result of drinking alcohol. "We do look at the dangers of drugs and alcohol but it's more about the choices that young people make cause it's about choices and consequences more than the actual substance itself" "It's like saying 'no' yourself maybe helping, looking out for, your friends and trying to encourage them and say 'maybe you've had a little too much here, why don't we just walk outside'"

Bibliographic reference	**Davies EL (2016)"The monster of the month": teachers' views about alcohol within personal, social, health and economic education (PSHE) in schools. Drugs and Alcohol today 16 (4) p279-288**		
Risk of bias	Item	Yes/No/Can't tell	Comments
	1. Was there a clear statement of the aim of the research?	Yes	Explore secondary school teachers' views on the quality and content of alcohol education delivered in PSHE
	2. Is a qualitative methodology appropriate?	Yes	The objective was to obtain the perspectives of teachers
	3. Was the research design appropriate to address the aims of the research?	Yes	Semi-structured interviews were appropriate
	4. Was the recruitment strategy appropriate to the aims of the research?	Can't tell	Recruitment via email advertisements. No details of inclusion criteria
	5. Was the data collected in a way that addressed the research issue?	Yes	Semi-structured interviews
	6. Has the relationship between researcher and participants been adequately considered?	Can't tell	No information reported
	7. Have ethical issues been taken into consideration?	Yes	The study received ethical approval from Oxford Brookes University Ethics Committee
	8. Was the data analysis sufficiently rigorous?	Yes	Thematic analysis was carried out.
	9. Is there a clear statement of findings?	Yes	Findings summarised in discussion
	10. How valuable is the research?	Yes	Although only 9 teachers were interviewed there was a good mix of roles.
Source of funding	Not reported		
Comments	None		

D.1.3 Hawkins 2016

Bibliographic reference	**Hawkins JL, Bravo P, Gobat N et al (2016) Group motivational interviewing in schools: Development of health promotion intervention. Health education journal 75(5) 513-527**		
Trial registration	None		
Study type	Qualitative		
Study dates	Not reported		
Aim	To identify common experiences among participants with regard to existing Personal and Social Education (PSE) practice		
Country/geographical location	UK		
Setting/School type	Secondary school		
Inclusion criteria	Not reported		
Exclusion criteria	Not reported		
Intervention	TIDieR Checklist criteria	Paper/Location	Details
	Brief Name	P280	PSE
	Rationale/theory/Goal	-	Not reported
	Materials used	-	Not reported
	Procedures used	-	Not reported
	Provider	-	Not reported
	Method of delivery	-	Not reported
	Location	-	Not reported
	Duration	-	Not reported
	Intensity	-	Not reported

Bibliographic reference	Hawkins JL, Bravo P, Gobat N et al (2016) Group motivational interviewing in schools: Development of health promotion intervention. Health education journal 75(5) 513-527		
	Tailoring/adaptation	-	Not reported
	Modifications	-	Not reported
	Planned treatment fidelity	-	Not reported
	Actual treatment fidelity	-	Not reported
	Other details		
Comparison	TIDieR Checklist criteria	Paper/Location	Details
	Brief Name	-	None
	Rationale/theory/Goal	-	Not applicable
	Materials used	-	Not applicable
	Procedures used	-	Not applicable
	Provider	-	Not applicable
	Method of delivery	-	Not applicable
	Location	-	Not applicable
	Duration	-	Not applicable
	Intensity	-	Not applicable
	Tailoring/adaptation	-	Not applicable
	Modifications	-	Not applicable
	Planned treatment fidelity	-	Not applicable

Bibliographic reference	Hawkins JL, Bravo P, Gobat N et al (2016) Group motivational interviewing in schools: Development of health promotion intervention. Health education journal 75(5) 513-527		
	Actual treatment fidelity	-	Not applicable
	Other details	-	Not applicable
Follow up	Not applicable		
Qualitative methods	Research question(s)	Not reported	
	Theoretical approach	Not reported	
	Data collection	Semi-structured interviews and focus groups which were audio-recorded and transcribed verbatim.	
	Method and process of analysis	Thematic analysis	
	Population and sample collection	Six students (aged 12-14 years) and 4 teachers	
Results	Outcome	Acceptability of intervention	
	Population	Key categories	
	Young people	Lack of structure	Students noted that the lack of structure of PSE sessions had a negative effect on their motivation for participation. “Some teachers don’t really bother with it, they just say what they’ve been told to say, and they don’t really chat to you about the problems and stuff about it, so I think outside of school we kind of forget about that”
		Non-participatory sessions	Students noted that PSE is typically delivered as a set of instructions to follow or a repetition of what they have previously done. This is seen to be ‘boring’ and does not stimulate their participation. “... it’s just copying or reading out of a book though, which is quite boring” “She just tells us what to do, and we all have this booklet, so it’s a page of that and then we do a poster for the rest of the lesson, I dunno why. We just do posters, every lesson!”

Bibliographic reference	Hawkins JL, Bravo P, Gobat N et al (2016) Group motivational interviewing in schools: Development of health promotion intervention. Health education journal 75(5) 513-527		
			"They like to give us some information and we have to do a poster on the subjects, where you're just seeing things; you're not taking anything in, it's like, if you discussed it with other people – like when my dad talks to me, he tries to make it quite fun, it's like he's not taking it seriously, but I'm learning something from him." "Yeah, lots of them just stick a DVD on about it and we just watch it"
		Facilitators are not credible	Identifying PSE facilitators as role models appears important to students. The teacher responsible for the PSE session should be knowledgeable, committed to what they are teaching, and transmit this commitment to the students. "Teachers lie in PSE. They do. All the time" "Some teachers say that they've never been drunk"
		Promoting autonomy	Students suggest that messages around right or wrong behaviours are usually met with resistance. They value being presented with options and having the responsibility to make their own decisions about their behaviour. "When they speak of things in a negative way, like, 'this is wrong; you shouldn't be doing this', then, some kids like to rebel, and think, 'well, if it's wrong, then I'll do it, 'cause I want to be bad', you should set people on the right track, but give them options, and say, 'it's not a black and white answer, you could choose to do" "Yeah, 'cause it's wrong to say to kids, 'oh, don't drink, it's bad for you', 'cause that's gonna make us drink more, we're obviously gonna drink at some point in our lives, so you might as well tell us which way's the best way to drink, more sensibly, then it'd give us something to think about" "Yeah. If it's your life choice, then you should be able to do it, but I don't like the way they teach it saying it's all bad, you should never do it, because you could drink, but then it's not really going to hurt you, if you don't always do it, every day, but I don't like the way they say, 'it's bad; you should never ever do it'."
		Group size and peer support	Working in small groups to discuss a PSE topic appeared important to students. They valued the opportunity for within-group peer support where they could relate their experiences to those of similar others. "You can relate to other people then, you know there's people in the same situation as you"

Bibliographic reference	**Hawkins JL, Bravo P, Gobat N et al (2016) Group motivational interviewing in schools: Development of health promotion intervention. Health education journal 75(5) 513-527**		
			“You might even be comfortable to open up and say something you’d really been worrying about, because everyone else has had a story, and you think, ‘well, they’re quite bad too, so I might as well say what I’ve been worrying about’, and then you open up and everyone’s just like, ‘yeah, that’s totally normal’, and then they can help with that, and you can talk about it in a group.” “But maybe if they had everyone in the group helping them on what that person’s said, so it’s not just the (facilitator) who’s giving them guidance; it’s also the students around them, all just helping each other that way, maybe it would work more as a group?” “You’re worrying about something ‘cause you think it’s really big, and then you hear someone else’s story and you think, ‘well, it’s not so bad’.” “If you’re listening to other people’s bad experiences you might realise that things you’ve done are also bad, realise it yourself, instead of someone telling you, by hearing someone else’s experiences”
		Confidentiality	“The only thing is, if someone does open up, you have to make sure that nobody’s going to leave that room and go tell everyone what that person has said, ‘cause that can lead to things like bullying”
		The effective facilitator	Students described that PSE session facilitators should be someone they recognise as trustworthy. They need to feel that the facilitator is interested in their thoughts about the topic and will engage them in discussion. “It’s the way they speak to you, if they say ‘oh, so you like this, how do you feel about that?’ If they just asked you questions about what you’re talking about, at least you’d feel like they’re interested, and they want to talk to you, and that they’re like, engaging with you”
		Empathic setting	The facilitator should be able to create an empathic and respectful atmosphere during the session, in which students can share their experiences and opinions fearlessly. For some, this could only be achieved by an external facilitator. “If they wanna talk to us about mature things, they should treat us like we want to be treated, and as we treat them as well, and be equal, it makes us feel comfortable” “There’s a rule around the school that we have to show respect to the teachers and they’ll show respect back to us, but some of them don’t”

Bibliographic reference	**Hawkins JL, Bravo P, Gobat N et al (2016) Group motivational interviewing in schools: Development of health promotion intervention. Health education journal 75(5) 513-527**		
	Parents/Caregivers	Not applicable	
	People delivering the intervention	Lack of structure	Teacher's identified student's lack of motivation to attend PSE sessions and consider their confusion about session locations as a form of avoidance. "a few (children) – will spend the majority of the lesson wandering round pretending they don't know where they're meant to be, whether that is the truth or whether they're just trying to avoid it I'm not sure."
		Non-participatory sessions	Teachers had similar observations to the students. "I remember having to teach about careers and I had no interest in it at all. So I would skip through that and think 'yeah, well you know just read that paragraph, ok?'"

Risk of bias	Item	Yes/No/Can't tell	Comments
	1. Was there a clear statement of the aim of the research?	Yes	To identify common experiences among participants with regard to existing Personal and Social Education (PSE) practice
	2. Is a qualitative methodology appropriate?	Yes	Appropriate methodology for the aim stated
	3. Was the research design appropriate to address the aims of the research?	Yes	Appropriate methodology for the aim stated
	4. Was the recruitment strategy appropriate to the aims of the research?	Can't tell	No information
	5. Was the data collected in a way that addressed the research issue?	Yes	Semi-structured interviews and focus groups appropriate
	6. Has the relationship between researcher and participants been adequately considered?	Can't tell	No information
	7. Have ethical issues been taken into consideration?	Yes	Ethics approval received by the School of Social Sciences, Cardiff University
	8. Was the data analysis sufficiently rigorous?	Yes	Themes identified with supporting statements
	9. Is there a clear statement of findings?	No	No statement of findings reported

Bibliographic reference	Hawkins JL, Bravo P, Gobat N et al (2016) Group motivational interviewing in schools: Development of health promotion intervention. Health education journal 75(5) 513-527		
	10. How valuable is the research?	Yes	Highlights common issues with implementing PSE (and similar) in a UK setting
Funding	National Institute for Social Care and Health Research		
Comments	None		

D.1.4 Milliken-Tull 2017

Bibliographic reference	Milliken-Tull A and McDonnell R (2017) Alcohol and drug education in schools. Mentor-Adepis and Health Attitude	
Trial registration	None	
Study type	Qualitative	
Study dates	May to July 2017	
Aim	To identify the current practice regarding the delivery of alcohol and drug education, support available from external sources and any perceived gaps in resources.	
Country/geographical location	UK	
Setting/School type	Secondary and special schools	
Inclusion criteria	Not reported	
Exclusion criteria	Not reported	
Qualitative methods	Research question(s)	Not specified
	Theoretical approach	Not reported
	Data collection	Online survey, interviews and focus groups

Bibliographic reference	Milliken-Tull A and McDonnell R (2017) Alcohol and drug education in schools. Mentor-Adepis and Health Attitude		
	Method and process of analysis	Not reported	
	Population and sample collection	Survey was completed by 172 participants (71/172 [41%] from secondary schools) The remainder were from primary schools or other educational settings (13%) including special schools and pupil referral units. 64 school-age children and young people were involved in focus groups	
Results	Outcome	Acceptability of intervention	
	Population	Key categories	
	Young people	Inconsistency across settings and lack of consultation with young people	There were significant differences in experiences of alcohol and drug education between schools “We’ve not had any drugs or alcohol education in Year 7. We were supposed to be doing something, but the teacher changed her mind and did something else instead.” “We had [an external provider] in school to run a session, it was awful.” “One to one is much better but hard to access unless you’re caught with drugs.” “We want to know more about how normal, average, students are feeling and how many are using drugs and alcohol and why. Scare stories where someone dies are upsetting, but everyone soon forgets about it and thinks it won’t happen to them.” “YADAS (Young Adults Drug & Alcohol Service in Poole) are good, they know how to talk to us.” “The main thing I remember was the scare tactics play. It was about a girl being exploited and they (the external organisation) said it was based on true story. She was given drugs and alcohol by an older man because she wasn’t ‘happy at home.” “The whole day was about the effects of alcohol on your future and how much it could be a problem.” “Didn’t ask us for our views we were talked at by the trainers.” “There has been no follow up, would be better if spread out across the year.” “We completed a questionnaire afterwards, it asked what we thought of the day.” “No one took it seriously.” “We worked in friendship groups, so it was basically a day of mucking around.”

Bibliographic reference	Milliken-Tull A and McDonnell R (2017) Alcohol and drug education in schools. Mentor-Adepis and Health Attitude		
	Parents/Caregivers	Not applicable	
	People delivering the intervention	Alcohol and drug education	Interviews with secondary school teachers suggested that some of these services may have been reduced in the last few years as a result of funding constraints “Until 2016 we had a qualified counsellor in school two days per week and we would refer students to him. The process was quick and effective, and in most cases the students benefited from this and were able to stay in school. Following budget cuts, we lost the counsellor and the pastoral lead now manages referrals to the local drugs service, but exclusions have increased. I know the picture is the same in other schools because they no longer use the counsellor.” “I was head of student services and PSHE lead for 6 years, and it was my job to make referrals and deal with safeguarding along with the deputy head. The process got increasingly difficult with waiting times for intervention increasing, especially if CAMHS were involved. I had to give up the role as my own mental health was suffering.”
		Provision of PSHE/alcohol and drug education	It was common practice to use varying methods of delivery. “We tend to use lots of different ways to deliver PSHE, but try to avoid drop down days” “Tutor time is used, but there’s not much time to get your teeth into anything. We also have themed assemblies throughout the year where external speakers come along. These are well received by students but there is never enough time for any effective follow up”
		Constraints on teaching alcohol and drug education	The foremost constraints on delivering good quality alcohol and drug education were a lack of time among secondary school staff, due to conflicts with other priorities and time required for other subjects. “I enjoy leading on PSHE and it’s a very important area but not everyone sees it that way and I get very little time for planning our lessons. It is also the class that get used if students need to do something else, for example a music lesson or an extra class for another subject. I teach across two other subject areas, so I don t have a lot of time for finding good resources.” Other constraints included: a lack of resources, less support from external agencies, particularly the local authority and budgetary constraints.

Bibliographic reference	Milliken-Tull A and McDonnell R (2017) Alcohol and drug education in schools. Mentor-Adepis and Health Attitude		
			"There's no support from our local authority unless we pay for it, and that's mainly for specialist interventions" Within secondary schools, PSHE leads reported being limited to what the non-specialist tutors who are responsible for delivering PSHE were prepared to teach. "The tutors point blank refuse to deliver some lessons, mainly the sexual health ones, but some won't deliver drugs education either. We want the right people to deliver good quality lessons and feel comfortable, but there doesn't seem to be enough of them. I've suggested some CPD but that hasn't been received well either, it's very frustrating."
		Quality of resources and quality assurance	There was no awareness of available resources, or prioritisation of reliable quality assurance of teaching. "If my tutors are delivering the material and the students are involved in the lessons we can assume that the quality is ok. We try to make sure we cover at least most of what is on the PSHE programme of study" "We haven't really thought about quality assurance when it comes to PSHE, because it's not statutory and we don t do any assessment so quality assurance hasn't hit the radar"
		Criteria for effective teaching resources	Teachers feel that lessons must be engaging for students which is why they turn to external providers. "Engaging lessons are key as otherwise they (the students) will switch off. This is where external speakers can help. I think they are often more credible than us."
		External support for alcohol and drug education	Teachers are not fully aware of the resources available to them (Mentor-ADEPIS) "This (Mentor-ADEPIS website and resources) would be really useful to us. Could it be part included in the Healthy Schools website, so we have regular reminders?" "I would have used the lesson plans, they could have enhanced some of the work we did with KS3, especially the social norms project with year 9" "I'm always looking for new ideas, this would have saved so much time!" "I was not aware of ADEPIS, possibly more publicity."

Bibliographic reference	Milliken-Tull A and McDonnell R (2017) Alcohol and drug education in schools. Mentor-Adepis and Health Attitude		
			Just over a third of respondents reported that they received any CPD within the past 3 years. Responses suggest the changing face of alcohol and drug support from local authorities had impacted the availability and/or quality of CPD. "A few years ago, we were able to regularly invite our local drug service into school to deliver lessons, the students enjoyed the sessions and got to know the team. Now, we can refer students with problems to the service, but there is no support or information provided more generally." "Our local authority provided very good CPD on everything from eating disorders, to self-harm and of course drugs and alcohol. I think there are still safeguarding course but everything else has stopped. We've looked for external courses, but most run in bigger cities and are expensive." "We don t even have a healthy schools team anymore and that was always the main way we heard about local training courses. As a team we do our best to put together relevant lessons and rely a lot on what we can find on line. I will be sure to look on the ADEPIS website."
Risk of bias	Item	Yes/No/Can't tell	Comments
	1. Was there a clear statement of the aim of the research?	No	Aim not stated
	2. Is a qualitative methodology appropriate?	Yes	Aim not stated but methods used were appropriate for obtaining views and experiences.
	3. Was the research design appropriate to address the aims of the research?	Yes	Aim not stated but methods used were appropriate for obtaining views and experiences.
	4. Was the recruitment strategy appropriate to the aims of the research?	Yes	Used Mentor-ADEPIS mailing lists but unclear how representative the sample is. However, areas with less responses were targeted with focus groups
	5. Was the data collected in a way that addressed the research issue?	Yes	Surveys and focus groups are appropriate

Bibliographic reference	Milliken-Tull A and McDonnell R (2017) Alcohol and drug education in schools. Mentor-Adepis and Health Attitude		
	6. Has the relationship between researcher and participants been adequately considered?	Can't tell	No information
	7. Have ethical issues been taken into consideration?	Can't tell	Not reported
	8. Was the data analysis sufficiently rigorous?	Yes	Responses discussed thoroughly and themes identified
Source of funding	Not reported (Adepis has organisation funding from Public Health England and the Home Office)		

D.1.5 Ogenchuk 2012

Bibliographic reference	Ogenchuk MJ (2012) High school students' perceptions of alcohol prevention programs. Canadian Journal of Education 32(1): 156-170		
Trial registration	None		
Study type	Qualitative		
Study dates	Not reported		
Aim	Explore students perceptions of programs relate to the prevention of alcohol use in high school settings		
Country/geographical location	Saskatchewan city, Canada		
Setting/School type	4 High schools- schools from 2 different school systems in 2 Saskatchewan cities,		
Participant characteristics	Description	Grade 9-12 students	
			Intervention (n =452)
	Age	17 years old, n (%)	226, (50%)
		16 years old, n (%)	203, (45%)

<table>
<tr><th>Bibliographic reference</th><th colspan="3">Ogenchuk MJ (2012) High school students' perceptions of alcohol prevention programs. Canadian Journal of Education 32(1): 156-170</th></tr>
<tr><td rowspan="2"></td><td rowspan="2">Gender</td><td>Male n (%)</td><td>226, (50%)</td></tr>
<tr><td>Female n (%)</td><td>226, (50%)</td></tr>
<tr><td>Inclusion criteria</td><td colspan="3">Enrolment in at least one grade 11 class
Presence during the time the study was conducted
Agreement to participate in the research
Minimum level of experience that the teachers and counsellors had in teaching content related to alcohol prevention was 8 years</td></tr>
<tr><td>Exclusion criteria</td><td colspan="3">None</td></tr>
<tr><td rowspan="4">Qualitative methods</td><td>Research question(s)</td><td colspan="2">Identify the intentions of the policies, the processes of implementation, and the students' experiences of the program.</td></tr>
<tr><td>Theoretical approach</td><td colspan="2">Guba s Domains Model (1985) provided a framework for examining students perceptions of alcohol prevention programmes</td></tr>
<tr><td>Data collection</td><td colspan="2">See below for domains:
Policy-in-intent: data collected from the administrators. 12 interview questions. Focused on aspects of alcohol preventions such as school policy, program components, promotional activities, strengths and challenges, indicators and processes used for assessment and program development.
Policy-in-implementation: data collected from teachers. Semi-structured interviews. 15 questions. Focused on aspects of alcohol prevention programming including professional development, approaches used, program efficacy, information, skills, and delivery methods.
Policy-in-experience: data collected from students. Questionnaire and 4 student focus groups. The questionnaire provided data on generalisability, patterns, and to tap the surface of meaning (included The Youth Alcohol Prevention Questionnaire). The focus group explored students perceptions of alcohol prevention programs</td></tr>
<tr><td>Method and process of analysis</td><td colspan="2">Data analysis was presented according to the 3 levels of Guba s Domains Model:
Policy-in-intent: Recorded and transcribed. Arrangement of data into categories (not themes). Analysed using the data analysis spiral. More detail as follows (a) reading and memoing (b) describing, classifying and interpreting, and (c) representing and coding using NVivo.
Policy-in-implementation: Taped, transcribed, returned to respondents for verification of accuracy, and analysed using data analysis spiral as before.</td></tr>
</table>

Bibliographic reference	Ogenchuk MJ (2012) High school students' perceptions of alcohol prevention programs. Canadian Journal of Education 32(1): 156-170		
		Policy-in-experience: focus groups data was auto-taped, transcribed into electronic format and printed as hard copies. Focus group data was analysed using the data analysis spiral. In the final phase, the content in each of the categories was reconsidered and the data was interpreted as a whole, synthesising data from all sources.	
	Population and sample collection	Purposeful sampling 8 teachers and 2 vice- principals were interviewed Student response was 61% (n= 275)t	
Results	Outcome	Acceptability of intervention	
	Population	Key categories	
	Students (policy-in-experience)	Relevant information based on student current use	From focus group, participants suggested that more information needed to be focused on grade 9, but also identified specific content to include at this level and method of delivery – " in grades 7 and 8 no one really cares….then in grade 9, they say I'll never do it, and bam, everyone who didn't drink, drinks"
		Content to engage students	Students reported that scare tactics don t work- "Give accurate information- don t tell kids that if they drink they are going to become an alcoholic" Students suggested appropriate content for grade 9 students should include resisting peer pressure and talking to them to inform them that it is ok not to drink- "you usually learn to do that yourself…they have to find reasons in their self why they would not drink." Students recommended increasing information for grade 11 and 12, they would like to hear about how people did not give into peer pressure including the bonuses that they got out of not drinking Students agreed the most effective approach was then the actual person comes to talk to you, about how it affected their life, then it really hits home because they're like an everyday person

t Calculated by reviewer

Bibliographic reference	Ogenchuk MJ (2012) High school students’ perceptions of alcohol prevention programs. Canadian Journal of Education 32(1): 156-170		
			Students want alcohol messages presented solely and not included with information on other pyscho-active agents because alcohol was viewed as more socially acceptable and not as much of a problem as ‘hard’ drugs “if you pile alcohol, drugs, heroin in one presentation, alcohol sort of gets lost…alcohol is overshadowed” Students already drinking suggested approaches that would make them stop and think. “…they should make you write an essay on what would happen if you got in an accident, and make you really think about hot it would change your life”
		Engaging methods of delivery: the value of interactive approaches	Students concurred that the exchange of ideas between older and younger students would be useful “when you are in grade 9, you look up to the grade 12s. They should talk to grade 9 s about school stuff, and it’s ok if you don t want to. That would have more influence than any of the teachers” Lecture type approaches are ineffective but hearing personal stories would be highly effective. Dissemination of information- “don’t be bossy” and make information as personal as possible
		Messages in alcohol prevention	Students reported hearing different messages on alcohol use between school, home and media “ even if the school tells you it is no good to drink, the family and friends need to tell you the same thing in order to really make you feel confident”
		Social support	Many students were aware that there was a counsellor in school, but were unaware of the processes available to refer themselves to the counsellor
	People delivering the intervention (policy-in-implementation)	Time	Not enough time delegated in the curriculum in alcohol prevention to try new things or to practice skills training, the content was dealt with in a couple of hours over two days

Bibliographic reference	Ogenchuk MJ (2012) High school students' perceptions of alcohol prevention programs. Canadian Journal of Education 32(1): 156-170		
Risk of bias	Item	Yes/No/Can't tell	Comments
	1. Was there a clear statement of the aim of the research?	Yes	To explore Grade 11 students perceptions for programs related to the prevention of alcohol use in a high school setting
	2. Is a qualitative methodology appropriate?	Yes	Used semi-structured interviews and focus groups
	3. Was the research design appropriate to address the aims of the research?	Yes	Semi-structured interviews and focus groups allow for views and perceptions to be recorded
	4. Was the recruitment strategy appropriate to the aims of the research?	Yes	Enrolled students from various cultures with relevant inclusion criteria
	5. Was the data collected in a way that addressed the research issue?	Yes	Used structured model to aid data collection
	6. Has the relationship between researcher and participants been adequately considered?	Can't tell	No information reported
	7. Have ethical issues been taken into consideration?	Can't tell	No information reported
	8. Was the data analysis sufficiently rigorous?	Can't tell	Findings were reported to support theories so it is not possible to tell whether this is the full extent of the views.
	9. Is there a clear statement of findings?	No	No clear summary of findings
	10. How valuable is the research?	Can't tell	Not possible to tell if the data is giving the full picture.
Source of funding	Not reported		
Comments	Not focusing on one complete intervention as such. More of a generalised opinion of alcohol interventions		
Additional references	Ogenchuk MJ (2013) Alcohol prevention programs: An exploration of grade 11 students' perceptions. Dissertation Abstracts International Section A: Humanities and Social Sciences 74		

D.1.6 Sumnall 2017

Bibliographic reference	**Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)**			
Study type	Qualitative study (from an RCT)			
Study dates	Pupil focus groups: May/June 2014			
Country/geographical location	Northern Ireland and Scotland			
Setting/School type	Post-primary schools			
Participant characteristics	Pupils			
	Description	A total of 16 schools, 129 pupils (15% of the schools involved in the trial)		
			Intervention N = 8 schools	Control N = 8 schools
	Age	Years (range)	13-14 years	
	Gender	Male, n (%)	62 (48%)	
		Female, n (%)	67 (52%)	
Inclusion criteria	Not reported			
Exclusion criteria	Not reported			
Number of Participants	129			
Intervention	TIDieR Checklist criteria	Paper/Location	Details	
	Brief Name	P3	Steps towards alcohol misuse prevention programme (STAMPP)	
	Rationale/theory/Goal	P3	Combines a harm reduction philosophy with skills training, education and activities designed to encourage positive behavioural change	
	Materials used	P8	Classroom curriculum component was adapted from the School Health and Alcohol Harm Reduction Project (SHAHRP)	

Bibliographic reference	**Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)**		
			Parent component included a presentation on the Chief Medical Officer's (CMO) 2009 guidelines on drinking in childhood, alcohol prevalence in young people and corrected (under) estimates of youth drinking rates, and it highlighted the importance of setting strict family rules around alcohol, with the recognition that children often model their own alcohol use behaviour on that of their parent(s)/carer(s). Follow up leaflet mailed to parents.
	Procedures used	P8	Classroom curriculum students plus a brief intervention for parents of students. The brief intervention was followed by a discussion on setting family rules on alcohol.
	Provider	P7	Trained teachers (curriculum) Trained facilitators (brief intervention)
	Method of delivery	P7	Group
	Location	P8	Classroom
	Duration	-	Not reported
	Intensity	P7	Phase 1: 6 lessons (16 activities) in year 9; Phase 2 4 lessons (10 activities) in year 10
	Tailoring/adaptation	P8	The curriculum component was adapted from the original Australian SHAHRP curriculum The brief intervention component was based in part on the Dutch adaptation of the Swedish Örebo Prevention Programme.
	Modifications	P8	The curriculum was modified to target 12-13 year olds rather than 13+ year olds and was reduced in terms of number of lessons and activities. The brief intervention was modified to just one parent evening, delivered by independent facilitators rather than the research team and used UK data.
	Planned treatment fidelity	P62	Intervention teachers were asked to complete two self-report surveys concerning fidelity and completeness of delivery of the two phases of SHAHRP. The extent to which each of the activities were delivered in each phase was measured from 0 = "not at all" to 2 = "fully" The degree to which the accompanying CD to support delivery was used was measured on a 10 point Likert scale of 1 "never used it" to 10 "I used it at all times".

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)		
	Actual treatment fidelity	P63	Phase 1 overall fidelity (sum of all activities/measures): mean (SD) 72.69 (17.98) Phase 2 overall fidelity (sum of all activities/measures): mean (SD) 68.76 (20.60)
	Other details	P64	Process evaluation: The classroom component was delivered largely as intended with some variation in fidelity scores between schools for numbers of lessons required to deliver content. The curriculum was enjoyed by pupils, who reported that they found it interesting, informative and relevant to their own experiences or how they believed they might use alcohol in future. On the whole, the classroom materials were perceived as useful and were used as intended by the majority of teachers and pupils. Teachers and school management believed that it was possible to accommodate the programme in the curriculum, supporting resources were useful and content was both experientially and age-appropriate. There was very low uptake of the parental/carer component, and postal returns of the parent/carer survey, which were used as an indicator of implementation of mailed intervention materials, were also relatively low. It should therefore be concluded that this component of the intervention was not successfully delivered.
Comparison	TIDieR Checklist criteria	Paper/Location	Details
	Brief Name	P9	Education as normal (EAN)
	Rationale/theory/Goal	-	None
	Materials used	P9	Standard personal, social and health education
	Procedures used	P9	Provision of alcohol use education as part of statutory education or usual school activities
	Provider	-	Not reported
	Method of delivery	-	Not reported
	Location	-	Not reported
	Duration	-	Not reported
	Intensity	-	Not reported

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)		
	Tailoring/adaptation	-	Not reported
	Modifications	-	Not reported
	Planned treatment fidelity	-	Not reported
	Actual treatment fidelity	-	Not reported
	Other details	-	Not reported
Follow up	12, 24 and 33 months from baseline (T1,T2 and T3 respectively)		
Qualitative methods	Research question(s)/ aims	To determine the degree to which participants in the classroom curriculum engaged with, enjoyed and perceived that they benefited from participation To ascertain to what extent control participants who received EAN engaged with, enjoyed and perceived that they benefited from participation.	
	Theoretical approach	Not reported	
	Data collection	Pupils Focus groups were conducted with pupils from both the intervention and control groups. Purposive sampling was used to ensure that both participating study geographies were represented and that there was an equal representation of sex, intervention and control participants and those attending different school types. Teachers Online self-report questionnaires were completed by teachers who had facilitated the classroom intervention and by teachers who had facilitated EAN. The questionnaires were designed to ascertain the intervention teacher’s perceptions of the SHAHRP intervention. Headteachers and/or senior staff The purpose of this work was to obtain a better understanding of how STAMPP complemented (or otherwise) the school s existing response to alcohol and to identify some of the challenges facing future delivery.	

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)		
	Method and process of analysis	Transcribed focus groups were analysed using thematic analysis involving the following 6 steps: 1) familiarisation, 2) generating initial codes, 3) searching for themes, 4) reviewing themes, 5) defining and naming themes and 6) producing the report	
	Population and sample collection	129 pupils took part in the focus groups (male n = 62 [48%] and female n=67 [52%] 111 teachers responded to the online survey (70 intervention and 41 control teachers) 19 senior staff were interviewed , 9 intervention and 10 control	
Results	Outcome	Acceptability of intervention	
	Population	Key themes	
	Young people	Learning outcomes	The intervention participants were positive in tone about the education they had received and felt that participation in the programme was beneficial. They felt that they had learned something from the programme. “It, sort of, gave you an insight into the units of alcohol, like, in each drink and shows how they can vary and affect your system differently.” In contrast the EAN was described as lacking structure, not engaging, boring and repetitive. “It’s really repetitive. We get it a lot every year, and it’s basically just the same information every single year, and it’s all negative views.” The students who received the intervention indicated that information on the consequences and effects of alcohol use would help them in making decisions about alcohol consumption now and in the future. “Plus, like, for later in life, it’s giving them information of alcohol and they can decide, because they know the facts about it. So they’re able to decide, knowing the facts, whether they want to drink or not, they know the facts and the consequences it’s going to have on them.” Although these topics are covered in EAN it was considered to not be as in-depth or aid with future decision-making. “. . they basically teach us don t do it at this age because it will have consequences, extreme consequences that will come back at you in the future . . .”

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)		
			The intervention participants also particularly favoured the components about real-life situations involving alcohol. “I quite liked the bit about the real-life situations because then you could, like, put it into real-life context. And then if you were ever put in a situation like that, you could know how to deal with it, and all.” Other students commented that younger drinker’s social behaviour and consumption levels were portrayed negatively and inaccurately and that the education was not age appropriate. “I know they cover when you drink when you’re older, but underage drinking, they could, kind of, cover in that, because there’s not much about that.” (intervention group) “It was well extreme. Like, no one our age is going to drink to that extent, like. The one on the video, like, had probably about a litre of vodka.” (control group)
		Materials	The students in the intervention generally favoured the workbooks and found that completing them helped to learn about alcohol and remember the facts that they learned. “I think it’s better when you’re, like, writing out in a book because you take it in more, as opposed to sitting there and, like, reading it.” In contrast, the EAN workbooks were negatively received. “We’re so used to books, you, kind of, just ignore them now.” Some students stated that they would prefer more discussion and activities. “Well, in a way, you know, there could have been, like, more physical activities instead of, like, always doing it in the book.” (intervention group) “It’s more books and, like, what we already know, rather than stuff us can ask about and, like, videos and stuff.” (control group) The students in the intervention group generally accepted the two workbooks (phase 1 and phase 2) and that they were delivered in the appropriate order. “Because this one [workbook for phase 1] was more like a teaching one, like this one explained it and, kind of, like, gave you answers and your teacher went through with you and, kind of, explained the facts and everything on you. So when that book came along

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)		
			[workbook for phase 2], you were able to think of the stuff you had learned, like, beforehand and you could put that, like, to the test and make sure you knew everything." The content was also considered age appropriate and that if it had been delivered a year later it would have been inappropriate. "I think if it was done maybe end of year 10, we would already have known most, well, quite a lot of the stuff that was already in the book, which would have made it, kind of, pointless, most of that section." The accompanying CD was sporadically used due to availability of equipment and the motivation of the individual teacher. When the CDs were used they were found to be enjoyable and a helpful resource compared to just writing in books. "I think it's not as, like, I don t want to say boring but, you know, you're not constantly looking at the book and listening to the teacher, you can do it for yourself on the computer." The control group also found videos more preferable to the written materials but that the videos were out of date, repetitive and delivered negative messages. "Yeah, they're all pretty old, so, you know, the messages back then would have been, kind of, different because obviously people can learn different things, so the curricular could change or something. And they could base it on different facts that have been discovered since then, like, this amount of alcohol won't hurt you if you re this old."
		Mode of delivery	In general, intervention participants indicated that they found it easy to discuss the subject of alcohol with their teachers; however, control participants were quite negative in this regard. Discussions that focused on their own drinking experiences (or the drinking of their peer group), however, were likely to be meaningful only if the specific teacher in question had a good personality, was younger, understood the complexity of adolescent drinking and/or would be empathetic to the pressures facing young people. ". . . quite easy to discuss it with our form teacher, like, because he is quite laid back . . ." (intervention group)

Bibliographic reference	**Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)**		
			“It, kind of, depends on the teacher . . . the younger ones are, kind of, more understanding about it . . .” (control group) “But if you had someone who was just stubborn in the mornings and wouldn’t talk to youse, it would make it far harder.” Some intervention participants had stated that undertaking programmes, such as the SHAHRP, with school teachers (as opposed to external speakers) meant that it was not just a one-off event in the school year. Knowing the teacher, having a good relationship with them, trusting them and believing that they would maintain confidentiality were also regarded as important factors that could help both intervention and control participants to discuss the issue of alcohol with their teachers. “The teachers can be, kind of, judgemental and, say, like, you said something about drinking, they can, kind of, like, make a name for you and, like, they could go around . . . like, they could tell other people, they can go to the staff room, like, did you hear about this student. They can do things like that and just not really trustworthy.” (control group) “I think it’s like the projects probably better with the teacher because, like, you see them every day and obviously you get to, like, to know the teacher. Whereas if it was just someone come in for 1 day, you might feel a bit more uncomfortable with answering questions and stuff like that.”
		Delivery style	In general, the intervention participants were satisfied with the programme delivery style. The opportunity to discuss the issue of alcohol with their classmates was appreciated, as it allowed people to share their opinions and experiences and listen to others opinions and experiences. In contrast, participants in the control group indicated that they would find it difficult to discuss the issue of alcohol in the presence of their classmates. The differing views may be due to the positive experience of alcohol education that the intervention group had. “Well, firstly, we used to do, like, our whole class did a class discussion of it. So it was helpful that everyone got to share their opinions and views, and everyone gets to see where they’re coming from. So that kind of learns you another aspect of other people s views of the book”

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)		
			Participants indicated that some pupils might not discuss alcohol use and disclose their own drinking behaviour because they fear judgement from others and becoming the subject of gossip. It was broadly suggested that those who consume alcohol might be less likely to disclose and discuss this behaviour, as they would probably be in the minority at this age. “I think there always is, like, that fear that you’re going to be judged in the group discussions when you know all the people and you see them every day. If you say something like if you did drink, you think some people might be really scared to actually say that because they could get really badly judged for it and they could be teased about it.” Intervention and control participants indicated that they would be more willing to discuss alcohol use and their own drinking behaviour if a spirit of friendship and trust existed between classmates. “No, it’s not difficult to speak with your friends around you, because they’re people you can ‘trust, even if the form teacher s in the room, you still have friends who you’d hang around with just in the school”.
	Parents/ Carers	Not applicable	
	People delivering the intervention	Intervention evaluation	Positive comments: “I liked the overall approach. I feel that it is a much planned approach to alcohol education. I think that there is a great deal of depth in the materials, without giving the pupils information overload.” “It was easy to access. Pitched at the correct level and the pupils engaged with the materials.” “Very good [phase 2 materials], I like that it takes a different approach. It is less factual than the [phase 1] book. Which is important, as it could easily get very repetitive. I like the way that the book focuses on the consequences, but without being preaching to the pupils about alcohol.” Negative comments were mostly related to age-appropriateness and user friendliness of the materials.

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)		
			"Seemed a bit advanced for some of the pupils in my class who could not relate to some of the activities. The video for example on the Night Out featured people in their 20s."
		Future delivery	"Resources may require to be updated" "Time constraints can be an issues – [we only have] 1 period per week [for personal development (PD) classes] and we have other core modules to cover." "It is [in my opinion] a very worthwhile insert to the PSE [personal and social education] programme." Senior staff Teachers are not experts in the subject area and, in order for them to feel confident in their ability to deliver SHAHRP and to be engaged in delivery, they require training. ". . . we're supposed to be so-called experts in all the different fields, but I know from personal experience . . . that a lot of teachers will kind of stick to what they're confident in, and if they're not confident, they all avoid it or they all just skim through it."
		Alcohol and schools (senior staff)	The majority of participants indicated that their schools had developed their own educational resources, drawing on materials from a variety of external sources, but that these were usually assembled in an unstructured manner from a variety of different sources. They indicated that schools would welcome new resources and training that improved on previous alcohol education provision. "It would have been just resources that you would have obtained out of various books that you'd have put together, to create a unit of work for teachers to deliver in the PD class." The majority reported that their schools also used outside speakers, such as the police or recovering alcoholics. Some believed this to be more effective because they thought that external speakers generally have greater expertise and, accordingly, students would pay more attention to them. On the other hand, some were sceptical about the value of outside speakers, given that some may be poor public speakers or unable to engage with children, and could potentially deliver an inappropriate message.

Risk of bias	Item	Yes/No/Can't tell	Comments
	1. Was there a clear statement of the aim of the research?	Yes	To determine the degree to which participants in the classroom curriculum engaged with, enjoyed

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)		
			and perceived that they benefited from participation To ascertain to what extent control participants who received EAN engaged with, enjoyed and perceived that they benefited from participation.
	2. Is a qualitative methodology appropriate?	Yes	Required to get views and experiences from participants
	3. Was the research design appropriate to address the aims of the research?	Yes	Focus groups were chosen for several reasons: they provided a quick and convenient way to collect data from several participants concurrently
	4. Was the recruitment strategy appropriate to the aims of the research?	Can't tell	A contact teacher in each school selected what they considered to be a representative sample of their school. It is not clear whether this was a broad representation.
	5. Was the data collected in a way that addressed the research issue?	Yes	A series of open-ended questions was developed in order to stimulate discussion, to minimise any bias and to ensure consistency between the focus groups
	6. Has the relationship between researcher and participants been adequately considered?	Can't tell	No information
	7. Have ethical issues been taken into consideration?	Yes	Liverpool John Moores University Research Ethics Committee
	8. Was the data analysis sufficiently rigorous?	Yes	Positive and negative comments were presented and discussed using a thematic approach.
	9. Is there a clear statement of findings?	Yes	Summarised in the overall discussion
	10. How valuable is the research?	Yes	The findings provide insights into what both students and teachers feel are important for a successful intervention.
Source of funding	Public Health Research programme of the National Institute for Health Research		
Comments	It may be possible that bias in pupil interviews was non-equivalent. As they generally reported positive engagement with SHAHRP, this may have led to discounting or under-reporting of other negative aspects. Similarly, although alcohol EAN tended to be viewed negatively overall, this may have led to underreporting of positive aspects.		

Bibliographic reference	Sumnall H, Agus A, Cole J et al (2017) Steps towards alcohol misuse prevention programme (STAMPP): a school- and community-based cluster randomised controlled trial. Public Health Research 5(2)
Additional references	Harvey SA, McKay and Sumnall HR (2016) Adolescents reflections on school-based alcohol education in the United Kingdom: education as usual compared with a structured harm reduction intervention. Journal of substance use. 21(6) 640-645 McKay, MT, Sumnall, H, Harvey, SA et al JC (2017) Perceptions of school-based alcohol education by educational and health stakeholders: “Education as usual” compared to a randomised controlled trial. Drugs: Education, Prevention, and Policy 25(1) 77-87

Appendix E: GRADE CERQual tables

E.1.1 Table 5: Acceptability of interventions

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
Challenges/barriers to implementation						
The most common challenge for teachers delivering alcohol prevention education was that there was just not enough time delegated to it within the curriculum due to conflicting priorities with other subjects. Challenges relate to reduced funding, lack of awareness of available resources and lack of support from external agencies. Due to the perceived lack of priority for alcohol and drug education there is a lack of structure and also less consideration for quality assurance of the	Ogenchuk 2012, Davies 2016, Hawkins 2016, Sumnall 2017, Milliken-Tull 2017	**Moderate concerns** (3 studies with minor, 2 studies with moderate; unclear reflexivity, 1 study with concerns on data analysis and 1 study not	**No concerns** Finding reflects the data from all studies that report barriers to implementation.	**No concerns** Data obtained from 5 studies with a large sample of people. The teachers interviewed had various roles.	**No concerns** All studies included related to the views and perceptions of teachers and young people delivering/receiving alcohol interventions.	**High confidence** There was still consistency in the findings between the studies with minor concerns and those with

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
teaching. There was concern over the training available to teachers and the changes that have occurred across alcohol and drug support from local authorities has impacted on the availability and quality of CPD leading to concerns that an inexperienced teacher will lack confidence to teach these topics and/or may deliver inappropriate messages.		reporting ethics approval).				moderate concerns.
Content						
It was felt that the content of alcohol interventions are required to be more age appropriate as well as targeting the delivery at the right time. The content needs to reflect realistic drinking habits of the target audience but also target the age groups that are likely to at least be thinking about drinking. Students' experience of alcohol education is that it is usually combined with drug education but they feel that as alcohol is more socially acceptable, the two should not be taught together. The scare tactics and negative alcohol messages are reported as to not work as they can lead to resistance. Students and teachers believe that the aim of alcohol education is to equip young people with the skills that will help them make	Ogenchuk 2012, Davies 2016, Hawkins 2016, Sumnall 2017, Milliken-Tull 2017	**Moderate concerns** (3 studies with minor, 2 studies with moderate; unclear reflexivity, 1 study with concerns on data analysis and 1 study not reporting ethics approval).	**No concerns** Finding reflects the data from all studies that teachers and young people have similar views on intervention content.	**No concerns** Data obtained from 5 studies with a large sample of people. The teachers interviewed had various roles.	**No concerns** All studies included related to the views and perceptions of teachers and young people delivering/receiving alcohol interventions.	**High confidence** There was still consistency in the findings between the studies with minor concerns and those with moderate concerns.

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
decisions that they felt were sensible. Students like to explore real-life situations about peer-pressure and how individuals have dealt with this. There were mixed views from students on the use of workbooks. Some found it repetitive whereas others found that they were more likely to learn something from writing in the books. It was consistent across teachers and young people that knowledge of alcohol units was important especially in regards to differences in drinking in a pub where the units are measured compared to drinking at home.						
Method of delivery						
There were mixed views on how alcohol interventions should be delivered. Young people and reasons for preferring the group approach as well as the individual approach. Teachers noted that there are different methods of delivery used. Some young people favour an approach for alcohol and drug education that is delivered as a group as it allows for more discussion and activities. Many favoured the option to discuss views and opinions with their peers and in particular would prefer it if delivered in small groups with their friends. In contrast,	Hawkins 2016, Sumnall 2017, Milliken-Tull 2017	**Moderate concerns** (2 studies with minor, 1 study with moderate; unclear reflexivity and 1 study not reporting ethics approval).	**Minor concerns** The majority of participants favoured group sessions but there were some conflicting views where some had a preference for an individual approach.	**No concerns** Data from 3 studies which included a large number of participants.	**No concerns** All studies included related to the views and perceptions of teachers and young people delivering/receiving alcohol interventions.	**High confidence** There was still consistency in the findings between the study with minor concerns and the study with moderate concerns.

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
some young people prefer the one-to-one approach and shy away from discussion with their peers for fear of being judged and value confidentiality as a key component. It is common practice to deliver alcohol and drug education in a variety of different methods which is generally either in lesson time, 'drop-down' days (off-timetable sessions) or themed assemblies.						
Providers						
There were mixed views from both students and teachers on who should be delivering the interventions. Some favoured the specialist external provider whereas others favoured a teacher who could provide consistency and a good relationship. The majority of teachers reported a strong preference for inviting external speakers to speak with students about alcohol as external speakers would be more engaging and have more experience compared to teachers who are uncomfortable teaching these topics. However, some teachers note that the real impact of these speakers was unknown due to some experiencing external people who were poor public speakers or unable to	Davies 2016, Hawkins 2016, Sumnall 2017, Milliken-Tull 2017	**Moderate concerns** (3 studies with minor, 1 study with moderate; unclear reflexivity and 1 study not reporting ethics approval).	**Minor concerns** Clear differences between students and teachers in views on external speakers but consistent within each group.	**No concerns** Data obtained from 4 studies with a combined large sample of people. The teachers interviewed had various roles.	**No concerns** All studies included related to the views and perceptions of teachers and young people delivering/receiving alcohol interventions.	**High confidence** There was still consistency in the findings between the studies with minor concerns and the study with moderate concerns.

Summary of review finding	Studies contributing to the review finding	Methodological limitations	Coherence	Adequacy	Relevance	CERQual assessment of confidence in the evidence
engage with children and that due to the 'one-off' nature of the talk, there was less opportunity to follow up any important issues raised. In contrast, students preferred to discuss these issues with their teachers, providing they had a good relationship with them and were able to speak freely. They also favoured the continuity teachers provided as opposed to a 'one-off' session. Students also disliked the 'one-sided' nature of some of the interventions where the external providers did not ask their views.						
Impact of family component of the intervention						
Parents and young people reported improvements in the young person's emotional health and wellbeing during the course of SPF-10-14 and that they were dealing with emotional issues more constructively. Young people reported that improved behavioural management had brought benefits to family relationships and functioning. Young people and parents reported that the way they were dealing with drug and alcohol use had changed significantly, including the improvement of peer resistance skills.	Coombes 2009	**Moderate concerns** (unclear reflexivity and limited to only the positive findings)	Not applicable as only one study included	**No concerns** Study included the views and perceptions of young people and their parents.	**Minor concerns** Limited to just the family component of the intervention.	**Moderate confidence** As this is a single study we have retained moderate as we are unable to check for consistency.

Appendix F: Excluded studies

Table 6: Public Health studies

See universal interventions review