



Alcohol interventions in secondary and further education

NICE guideline

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Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline replaces PH7.

This guideline is the basis of QS83.

Overview

This guideline covers interventions in secondary and further education to prevent and reduce alcohol use among children and young people aged 11 up to and including 18. It also covers people aged 11 to 25 with special educational needs or disabilities in full-time education. It will also be relevant to children aged 11 in year 6 of primary school.

Who is it for?

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

Recommendations

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

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

1.1 *Planning alcohol education*

Organising alcohol education

1.1.1 Plan and deliver alcohol education ([universal](#) and [targeted interventions](#)) as part of a [whole-school approach](#) to relationships education, relationships and sex education (RSE) and health education or personal, social, health and economic education (PSHE). Do this by using, for example:

- classroom curriculum activities
- pastoral support, school policies (including school ethos) and other actions to support pupils in the wider school environment
- activities that involve parents or carers, families and communities (see the [section on making it as easy as possible for people to get involved in NICE's guideline on community engagement](#)).

1.1.2 Ensure those planning and delivering relationships education, RSE, health education or PSHE have the materials, planning time and training they need to support, promote and provide alcohol education. Be aware that there are resources available that can be used for planning and delivering alcohol education (see the [Department for Education's guidance on relationships education, RSE and health education](#)).

To find out why the committee made the recommendations on organising alcohol education and how they might affect practice, see [rationale and impact](#).

Planning alcohol education content

- 1.1.3 Use a [spiral curriculum](#) when planning and delivering alcohol education.
- 1.1.4 When planning alcohol education:
- ensure it is appropriate for age and maturity and aims to minimise the risk of any unintended adverse consequences (see recommendation 1.2.1).
 - tailor it to take account of each pupil's learning needs and abilities
 - tailor it to the group's knowledge and perceptions of alcohol and alcohol use
 - take into account that those aged 18 and over can legally buy alcohol.
- 1.1.5 Think about how to adapt alcohol education for pupils with special educational needs and disabilities so that it is tailored to the pupil's learning needs, abilities and maturity (see chapter 6 of the [Department for Education's SEND code of practice: 0 to 25 years](#)).

To find out why the committee made the recommendations on planning alcohol education content and how they might affect practice, see [rationale and impact](#).

Confidentiality and safeguarding

- 1.1.6 Ensure all involved in giving the alcohol education sessions are aware of the school's process for handling confidential disclosures.
- 1.1.7 Ensure pupils understand:
- how they can raise any concerns and how they will be supported
 - that any information or concerns they disclose will be dealt with at an appropriate level of confidentiality
 - how disclosures will be handled if there are safeguarding concerns.
- 1.1.8 Use safeguarding arrangements to refer pupils for extra support if they have:
- raised concerns, for example about alcohol-related harm or

- had concerns raised about them (see the [Department for Education's keeping children safe in education](#)).

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

To find out why the committee made the recommendations on confidentiality and safeguarding and how they might affect practice, see [rationale and impact](#).

Referral for further support

1.1.10 Use clear referral pathways, for example into school nursing, school counselling, early help services, voluntary sector services, young people's drugs and alcohol services or to a youth worker, as needed.

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

To find out why the committee made the recommendations on referral for further support and how they might affect practice, see [rationale and impact](#).

1.2 *Delivering universal alcohol education*

Structuring alcohol education

1.2.1 When delivering alcohol education, aim to:

- use a positive approach to help pupils to make informed, safe, healthy choices
- encourage pupils to take part in discussions
- avoid unintended consequences (for example the pupil becoming curious about alcohol and wanting to try it, or substituting it with another substance)
- avoid using scare tactics
- avoid only giving out information, for example by lectures or leaflets.

To find out why the committee made the recommendation on structuring alcohol education and how it might affect practice, see [rationale and impact](#).

Using additional support for alcohol education

1.2.2 Use school nurses, local public health officers and drug and alcohol services or other external providers to provide additional support for alcohol education.

1.2.3 If using external providers to supplement alcohol education:

- use providers offering content that is consistent with the school's planned alcohol education
- follow guidance on quality assurance and delivery (see the section on working with external agencies in the [Department for Education's guidance on relationships education, RSE and health education](#)).

To find out why the committee made the recommendations on using additional support for alcohol education and how they might affect practice, see [rationale and impact](#).

1.3 Targeted interventions

Selecting pupils for targeted interventions

1.3.1 When selecting pupils to offer a targeted intervention to, avoid treating them in a way that could:

- stigmatise them or
- encourage them to see themselves as likely to use alcohol or see it as normal behaviour or
- have a negative impact on their self-esteem.

1.3.2 When using targeted interventions, always seek to involve the pupils in decisions about them and the interventions offered to them.

1.3.3 Seek consent to include a pupil in a targeted intervention. This should be from the pupil themselves, or the pupil's parent or carer, as appropriate to the situation.

1.3.4 Offer a targeted individual or group intervention (for example counselling or a

brief intervention) to pupils who are assessed as vulnerable to alcohol misuse.

- 1.3.5 Ensure a targeted group intervention is appropriate for the age and maturity of the pupils and aims to minimise the risk of any unintended adverse consequences and stigma (see recommendation 1.3.7).

To find out why the committee made the recommendations on selecting pupils for targeted interventions and how they might affect practice, see [rationale and impact](#).

Tailoring targeted interventions

- 1.3.6 For each person or group offered an intervention, identify their specific risk factors, vulnerabilities and any concerns about their behaviour so that the intervention can be tailored to their needs. Use, for example:

- formal sources of information about risk factors (for example information provided by a [level of needs assessment](#), children's services [including children's social care] or through the whole-school approach)
- informal sources of information about pupils' behaviour (for example reports from the local community informing the school after witnessing pupils drinking alcohol).

To find out why the committee made the recommendation on tailoring targeted interventions and how it might affect practice, see [rationale and impact](#).

Avoiding unintended consequences of group interventions

- 1.3.7 Avoid normalising unhealthy drinking behaviours when delivering targeted group interventions (for example by not mixing different age groups).

To find out why the committee made the recommendation on avoiding unintended consequences of group interventions and how it might affect practice, see [rationale and impact](#).

Terms used in this guideline

Level of needs assessment

An agreed threshold document from the local children's safeguarding board^[1] or safeguarding

partnership that sets out risk factors and considerations for what to do when worried about a child.

School

All schools (including academies, free schools and alternative provision academies) and pupil referral units (see the [Department for Education's explanation of types of schools](#)) and further education and sixth-form colleges as set out under the Further and Higher Education Act 1992 (see the [Department for Education's keeping children safe in education](#)).

Spiral curriculum

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

Targeted intervention

Interventions for children and young people who are not necessarily seeking help but who have risk factors that make them vulnerable to alcohol misuse.

Universal alcohol education

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

Vulnerable to alcohol misuse

This may include children and young people:

- whose personal circumstances put them at increased risk
- who may already be drinking alcohol
- who may already be regularly using another harmful substance, such as cannabis.

Whole-school approach

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

- curriculum subjects

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

It also promotes a proactive relationship between the school, children, young people and their parents or carers, outside agencies and the wider community.

^[1] From September 2019, all local authority areas in England should have completed their transition from local children's safeguarding boards to safeguarding partnerships.

Recommendations for research

The guideline committee has made the following recommendations for research.

1 Components of alcohol education delivery

What components of alcohol education delivery contribute to its effectiveness for children and young people aged 11 to 18 in full-time education, and those with special educational needs and disabilities (SEND) up to the age of 25?

To find out why the committee made the research recommendation on components of alcohol education delivery see the [rationale and impact section for planning alcohol education content](#) and the [rationale and impact section for using additional support for alcohol education](#).

2 Targeted school-based interventions

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

To find out why the committee made the research recommendation on targeted school-based interventions see the [rationale and impact section on selecting pupils for targeted interventions](#).

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

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

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

4 Targeted interventions for people aged 11 to 25 with SEND

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

To find out why the committee made the research recommendation on targeted interventions for those aged 11 to 25 with SEND see the [rationale and impact section for planning alcohol education content](#) and the [rationale and impact section on selecting pupils for targeted interventions](#).

5 Preventive work for people aged 11 to 25 with SEND

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

To find out why the committee made the research recommendation on prevention interventions for those aged 11 to 25 with SEND see the [rationale and impact section for planning alcohol education content](#).

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

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

To find out why the committee made the research recommendation on engaging parents and carers in the whole-school approach to alcohol education see the [rationale and impact section for organising alcohol education](#).

Rationale and impact

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

Organising alcohol education

Recommendations 1.1.1 to 1.1.2

Why the committee made the recommendations

It is current practice for schools to use a whole-school approach for alcohol education (universal and targeted) and other health-related topics that have a personal, social, health and economic education (PSHE) component. This helps schools ensure that consistent messages are given about a topic, such as alcohol education, whether taught through relationships education, relationships and sex education (RSE) and health education, or PSHE and the national science curriculum. In England universal alcohol education forms part of the usual curriculum delivered through health education or PSHE.

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

Although the published cost-effectiveness evidence was limited it indicated that universal interventions could be cost effective. The economic analysis showed the same. So the committee agreed that universal interventions could offer good value for money. However, they were mindful that cost effectiveness was closely related to the cost of the intervention. The benefits of the intervention, measured as a reduction in the number of related crime and hospital events, also had a significant impact on cost effectiveness because of their high associated costs.

The cost-effectiveness analysis showed that universal interventions are more likely to be cost effective in the older age groups that might be drinking already, than in the younger ones that might not. The committee were concerned that this might lead to a focus on interventions for older children and young people. However, they did not think the evidence justified prioritising

interventions for these groups because of limitations in study design. In addition, the studies used short follow-up, compared the interventions with usual education, and used outcomes such as problematic drinking (which is less common in younger age groups and unlikely to capture other benefits of alcohol education).

One of the elements of the whole-school approach is the involvement of parents and carers. The committee acknowledged that parents or carers have an influence on their child's health behaviours. They considered that involving them in the school's approach to alcohol education is essential to improve the consistency of messages that pupils receive. Evidence was identified on universal alcohol programmes that involved parents, but it was inconclusive. The committee believed that limitations in study design, such as short follow-up, might explain this. The evidence also showed that it can be difficult to engage parents successfully (for example to attend family education activities at school). The committee agreed that more research was needed to evaluate the different ways to do this ([research recommendation 6](#)).

Evidence from qualitative studies showed that teachers may lack confidence in teaching alcohol education and don't know the best materials to use. The committee were aware of accredited materials and training resources (although not reviewed by NICE) based on their experience of current practice. These include materials from PSHE Association, Public Health England and Mentor-ADEPIS.

The committee also reiterated that it was the school's responsibility to use materials that are free from bias, and informed by evidence if possible. Also, the committee were mindful of a 2016 review noting that the delivery of education messages by the alcohol industry has no significant public health effects (see [Public Health England's public health burden of alcohol: evidence review](#)). The committee were also aware of international criteria on how to select teaching materials and support resources (see the [United Nations Office on Drugs and Crime guidance on school-based education for drug abuse prevention](#)), but NICE did not review this.

The committee discussed that schools share experiences and knowledge and adopt examples of alcohol education that have worked in other local schools. However, there was no evidence to support this practice. There was also concern that adapting examples of good practice for local needs may alter the effectiveness of interventions (for example straying too far from key content and processes).

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

alcohol education in the curriculum.

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following and will become mandatory. However, the statutory changes may mean that schools need to make changes in how they prioritise health education as part of their overall curriculum planning.

Full details of the evidence and the committee's discussion are in [evidence review A: universal interventions](#).

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Planning alcohol education content

[Recommendations 1.1.3 to 1.1.5](#)

Why the committee made the recommendations

Evidence from qualitative studies showed that pupils and their teachers believe that the content of alcohol education needs to be age appropriate and should not be taught to a group of mixed ages. Pupils and teachers also believe that it should be tailored to the levels of need and maturity. Evidence from expert testimony highlighted that accounting for these factors will help avoid unintended consequences.

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

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

5).

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following. Schools should already be considering adapting education for their SEND pupils so it is not anticipated that there will be any resource impact.

Full details of the evidence and the committee's discussion are in [evidence review A: universal interventions](#).

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Confidentiality and safeguarding

[Recommendations 1.1.6 to 1.1.9](#)

Why the committee made the recommendations

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

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

It is current practice for schools to have a process in place so that pupils know that they can speak confidentially, and to allow for concerns to be raised and local safeguarding processes to be followed. (For example, see [Public Health England's guidance on safeguarding and promoting the](#)

[welfare of children affected by parental alcohol and drug use: a guide for local authorities.](#))

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following.

Full details of the evidence and the committee's discussion are in [evidence review A: universal interventions](#).

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Referral for further support

[Recommendations 1.1.10 to 1.1.11](#)

Why the committee made the recommendations

Alcohol education may bring to light some matters that may lead to safeguarding issues or unmet mental health needs (see the [Department for Health and Social Care and Department for Education's Transforming children and young people's mental health provision: a green paper](#)). Schools should ensure that alcohol education is considered in policies and practices introduced or updated in response to the green paper.

The committee advised that it is best practice for schools to have clear referral pathways to relevant specialist agencies such as school nursing. The local availability of specialist agencies varies, so the committee suggested examples of services that fulfil this criterion. The committee wanted to reinforce the need for all those providing alcohol education to be aware of safeguarding and of the referral pathways in place. This would help to provide as much support for pupils as possible. For example, the Early Help Assessment is designed to help ensure a pupil is offered the right support at an early stage. If these external specialist interventions are needed, the school needs to involve the pupil and their parents or carers. The committee thought that this would be a way of increasing the chances of success of any intervention by allowing them to consult and agree on the best approach for referral to these services.

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following. However, statutory changes may mean that

schools need to make changes in how they prioritise health education as part of their overall curriculum planning. Schools currently refer pupils to school nursing, school counsellors or external specialist services such as young people's specialist drug and alcohol services. There may be some resource implications depending on who delivers the interventions if the number of referrals increases.

Full details of the evidence and the committee's discussion are in [evidence review A: universal interventions](#).

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Structuring alcohol education

Recommendation 1.2.1

Why the committee made the recommendation

Evidence from qualitative studies and expert testimony suggests that negative messages, scare tactics or providing information about alcohol in isolation do not work and may lead to harm, especially when they are not age appropriate. These approaches are not likely to be tailored to pupils' current understanding and perceptions of alcohol and therefore pupils may rebel against such messages. The evidence showed that pupils favour a non-judgemental environment where they can discuss alcohol in the context of real-life situations.

Evidence from expert testimony highlighted that tailoring alcohol education to age, levels of need and maturity will help avoid unintended consequences. For example, a pupil who has not started drinking alcohol may want to try it once they start to learn more about it. Or when they learn that they should not drink alcohol or cannot buy it, they may choose another substance instead.

The committee acknowledged that the number of children and young people drinking is decreasing. They considered that this trend will help to frame alcohol education in a positive way by normalising not drinking. It will also promote inclusivity for those who choose to not drink or to delay starting to drink, or who do not drink for cultural or religious reasons.

Taking all this into consideration, the committee agreed that it is important to highlight the hazards of excessive drinking. Education that encourages discussion (for example around healthy lifestyle decisions) is more beneficial than merely giving out information – for example, using leaflets or 'one-way' lectures.

How the recommendation might affect practice

The recommendation will aim to reinforce current best practice because it is based on existing processes that all schools should be following and will become mandatory. However, the statutory changes may mean that schools need to make changes in how they prioritise health education as part of their overall curriculum planning.

Full details of the evidence and the committee's discussion are in [evidence review A: universal interventions](#).

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Using additional support for alcohol education

[Recommendations 1.2.2 to 1.2.3](#)

Why the committee made the recommendations

The evidence is consistent with current practice that school staff and other providers, including external speakers, can deliver alcohol education. However, there is conflicting evidence on who is best placed to deliver these interventions. Pupils favour a familiar member of school staff, but teachers may lack confidence in teaching alcohol education. Research is needed on the effectiveness of the different components of alcohol education delivery, including providers of the education (see [research recommendation 1](#)).

Evidence suggests that using trained external providers to supplement alcohol education may benefit pupils, as well as offering a solution to teachers who are not confident in teaching the subject. However, evidence also supported the committee's experience that some external providers may be unsuccessful in getting the right message across and their approach may be potentially harmful. Experts on the committee said that negative approaches and scare tactics sometimes used by police officers or people who misuse alcohol (or are dependent on it), for example, could either scare pupils or inadvertently glamorise alcohol misuse. The committee agreed that it is the school's responsibility to ensure the external providers they choose meet standards that allow pupils to learn safely and effectively. The committee were aware of examples of how to access guidance to assess external providers, for example PSHE Association and Mentor-ADEPIS.

How the recommendations might affect practice

The recommendations will aim to reinforce current best practice because they are based on existing processes that all schools should be following. The use of external providers (such as school nurses, local public health officers and drug and alcohol services) to support alcohol education varies, and there may be a cost associated with this provision. This may then affect staff workload in terms of planning and delivering the alcohol education.

Full details of the evidence and the committee's discussion are in [evidence review A: universal interventions](#).

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Selecting pupils for targeted interventions

[Recommendations 1.3.1 to 1.3.5](#)

Why the committee made the recommendations

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

Although the published cost-effectiveness evidence was limited, it indicated that targeted interventions could be cost effective. The economic analysis showed the same. So the committee agreed that targeted interventions could be good value for money. However, they were mindful that cost effectiveness was closely related to the cost of the intervention. The interventions' benefits, measured as a reduction in the number of related crime and hospital events also had a significant impact on cost effectiveness because of their high associated costs.

The cost-effectiveness analysis showed that targeted interventions are more likely to be cost effective in the older age groups that might be drinking already, than in the younger ones that might not. The committee were concerned that this might lead to a focus on interventions for older children and young people. However, they did not think the evidence justified prioritising

interventions for these groups because of limitations in study design. In addition, the studies used short follow-up, compared the interventions with usual education, and used outcomes such as problematic drinking (which is less common in younger age groups and unlikely to capture other benefits of alcohol education).

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

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

How the recommendations might affect practice

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

Full details of the evidence and the committee's discussion are in [evidence review B: targeted interventions](#).

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Tailoring targeted interventions

[Recommendation 1.3.6](#)

Why the committee made the recommendation

The identified studies used varying risk factors to determine if a pupil was vulnerable to alcohol misuse – for example drinking in a risky way, using other substances, or showing challenging behaviour at school. This is consistent with how schools might consider whether a pupil is vulnerable to alcohol misuse. The committee also noted that other groups (for example children

who do not drink but are vulnerable to other people's drinking, and those in the criminal justice system) may also be particularly vulnerable. How best to identify those who may benefit from targeted interventions was not included in the scope and so the committee were not able to make a recommendation on this issue.

Schools might use several factors to determine whether a pupil is vulnerable to alcohol misuse. In addition, the committee thought it important to ensure that the alcohol intervention is tailored to the pupil's needs. Therefore they agreed that there should be an assessment of the pupil's individual risk factors and needs, as well as planned outcomes in respect of this. The committee suggested using existing processes, for example by using information from a [level of needs assessment](#). Other sources include information derived from the whole-school approach or children's services (including children's social care), as well as more informal sources such as reports from the local community.

How the recommendation might affect practice

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

Full details of the evidence and the committee's discussion are in [evidence review B: targeted interventions](#).

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Avoiding unintended consequences of group interventions

[Recommendation 1.3.7](#)

Why the committee made the recommendation

There could be many reasons why someone is vulnerable to alcohol misuse, and including them in a targeted group intervention may lead to normalising unhealthy drinking behaviours. For example, if the group includes people of different ages and the older pupils are already drinking, the younger pupils (who may be non-drinkers) might try alcohol because they begin to see it as 'normal'. The committee agreed with expert testimony that unintended consequences of interventions should be avoided when deciding on the best approach for group interventions.

How the recommendation might affect practice

The recommendation will reinforce best practice because it is based on existing processes and existing guidance. But having multiple groups based on age may result in additional resource impact depending on who delivers these interventions and how frequently they are run.

Full details of the evidence and the committee's discussion are in [evidence review B: targeted interventions](#).

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Context

Children and young people risk disease, poisoning, injury, violence, depression and damage to their development from drinking alcohol, especially those who drink heavily ([Statistics on alcohol, England, 2018, National Statistics](#)). Drinking at an early age is also associated with a higher likelihood of alcohol dependence.

The statistics on alcohol also show that:

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

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

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

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

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

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

Unlike PH7, this guideline does not cover alcohol education for children of primary school age.

Children under 11 will be covered in the next update of [NICE's guideline on social and emotional wellbeing in primary education](#).

Finding more information and resources

To find out what NICE has said on topics related to this guideline, see [NICE's web page on alcohol](#).

Update information

August 2019: This guideline is an update of NICE guideline PH7 (published November 2007) and has replaced it.

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Accreditation

