

DRUG & ALCOHOL FINDINGS *Research analysis*

This entry is our analysis of a study considered particularly relevant to improving outcomes from drug or alcohol interventions in the UK. The original study was not published by Findings; click [Title](#) to order a copy. Free reprints may be available from the authors – click [prepared e-mail](#). The summary conveys the findings and views expressed in the study. Below is a commentary from Drug and Alcohol Findings.

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► **Brief alcohol intervention for risky drinking in young people aged 14–15 years in secondary schools: the SIPS JR-HIGH RCT.**

Giles E.L., McGeechan G.J., Coulton S. et al.
Public Health Research: 2019, 7(9).

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Already delivering alcohol advice to young people as part of the curriculum, did UK secondary schools see a reduction in risky drinking after supplementing it with brief counselling sessions?

SUMMARY The Chief Medical Officer for England [recommends](#) that young people and children under the age of 15 years refrain from drinking alcohol. For young people between 15 and 17 years who do drink alcohol the [recommendation](#) is that they do so infrequently, no more than once per week, and not exceeding adult daily limits.

Evidence suggests that screening and brief interventions, which have been around since the 1970s, are effective in reducing alcohol consumption in young people. However, there is currently insufficient evidence to be confident about their use for reducing risky drinking and alcohol-related harm among young people in a school setting.

Delivered by non-specialists, brief interventions typically focus on providing one-to-one feedback on an individual's drinking behaviours, are of short duration, and are often based on the principles of [motivational interviewing](#). The featured study assessed the effectiveness and cost of a brief intervention aimed at reducing risky drinking in young people aged 14–15 years. The intervention consisted of a 30-minute counselling session delivered by learning mentors (school support staff) in one-on-one sessions, which was guided by a worksheet covering the following: what young people were drinking; who they were drinking with; what they thought about their drinking; what they thought other people felt about their drinking; and goal-setting in relation to their drinking.

Pupils in 30 secondary schools across London, Kent, north-west England, and north-east England were asked to complete a survey, and those who were assessed as risky drinkers were allocated at random to one of two groups: an intervention group, and a [control](#) group. Young people in both groups received an alcohol advice leaflet, identified in a [pilot feasibility trial](#) as a suitable, age-appropriate resource that was acceptable to young people. Additionally, young people continued to receive standard alcohol advice delivered as part of the school curriculum, with the exception of one school which did not currently deliver advice on alcohol. Those in the control group were not informed that they had screened positive for risky drinking.

Schools were asked to report what their usual alcohol education looked like. It varied from school to school, but included advice on drinking responsibly, alcohol facts, provision of leaflets from Addaction (rebranded under the name [We Are With You](#)), assemblies on alcohol, advice on wider lifestyle choices, an alcohol awareness week, use of [Drinkaware](#) resources, and alcohol-awareness evenings for parents. This advice was delivered by a combination of teachers, pastoral leads, tutors, nurses, learning mentors and external speakers.

Of the 4,523 young people who completed the initial survey, 1,064 screened positive for risky drinking, and 443 were eligible to take part in the trial – 210 being allocated to the brief intervention group and 233 to the control group. One year on, 84% of young people were followed up, completing the survey again and recalling their drinking with the help of a calendar.

The primary outcome was total amount of alcohol consumed in the last 28 days. Other measures included risky drinking, general psychological health, sexual risk-taking, energy drink consumption, age of first smoking, quality of life, health benefits of the intervention, and use of services.

Interviews were also conducted with nine teaching staff, 21 learning mentors, 33 young people and two parents to gather their views about the study and the intervention. Further aims of interviews with learning mentors and teachers were to understand the mechanisms and processes of implementing the intervention and how it could be embedded into the work of school staff.

Main findings

Drinking outcomes

There was evidence of a reduction in drinking over the 12-month period among participants in both the intervention and control arms of the trial:

- 71% of pupils in the intervention group had AUDIT scores indicative of hazardous drinking at baseline compared with 61% at the 12-month follow-up, and 67% of pupils in the control group had AUDIT scores indicative of hazardous



Key points From summary and commentary

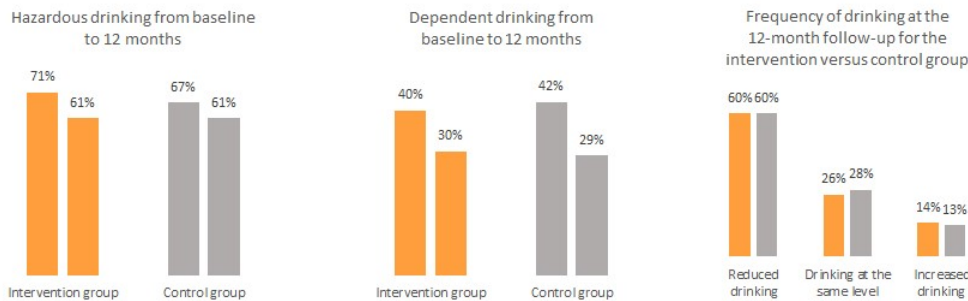
The featured study assessed the impact and cost of a school-based brief counselling intervention, aimed at reducing risky drinking in young people aged 14–15 years.

At the 12-month follow-up there was a reduction in drinking across the board, but no statistically significant difference in consumption between pupils allocated to the brief intervention versus the leaflet-only group.

The intervention was well received by young people and school staff. However, the findings do not support the introduction of this particular intervention into secondary schools.

drinking at baseline compared with 61% at the 12-month follow-up.

- 40% of pupils in the intervention group had AUDIT scores indicative of dependent drinking at baseline compared with 30% at the 12-month follow-up, and 42% of pupils in the control group had AUDIT scores indicative of dependent drinking at baseline compared with 29% at the 12-month follow-up.
- According to a single screening question for drinking frequency asked at baseline and 12 months later, 60% of pupils in the intervention group reduced their drinking, 26% were drinking at the same level, and 14% increased their drinking. Similarly, 60% of pupils in the control group reduced their drinking, 28% were drinking at the same level, and 13% increased their drinking.



Charts show an overall reduction in drinking at the 12-month follow-up, but no evidence of a benefit for any alcohol-related measure in the intervention group

At 12 months, 21% in the intervention arm and 28% in the control arm reported drinking no alcohol in the previous 28 days. There was no statistically significant difference in the alcohol consumed, whether or not they received the intervention. The average total units was 7.3 units (standard drinks equating to 8 g of alcohol) in the intervention group and 7.7 in the control group.

The sample size was deemed sufficient to detect a difference between the two groups, if there was one. This confirmed that there was strong evidence to suggest there was no difference in alcohol consumed between the groups.

Other health and wellbeing outcomes

A similar proportion of young people started smoking during the follow-up period in the intervention and control arms (13% and 14%). Similar numbers also reported smoking either more or fewer cigarettes over time.

From baseline to 12 months, half of young people (51%) in the intervention group had either stopped consuming energy drinks or reported consuming fewer energy drinks, compared with 42% of participants in the control group.

Responses to questions about regretted sexual intercourse were not reported in percentages as the numbers were too small. The number of young people who had engaged in sexual intercourse that they regretted over the 12-month period was 11 in the intervention arm and 12 in the control arm. The number of young people who had engaged in sexual intercourse without a condom over the 12-month period was 12 in the intervention arm and 10 in the control arm. Data was missing at 12 months for a substantial minority, and there were some inconsistent results, although this may have been because of the way the question was phrased.

Implementation in the secondary school setting

The intervention materials were well received by young people and school staff. The intervention worksheet was viewed as a useful tool for engaging young people in a conversation about risky behaviour, and overall, school staff, young people and parents felt that the intervention could have an impact on young people who were drinking alcohol. However, most also perceived the screening tool to be too sensitive – targeting young people who were consuming only small amounts of alcohol. They suggested it could be adapted in the future to allow the school to forgo screening and instead target people who they believed to be drinking excessively and (in their opinion) in need of an intervention.

The study examined fidelity to the brief intervention model on a scale from 'not at all' (score of zero) to 'a great extent' (score of four). It found that learning mentors delivered the prescribed form of behaviour change counselling to 'some extent' (score of two) – typically performing well when discussing the risks associated with young people's drinking, and less well in respect of skills relating to discussing and exploring behaviour change.

Learning mentors seemed to be well suited to the role of conducting alcohol screening and brief interventions. While the impact on the workloads of learning mentors was seen as manageable overall, impact varied according to factors such as the number of learning mentors within the school, the number of young people they were allocated to, and the availability of support from other staff within the school.

School staff perceived some components of the intervention to be similar to pastoral work they already undertook, although the intervention emphasised drinking more strongly than standard alcohol education. Learning mentors who delivered the intervention and control sessions felt that they were well prepared for delivering the sessions and that the preparatory training that they had received was well planned and thorough. A few learning mentors indicated that they would have liked refresher sessions when there had been a time lag between training and the intervention period.

Young people thought secondary schools were an acceptable setting for alcohol screening and brief interventions, and the survey was easy to complete and understand.

Given the poor recruitment of parents to take part in an interview, there was limited data to analyse. The two parents who participated agreed that school was an appropriate setting in which to deliver an alcohol intervention to young people and that interventions such as this were an important way of informing young people about the dangers of consuming alcohol.

Costs and savings

The total cost of the intervention included the cost of materials to deliver the intervention, the cost of training learning mentors in the brief intervention techniques, and the cost of learning mentors' time spent preparing and delivering the intervention. Total savings included the costs of using health and social care resources (eg, visits to general practitioners), hospitalisations, arrests, and the value of health benefits.

The average cost of delivering the intervention was £31.30 per participant. The average net cost-saving was £2,865, with a 76% probability of saving costs compared with usual practice. Excluding the effect of school days missed due to problems with alcohol consumption, the average cost-saving was £1,324, with a 77% probability of the intervention saving costs compared with usual practice.

Health benefits were measured in quality-adjusted life-years (known as QALYs), where one QALY is equal to one year of life in perfect health. The intervention had an estimated 74% probability of being cost-effective based on being willing to pay between £20,000 and £30,000 per QALY. There was no statistically significant difference in QALYs between the intervention and control group. However, as the trial was not specifically designed to change participants' quality of life this was not necessarily unexpected. Moreover, the impact on health may only be evident in the medium or long term.

The authors' conclusions

There was insufficient evidence to recommend implementing this brief alcohol intervention in a secondary school setting. Although there were reductions in drinking in both groups after 12 months, there was no evidence of a benefit for any alcohol-related measure in the intervention group. Other trials with adults (1 2 3 4) and [young people](#) have found reductions in alcohol consumption in both intervention and control groups. Together, these findings [could indicate](#) 'regression to the mean', a phenomenon where participants scoring as risky drinkers at the start move towards the average of the population when reassessed.

School staff, young people and parents were largely accepting of the trial procedures and processes, perceived learning mentors to be appropriate people to deliver brief interventions in a school setting, and felt that the intervention itself was a clear and informative way to inform young people about their drinking behaviours. One suggestion from the interviews was that the intervention could be adapted in the future to skip the screening stage and instead target young people believed to be drinking excessively. However, given that many young people receiving the intervention were not those who the school would have known were drinking alcohol, a targeted approach could potentially miss many young people who would benefit from an intervention.

FINDINGS COMMENTARY In contrast to treatment, screening and brief interventions are usually seen as public health measures – aiming to reduce alcohol-related harm across a whole population, including those unaware of or unconcerned about their risky drinking. In the featured study, young people aged 14–15 were the targets, and their secondary schools the settings for screening and brief interventions. The findings did not support the introduction of this intervention in schools, but did find that the intervention was acceptable to the young people receiving it and the school staff delivering it. While there were changes indicative of reductions in risky drinking, these reductions occurred among pupils in both the intervention and control arms of the study, which, as the authors said, could have been explained by behaviour normalising over time. The researchers also found that the intervention may deliver cost-savings, but in the absence of findings that the intervention was effective, this has to be treated with caution.

Overall, school-based staff, young people and parents felt that the intervention could have an impact on young people who were drinking alcohol. However, most participants felt that the screening tool was too sensitive and targeted young people who were consuming only small amounts of alcohol, and could be adapted in the future to allow the school to forgo screening and instead target people who they believed to be drinking excessively and (in their opinion) in need of an intervention. Adopting this approach would risk missing many young people who were drinking in a risky way, as the authors noted, and furthermore would run counter to [the need to](#) implement brief intervention programmes widely enough in order to see an improvement in health across the entire population.

The [advent of](#) brief interventions represented a radical realignment away from aiming for abstinence among the (relatively) few people dependent on alcohol, to reducing harm and preventing more serious problems among the bulk of non-dependent heavy drinkers (1 2). Instead of narrow and intensive, the strategy [was](#) (and remains) to spread thin and wide, deploying easily-learned interventions delivered in a few minutes by non-specialist staff.

Young people in the UK report some of the highest rates of heavy drinking in Europe (1 2), making it an ongoing public health and policy concern. Screening and brief interventions – one way of trying to tackle this – have been developed primarily for use with adults, and where tested among young people, have generally involved older young people aged 18–25, in primary care, college, or school settings.

To understand the evidence base for brief interventions, a good place to start is the Effectiveness Bank [hot topic](#) "My GP says I drink too much": screening and brief intervention", followed by [row one](#) of the Alcohol Treatment Matrix, which moves from the effectiveness of screening and brief interventions, to the influences of the practitioner, management and the organisation, and finally to generating system-wide programmes.

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