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**A qualitative account of young people's experiences of alcohol screening and brief interventions in schools: SIPS Jr-HIGH trial findings**

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3 A qualitative account of young people's experiences of alcohol screening and brief  
4 interventions in schools: SIPS Jr-HIGH trial findings  
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## **Abstract**

### **Background**

The United Kingdom has seen a decrease in the number of young people drinking alcohol. However, the UK prevalence of underage drinking still ranks amongst the highest in Western Europe. Whilst there is a wealth of evidence reporting on the effectiveness of both primary, and secondary interventions, there are few reports of the experiences of young people who receive them.

### **Methods**

The present study reports findings from interviews with 33 young people who were involved in an alcohol screening and brief intervention randomised controlled trial in schools in England. All interviews were analysed using inductive applied thematic analysis.

### **Results**

Three major themes emerged following the analysis process: 1) drinking identities and awareness of risk; 2) access to support and advice in relation to alcohol use; and 3) appraisal of the intervention and potential impact on alcohol use.

### **Conclusions**

There appeared to be a reluctance from participants to describe themselves as someone who drinks alcohol. Furthermore, those who did drink alcohol often did so with parental permission. There was variation amongst participants as to how comfortable they felt talking about alcohol issues with school staff. Overall participants felt the intervention was useful, but would be better suited to 'heavier' drinkers.

### **Keywords**

Young people, alcohol, drinking, qualitative research, interviews, school, brief interventions

## Introduction

Young people (aged between 10-24) [1] are at particular risk from negative physical and psychological health effects due to alcohol consumption, which led to the Chief Medical Officer for England advising that those under the age of 15 should not drink alcohol at all [2]. Evidence suggests that drinking alcohol before the age of 18 can impact on brain development, increase the risks of accidents and injury, teenage pregnancy, sexually transmitted infections [3-5], and is a strong prognostic indicator for the development of alcohol related issues in adulthood [6].

The number of young people who have ever tried alcohol in the United Kingdom (UK) is declining. Whilst 64% of young people aged 11-15 reported ever having tried alcohol in 2003, reducing to 44% in 2016 [7]. However, as young people become older, the level to which they consume alcohol increases [7], and those who do use alcohol are drinking more than people of the same age in the past [8]. Furthermore, the prevalence of drinking among young people in England remains amongst the highest in Europe [9]. Therefore, there are still those who remain at risk from their alcohol use, demonstrating a need for effective interventions.

Previous research suggests that the school is an ideal setting for delivering alcohol interventions, [10, 11] by providing access to a captive audience who [12] are used to receiving health and social care education [12]. Typically, in school settings, interventions tend to be primary prevention, aimed at the whole school population (e.g. in assemblies) regardless of individual consumption levels. Alcohol screening and brief interventions (ASBIs) are defined as a form of secondary prevention intervention, targeting individuals identified to be drinking alcohol at risky levels, which require limited curriculum time to deliver [13]. Risky drinking is typically defined in relation to harmful drinking – levels of consumption that increase the chance of health issues developing; hazardous drinking – consumption which has already led to such issues and heavy episodic drinking – consuming more than six unit of alcohol in one sitting [14]. Whilst there is some evidence exploring the use of ASBIs for risky drinking amongst young people in other settings including emergency departments and universities, there is limited research in school settings [15]. Furthermore, within these studies, there is a lack of exploration of the views of young people who have received targeted secondary prevention approaches; such views are required to understand the key mechanisms and acceptable processes that can lead to the effective implementation of these interventions.

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3 This study formed part of a process evaluation of a large, multi-centre randomised controlled  
4 trial looking at the effectiveness and cost-effectiveness of a high school based alcohol screening  
5 and brief intervention [16, 17].  
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8  
9 The aim of the present paper is to outline the findings from interviews with young people  
10 exploring their views of being involved in the trial and their views on any derived benefits,  
11 adverse events or improvements related to an ASBI delivered in a school setting.  
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## 14 15 **Methods**

### 16 17 *Intervention*

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19 The authors have detailed the intervention elsewhere [16, 17]. To summarise, learning mentors  
20 working within schools were trained to deliver a screening questionnaire followed by either an  
21 alcohol brief intervention based on principles of motivational interviewing [18] or treatment as  
22 usual. The screening questionnaire included lifestyle questions on smoking, energy drink  
23 consumption and risky sexual behaviour; questions related to well-being and the questions on  
24 alcohol consumption including the adolescent single alcohol question (A-SAQ) which is a  
25 modified version of the single alcohol-screening questionnaire [19, 20].  
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### 33 34 *Participant Recruitment*

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36 To be eligible for the interviews, young people had to have agreed to be contacted about taking  
37 part in an individual interview and left their name on the screening questionnaire. Purposive  
38 sampling was employed to ensure representative recruitment in terms of sex, ethnicity, score  
39 on the A-SAQ (positive or negative), and study site (See Table 1 below). For the interviews,  
40 the aim was to recruit 10 young people from each of the four regions, five boys and five girls  
41 (40 in total). As the researchers were blinded to the study condition, it was not possible to  
42 recruit in line with trial arm. Therefore, for those participants who scored positive on the A-  
43 SAQ, we did not know prior to the interview whether or not they had received the ASBI.  
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51 Schools participating in the trial acted as gatekeepers for the qualitative interviews. They  
52 distributed the information sheets and invitation letters to those young people who consented  
53 to be contacted about the interviewed (n=206), young people then informed their learning  
54 mentors if they did not want to participate in the interviews. Learning mentors then liaised with  
55 the research team to organise a suitable date and time for interviews to take place. In order to  
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3 minimise impact on schools the 206 eligible young people were randomly allocated to the  
4 sampling framework, with each young person approached in turn. All of those young people  
5 who were approached for an interview (n=33) agreed to take part and were subsequently  
6 interviewed. Ethical approval was obtained from the School of Health and Social Care Ethics  
7 and Research Governance Committee (047/16).  
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### 10 11 12 *Data collection*

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15 A standardised semi-structured interview guide was developed which asked a number of  
16 questions on the experiences of young people's involvement in the ASBI and wider views on  
17 alcohol use.  
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22 All interviews were held on school premises. Researchers undertook the interviews with young  
23 people in their region. Written assent or consent was obtained immediately prior to the  
24 interview, dependent on whether the young person was aged 15 or 16 years old respectively.  
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### 27 28 29 *Analysis*

30  
31 All interviews were recorded using a Dictaphone, and then transcribed verbatim. Any  
32 identifying information was removed from the transcripts to ensure anonymity. Interviews  
33 were subjected to applied thematic analysis [21] with an inductive approach undertaken as we  
34 were not coding in line with theory. This allowed for a greater depth of experience to emerge  
35 as the analysis was not constrained by the researchers *a priori* assumptions [22].  
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39  
40 One researcher (GM) conducted initial coding of the transcripts, whilst a senior researcher (EG)  
41 second coded a proportion of the transcripts to ensure reliability of interpretation of the  
42 emergent themes [23]. Any disagreement between coders was resolved through discussion.  
43 Final themes were agreed in consultation with the study's qualitative steering group.  
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### 47 48 **Results**

49  
50 Whilst the initial aim was to recruit 40 participants, due to time constraints it was only possible  
51 to recruit 33 young people to these interviews. Of those who took part in the interviews, 20  
52 were girls and 13 were boys. Interviews lasted on average 20 minutes (range = 8-36 minutes).  
53 Participant characteristics are outlined in Table 2.  
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56  
57 Following analysis, three themes were identified: 1) drinking identities and awareness of risk;  
58 2) access to support and advice in relation to alcohol use; and 3) appraisal of the intervention  
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3 and potential impact on alcohol use. Illustrative quotations are provided below within each  
4 theme.  
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8 *Drinking identities and awareness of risk*  
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10 Most of the young people clearly identified themselves within the interviews as non-drinkers.  
11 Although some said that they did drink alcohol, they did not self-identify as drinkers, instead  
12 identifying ‘others’ who drank more than they did as such. This suggests that young people  
13 draw a sense of identity from their level of consumption and there is perhaps a level of stigma  
14 associated with being a ‘drinker’.  
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20 *“I think if I was drinking a lot more, or a little bit more, it would definitely change*  
21 *it, but because I don’t drink that much, it [intervention] didn’t have too much of*  
22 *an effect.” – Young Person (YP) 1*  
23  
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26 Participants were able to identify potential immediate risks associated with drinking at younger  
27 ages, particularly accidents and being separated from friends. However, some did also consider  
28 longer-term risks to health associated with initiating alcohol consumption at a young age.  
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32 *“You know that you’re on your way to being drunk? That’s when I know that I*  
33 *should stop. I wouldn’t feel safe. If I had to walk home by myself, I wouldn’t feel*  
34 *safe.” YP15*  
35  
36  
37

38 *“I think it was something to do with like, I can’t remember what it was, but it can*  
39 *lead to cancer and stuff and there’s just loads of illnesses that you can get from*  
40 *it.” – YP3*  
41  
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44

45 The social side of drinking was highlighted by many young people, alongside the extra  
46 confidence that drinking alcohol provided. Drinking was seen as a fun activity, and a way to  
47 de-stress, particularly at exam time and as part of a shared social identity. Those who did not  
48 conform could be subjected to peer pressure, a common reason offered by participants as to  
49 why they consumed alcohol. Such peer pressure seemed to come from wider social circles  
50 rather than from their immediate friendship group.  
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55 *“So it may be, if you don’t do it, you feel, like you’re going to be judged by your*  
56 *friends, judged by others, or, another, reason why you may go drink out, like you*  
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3 *go out to parties and, having the like, forced to drink, is, because maybe people,*  
4 *who are this age, think it's cool to drink.” – YP4*

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7 *“I can just go out and like only two people drink, if they want to drink they can,*  
8 *some people don't want to, so we're not bothered.” – YP5*

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12 Inter-generational influences were said to have an impact on whether the participants consumed  
13 alcohol. Some participants only drank alcohol with parental agreement, usually for special  
14 occasions. That said, this parental influence could vary depending on cultural differences, with  
15 one participant in particular, from an Asian background, describing strict rules within their  
16 household relating to alcohol consumption. Furthermore, even with parental consent, there was  
17 a recognition that consumption needed to be within certain boundaries, and if they drank too  
18 much alcohol there would be repercussions. This trust between parents and young people  
19 allowed them to experiment with alcohol, but within a safe context.  
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27 *“She [mother] doesn't like it. Sometimes like if I was at a party she'd go like in*  
28 *the shop for me and get me something to drink so she'd know what I was drinking*  
29 *and stuff but then if I was just saying I was drinking in the street or I drank like*  
30 *two days in a row then she'd say (name), don't drink anymore.” – YP2*

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35 *“My parents do not allow drinking, but English people, I shouldn't say this,*  
36 *English people might find it alright to let the children drink at certain age, like*  
37 *16 is alright.” – YP6*

#### 38 39 40 41 *Access to support and advice on alcohol use*

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44 When discussing support and advice on alcohol use a distinction could be drawn in terms of  
45 formal support – that provided by individuals or organisations trained to offer such advice; and  
46 informal support – that delivered by peers or family members. In terms of formal support,  
47 young people felt there was a lack of guidance within the school. They acknowledged that  
48 schools provided general assemblies on alcohol, as well as one-off sessions within Personal,  
49 Social, Health and Economic Education (PSHE) lessons. However, they perceived it to be out-  
50 dated, and that it did not apply to them.  
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3       *“No, it does pop up in assembly, like, a couple of times, but they don’t go into*  
4 *depth about it. Just like kind of mention it and then go onto something else.” –*  
5 *YP7*  
6  
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9       *“I believe that erm young people should be aware of the drinking and but I don’t*  
10 *feel like what they are giving us is effective enough. I feel like it is just a waste of*  
11 *time, a waste of their money, a waste of our valuable education.” – YP9*  
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15  
16 As support and advice provided by schools was viewed as insufficient, participants pursued  
17 other sources of support. For example, young people sought advice from older friends, and  
18 family members. However, there were mixed feelings when it came to speaking to parents,  
19 very much depending on whether or not they allowed alcohol consumption. Those who did  
20 not discuss alcohol with their parents were perhaps fearful of repercussions from doing so,  
21 instead seeking advice from another family member or friend.  
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27       *“And I’ve also had some advice from my brother as well, he says to make sure*  
28 *you go out with people you’re actually good friends with so they don’t leave you*  
29 *if you’re really drunk.” – YP10*  
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33       *“Probably like my stepdad, my stepdad’s kind of got the whole mentality of like,*  
34 *he kind of realised what it was like because he did it when he was my age and he*  
35 *could probably help me with it.” – YP11*  
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### 39 *Appraisal of the intervention and potential impact on drinking behaviour*

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42 Those participants randomised to the intervention arm of the trial thought it would have limited  
43 impact on their own drinking. The effectiveness of the intervention was linked to their identity  
44 – or not – as a drinker and feeling that because they did not drink a lot of alcohol they did not  
45 require support. That said, some of the young people who received the intervention did state  
46 that they had consequently made some small changes.  
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51       *“I was really confused. I was like, ‘Why am I doing this?’ The closest I’ve got to*  
52 *something relating to alcohol is probably sparkling water.” – YP12*  
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56       *“So then like from the session, so I wanted to do it ‘cause like it made me*  
57 *understand why I shouldn’t do it and supported me in thinking why I should*  
58 *probably drink less. She was like you shouldn’t drink that much because these are*  
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3 *the reasons why, so basically it supported me into like reducing how much I drink,*  
4 *yeah.” – YP13*  
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8 Most young people who received the intervention said that they were comfortable discussing  
9 alcohol with learning mentors, and felt reassured that the sessions were confidential. However,  
10 some students were aware that no matter how informal their relationship with learning mentors  
11 was, mentors were still school staff. This led to a fear amongst some that fully disclosing the  
12 level of their alcohol use could lead to negative consequences, and as such, some students  
13 withheld information.  
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19 *“Because I think, I knew that no one would be told about it and it’s like personal*  
20 *and secretive so I knew like my name wouldn’t be like going around and like and*  
21 *that it wouldn’t be broadcast.” – YP13*  
22  
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24  
25 *“I just don’t think it’s one of those things that you’d really want to go and speak*  
26 *to someone about like going and talking to (name), because (name’s) nice but I*  
27 *wouldn’t feel comfortable just sitting there and telling him everything about me,*  
28 *do you know what I mean?” – YP16*  
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### 33 **Discussion**

#### 34 *Main findings of the study*

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38 Within this study, it was clear that young people were wary of identifying themselves as  
39 ‘drinkers’. However, it must be noted that those randomised to the intervention, who  
40 described themselves as non-drinkers, had scored positively on a validated measure for  
41 risky drinking [24]. This incongruity could be linked to social desirability bias, or that  
42 they were unwilling to fully disclose alcohol use to school staff. There was perhaps some  
43 stigma attached to being identified as an underage drinker.  
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50 Whilst many of the young people could identify both short- and long-term risks  
51 associated with consuming alcohol, they tended to focus more on the short-term risks.  
52 Additionally, parental influences were identified as important in determining whether  
53 young people drank alcohol. Often, young people were only permitted to drink with  
54 parental consent, as part of a trusting relationship.  
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3 Young people found it acceptable to receive an alcohol brief intervention in school;  
4 however, there was concern around discussing their alcohol use with school staff. This  
5 may be indicative of an unwillingness to self-identify as a drinker.  
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9 *What is already known on this topic?*  
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12 Research indicates that young people (11-15) associate more with a prototype of a ‘non-  
13 drinker’[25] however the term non-drinker can mean different things to different young  
14 people and may be related to the dominant norms within their social group such that ‘non-  
15 drinkers’ can be on a continuum ranging from tee-total to occasional drinker [26].  
16 Furthermore, research has highlighted that in order for young people to fit in with their  
17 peers then they must keep up with social norms [27], suggesting that they may model  
18 their consumption levels based on their peer group yet apply labels to their behaviour  
19 based on dominant norms [28, 29]. However, other studies have suggested that those who  
20 self-identify as occasional, or light drinkers are actually at high risk of harm [30]. This  
21 suggests that young people’s reluctance to self-identify as a drinker may be more to do  
22 with social identity, and unrealistic optimism than actual levels of consumption [7, 31,  
23 32].  
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34 Parental influence has implications for reducing alcohol consumption by young people,  
35 in that the targets of health promotion interventions may not always need to be the young  
36 people themselves; rather, targeting parents may also be required [33, 34]. Parents and  
37 families are important influences on adolescents and factors such as communication  
38 about alcohol use, parental modelling of behaviour, parental monitoring/supervision of  
39 free time, and availability of alcohol have all been shown to effect children’s own alcohol  
40 use. Furthermore, as touched on in our results there may be cultural differences in alcohol  
41 use such that children from Asian or African backgrounds may face greater parental  
42 monitoring and stronger disapproval of consumption compared to White British children.  
43 This could then lead to a barrier in accessing services for some ethnic minority children  
44 who do drink, for fear of reprisal [35].  
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54 Some parents may be willing to supply alcohol to their children in an attempt to minimise  
55 harm [36, 37], feeling that they would probably drink alcohol anyway, and a desire not  
56 to isolate them from their peers [38]. However, research suggests that parental supply of  
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3 alcohol can be associated with increased drinking episodes and harms amongst young  
4 people [39].  
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8 Within this present study we aimed to recruit a number of parents to interviews to discuss  
9 their view on the intervention. However parents proved to be an extremely hard group to  
10 recruit, as found in previous work [15]. Nonetheless, given that many of our participants  
11 drank with their parents' permission and the potential adverse impact of parental supply,  
12 parents remain a potentially valuable component in addressing adolescent alcohol  
13 consumption. Indeed a recent review of combined school and parental interventions  
14 highlighted their potential efficacy as parents and families can play a key role in  
15 influencing and delaying alcohol use in young people. This can be achieved by setting  
16 clear rules on alcohol use, encouraging open and honest dialogue to provide informal  
17 support to young people and by limiting parental supply [40].  
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26 Previous research looking at the effectiveness of alcohol screening and brief interventions  
27 has been limited to primary prevention models, with limited research into the  
28 effectiveness of secondary prevention [10, 11, 41]. Therefore, it is important to explore  
29 young people's experiences of such interventions to ascertain whether they are a feasible  
30 model of delivery [15, 42]. Previous evidence has also highlighted that a lack of trust  
31 between young people and those delivering an intervention can be a barrier to  
32 effectiveness [43, 44]. Further evidence suggests that young people may be more willing  
33 to engage with a digital intervention which would potentially resolve this barrier [4, 45].  
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#### 41 *What this study adds*

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43 To the best of our knowledge this is the first study to explore young people's experiences  
44 of an individually randomised ASBI delivered in schools in England [19]. The results of  
45 this study have highlighted that the students' informal relationship with learning mentors  
46 may have facilitated discussions with staff about alcohol use. However, some students  
47 admitted to withholding information, as they did not feel comfortable discussing alcohol  
48 use with school staff.  
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54 Health promotion messages often tend to focus on adopting short- to medium-term  
55 healthy behaviours to result in longer-term health benefits [46]. In this respect, it may be  
56 important with this age group that such health promotion messages and interventions  
57 focus more on the short- to medium-term risks, or the issues prevalent to young people  
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3 such as being separated from friends on a night out, which may help deliver more  
4 appropriate harm minimizing messages [32, 47, 48]. The results of this study indicate  
5 that young people are willing to receive advice and support in relation to alcohol use,  
6 however formal support offered in schools is outdated and does not resonate with them.  
7 Instead, they seek more informal advice from friends and family. As evidence suggests  
8 parental involvement in such interventions can be effective then future research should  
9 focus on how to better involve parents in school-based services and/or interventions [40].  
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### 15 16 *Limitations of this study*

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19 Whilst we aimed to recruit a purposive sample of participants from across the four study  
20 sites, this was not possible due to regional variations in recruitment to the trial as a whole.  
21 Furthermore, whilst we aimed to recruit 40 participants, we were only able to interview  
22 33 young people due to time constraints within schools. However, no regional specific  
23 issues were identified and data saturation was reached. Finally, the length of the  
24 interviews was quite short, averaging 20 minutes however, this is consistent with  
25 previous qualitative research with children [49].  
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### 32 **Conflicts of Interest**

33  
34 Professor Eileen Kaner was a funding board member of the NIHR Public Health Research  
35 funding board when this grant was awarded and is Deputy Chair of the NIHR Postdoctoral  
36 Fellowships panel and is a co-applicant on the NIHR School of Public Health research, NIHR  
37 School of Primary Care Research and NIHR Innovation observatory.  
38

39 Ms Denise Howel is a panel member for the NIHR Program Grants for Applied Research.

40  
41 Professor Luke Vale is a panel member NIHR HTA CET panel, was a panel member for the  
42 NIHR PGfAR (2008-2015), and is Co-Director NIHR Research Design Service North East.  
43

44  
45 Professor Elaine McColl was an editor for the NIHR journals series PGfAR (2013-2016) and  
46 a panel member for NIHR PGfAR (2008 to 2016).  
47

48  
49 Professor Harry Sumnall reports grants from Diageo, outside the submitted work; and is an  
50 unpaid trustee of a drug and alcohol prevention charity, Mentor UK, who seek funding to  
51 deliver evidence-based prevention programmes.  
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54

### 55 56 **Contributorship**

57  
58 ELG and GJM wrote the first draft of the manuscript, with all authors commenting and  
59 approving the final version.  
60

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## References

1. United Nations. *Definition of Youth*. 2017 [10/05/2019]; Available from: <http://www.unesco.org/new/en/social-and-human-sciences/themes/youth/youth-definition/>.
2. Department of Health, *Guidance on the consumption of alcohol by children and young people*, Sir Liam Donalson, Editor. 2009.
3. Newbury-Birch, D., et al., *Impact of alcohol consumption on Young People: A Review of Reviews*. 2009.
4. Patton, R., et al., *Alcohol Screening and Brief Intervention for Adolescents: The How, What and Where of Reducing Alcohol Consumption and Related Harm Among Young People*. *Alcohol and Alcoholism*, 2014. **49**(2): p. 207-212.
5. Clark, D.B., et al., *Health Problems in Adolescents With Alcohol Use Disorders: Self-Report, Liver Injury, and Physical Examination Findings and Correlates*. *Alcoholism: Clinical and Experimental Research*, 2006. **25**(9): p. 1350-1359.
6. DeWit, D.J., et al., *Age at first alcohol use: a risk factor for the development of alcohol disorders*. *American Journal of Psychiatry*, 2000. **157**(5): p. 745-750.
7. National Health Service, *Smoking, Drinking and Drug Use Among Young People in England*. 2016.
8. Emerson, E., et al., *Predictors of self-reported alcohol use and attitudes toward alcohol among 11-year-old British children with and without intellectual disability*. *Journal of Intellectual Disability Research*, 2016. **60**(12): p. 1212-1226.
9. Hibell, B., et al., *The 2011 ESPAD Report: Substance Use Amongst Students in 36 European Countries*. 2012: EPSAD.



10. Hale, D., N. Fitzgerald-Yau, and R. Viner, *A Systematic Review of Effective Interventions for Reducing Multiple Health Risk Behaviors in Adolescence*. American Journal of Public Health, 2014. **104**(5): p. e19-e41.
11. National Institute for Health and Clinical Excellence, *Interventions in schools to prevent and reduce alcohol use among children and young people*. 2007.
12. Siegel, D.M., M.J. Aten, and M. Enaharo, *Long-term effects of a middle school–and high school–based human immunodeficiency virus sexual risk prevention intervention*. *Archives of Pediatrics & Adolescent Medicine* 2001. **155**(10): p. 1117-1126.
13. World Health Organization. *Prevention and Young People*. 2019 10/05/2019]; Available from: [https://www.who.int/substance\\_abuse/activities/prevention/en/](https://www.who.int/substance_abuse/activities/prevention/en/).
14. Wilson, G.B., et al., *Brief intervention to reduce risky drinking in pregnancy: study protocol for a randomized controlled trial*. *Trials*, 2012. **13**(1): p. 174.
15. McKay, M.T., et al., *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*, 2018. **25**(1): p. 77-87.
16. Giles E. L., et al., *A multi-centre individual-randomized controlled trial of screening and brief alcohol intervention to prevent risky drinking in young people aged 14-15 in a high school setting (SIPS JR-HIGH): Study protocol*. *BMJ open*, 2016. **6**(12): p. e012474.
17. Giles, E.L., et al., *Brief alcohol intervention for risky drinking in young people aged 14 15 years in secondary schools: the SIPS JR-HIGH RCT*. *Public Health Research*, 2019. **7**(9).
18. Miller, W.R. and S. Rollnick, *Motivational Interviewing: Helping people change* 2nd ed. 2002: Guildford Press.

- 1  
2  
3 19. Newbury-Birch, D., et al., *A pilot feasibility cluster randomised controlled trial of*  
4 *screening and brief alcohol intervention to prevent hazardous drinking in young people*  
5 *aged 14-15 in a high school setting (SIPS JR-HIGH)*. 2014, NIHR Public Health  
6 Research Program Report: London.  
7  
8  
9  
10  
11
- 12 20. Canagasaby, A. and D.C. Vinson, *Screening for hazardous or harmful drinking using*  
13 *one or two quantity–frequency questions*. . Alcohol and Alcoholism, 2005. **40**(3): p.  
14 208-213.  
15  
16  
17  
18
- 19 21. Braun, V. and V. Clarke, *Using thematic analysis in Psychology*. Qualitative Research  
20 Psychology, 2006. **3**(2): p. 77-101.  
21  
22  
23
- 24 22. Patton, M.Q., *Qualitative Evaluation and Research Methods*. 1990, Thousand Oaks,  
25 CA: United States of America: Sage Publications.  
26  
27
- 28 23. Barbour, R.S., *The Newfound Credibility of Qualitative Research? Tales of Technical*  
29 *Essentialism and Co-Option*. Qualitative Health Research, 2003. **13**: p. 1019-1027.  
30  
31  
32
- 33 24. Engs, R.C. and D. Hanson, *The student alcohol questionnaire: An updated reliability*  
34 *of the drinking patterns, knowledge, and attitudes sub-scales*. Psychological reports,  
35 1994. **74**(1): p. 12-14.  
36  
37  
38  
39
- 40 25. Davies, E.L., J. Martin, and D.R. Foxcroft, *Age differences in alcohol prototype*  
41 *perceptions and willingness to drink un UK adolescents*. Psychology, Health and  
42 Medicine, 2016. **21**: p. 317-329.  
43  
44  
45  
46
- 47 26. Piacentini, M.G. and E.N. Banister, *Managing anti-consumption in an excessive*  
48 *drinking culture*. Journal of Business Research, 2009. **62**(2): p. 279-288.  
49  
50
- 51 27. Scott, S., et al., *Hidden Habitus’: A Qualitative Study of Socio-Ecological Influences*  
52 *on Drinking Practices and Social Identity in Mid-Adolescence*. Int. J. Environ. Res.  
53 Public Health, 2017. **146**(6): p. 611.  
54  
55  
56  
57  
58  
59  
60

- 1
- 2
- 3 28. Borsari, B. and K. Carey, *Peer influences on college drinking: A review of the research.*
- 4
- 5 Journal of Substance Abuse., 2001. **13**(4): p. 391-424.
- 6
- 7
- 8 29. Lau-Barraco, C. and A.N. Linden, *Drinking buddies: Who are they and when do they*
- 9
- 10 *matter?* Addiction Research & Theory., 2014. **22**(1): p. 57-67.
- 11
- 12 30. Pettigrew, S., et al., *Drinkers' identification with varying alcohol consumption*
- 13 *prototypes.* Drug and Alcohol Review, 2017. **36**(4): p. 464-467.
- 14
- 15
- 16 31. Pennay, A., M. Livingston, and S. MacLean, *Young people are drinking less: It is time*
- 17 *to find out why.* Drug and Alcohol Review, 2015. **34**(2): p. 115-118.
- 18
- 19 32. Currie, C., et al., *Social determinants of health and well-being among young people:*
- 20 *Health Behaviour in School-Aged Children (HBSC) Study: International Report From*
- 21 *the 2009/2010 survey.* 2012: Copenhagen, Denmark.
- 22
- 23
- 24
- 25
- 26
- 27
- 28 33. Koutakis, N., H. Stattin, and M. Kerr, *Reducing youth alcohol drinking through a*
- 29 *parent-targeted intervention: the Örebro Prevention Program.* Addiction, 2008.
- 30
- 31 **103**(10): p. 1629-1637.
- 32
- 33
- 34
- 35 34. Mattick, R.P., et al., *Association of parental supply of alcohol with adolescent drinking,*
- 36 *alcohol-related harms, and alcohol use disorder symptoms: a prospective cohort study.*
- 37
- 38 The Lancet Public Health, 2018. **3**(2): p. e64-e71.
- 39
- 40
- 41
- 42 35. Chan, G.C., et al., *Does parental monitoring and disapproval explain variations in*
- 43 *alcohol use among adolescents from different countries of birth?* Drug Alcohol
- 44
- 45 Review., 2016. **35**(741-749).
- 46
- 47
- 48
- 49 36. Gilligan, C., K. Kypri, and D. Lubman, *Changing Parental Behaviour to Reduce Risky*
- 50 *Drinking Among Adolescents: Current Evidence and Future Directions.* Alcohol and
- 51
- 52 alcoholism, 2012. **47**(3): p. 349-354.
- 53
- 54
- 55
- 56 37. Van Der Vorst, H., et al., *The role of alcohol specific socialization in adolescents'*
- 57 *drinking behaviour.* Addiction, 2005. **100**(10): p. 1464-1476.
- 58
- 59
- 60

- 1  
2  
3 38. Gilligan, C. and K. Kypri, *Parent attitudes, family dynamics and adolescent drinking: qualitative study of the Australian parenting guidelines for adolescent alcohol use.* *BMC Public Health*, 2012. **12**(1): p. 491.
- 4  
5  
6  
7  
8  
9  
10 39. Abar, C., B. Abar, and R. Turrisi, *The impact of parental modelling and permissibility on alcohol use and experienced negative drinking consequences in college.* *Addictive Behaviors*, 2009. **34**(6-7): p. 542-547.
- 11  
12  
13  
14  
15  
16  
17 40. Newton, N.C., et al., *A systematic review of combined student- and parent-based programs to prevent alcohol and other drug use among adolescents.* *Drug and Alcohol Review*, 2017. **36**(3): p. 337-351.
- 18  
19  
20  
21  
22  
23  
24 41. Griffin, K.W. and G.J. Botvin, *Evidence-Based Interventions for Preventing Substance Use Disorders in Adolescents.* *Child and Adolescent Psychiatric Clinics of North America*, 2010. **19** (3): p. 505-526.
- 25  
26  
27  
28  
29  
30  
31 42. Derges, J., et al., *Alcohol screening and brief interventions for adults and young people in health and community-based settings.* *BMC Public Health*, 2017. **17**(1): p. 562.
- 32  
33  
34  
35  
36 43. Gulliver, A., K.M. Griffiths, and H. Christensen, *Perceived barriers and facilitators to mental health help-seeking in young people: A systematic review.* *BMC Psychiatry*, 2010. **10**(1): p. 113.
- 37  
38  
39  
40  
41  
42 44. Derges, J., et al., *'DrinkThink' alcohol screening and brief intervention for young people: a qualitative evaluation of training and implementation.* *Journal of Public Health*, 2017. **In Press**.
- 43  
44  
45  
46  
47  
48  
49 45. Van de Mortel, T.F., *Faking it: social desirability response bias in self-report research.* *Australian Journal of Advanced Nursing*, 2008. **25**(4).
- 50  
51  
52  
53  
54 46. Adams, J. and D. Nettle, *Time perspective, personality and smoking, body mass, and physical activity: An empirical study.* *British Journal of Health Psychology*, 2009. **14**(1): p. 83-105.
- 55  
56  
57  
58  
59  
60

- 1  
2  
3 47. Coleman, L. and S. Carter, *Underage 'binge' drinking: A qualitative study into*  
4 *motivations and outcomes*. *Drugs: Education, Prevention and Policy*, 2005. **12**(2): p.  
5 125-136.  
6  
7  
8  
9  
10 48. Viner, R.M. and M. Barker, *Young people's health: the need for action*. . *British*  
11 *Medical Journal*, 2005. **3307**(496): p. 901-903.  
12  
13  
14 49. Harden, J., et al., *Can't talk, won't talk?: methodological issues in researching children*.  
15 *Sociological research online*, 2000. **5**(2): p. 1-12.  
16  
17  
18  
19  
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Table 1 – Young People Interview Sampling Framework

Region		North East				North West				London				Kent				Total
A-SAQ		positive		negative		positive		negative		positive		negative		positive		negative		
<b>Target</b>		8		2		4		6		2		8		6		4		40
<b>Recruited</b>		7		1		3		4		1		7		6		4		33
<b>Ethnicity</b>																		
<b>White</b>	Target	6		0		3		1		1		1		4		2		17
		2M	4F	0M	0F	2M	1F	1M	0F	1M	0F	0M	1F	3M	1F	1M	1F	
	Recruited	5		0		2		0		0		1		4		2		14
		2M	3F	0M	0F	2M	0F	0M	0F	0M	0F	0M	1F	3M	1F	1M	1F	
<b>Asian</b>	Target	0		1		0		1		0		1		2		1		6
		0M	0F	1M	0F	0M	0F	0M	1F	0M	0F	1M	0F	0M	2F	0M	1F	
	Recruited	0		1		0		1		0		0		2		1		5
		0M	0F	1M	0F	0M	0F	0M	1F	0M	0F	0M	0F	0M	2F	0M	1F	
<b>Black</b>	Target	0		1		1		2		0		6		0		1		11

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		0M	0F	0M	1F	0M	1F	1M	1F	0M	0F	3M	3F	0M	0F	0M	1F	
	Recruited	0		0		1		2		0		6		0		1		10
		0M	0F	0M	0F	0M	1F	1M	1F	0M	0F	1M	5F	0M	0F	0M	1F	
<b>Mixed</b>	Target	1		0		0		1		1		0		0		0		3
		1M	0F	0M	0F	0M	0F	0M	1F	0M	1F	0M	0F	0M	0F	0M	0F	
	Recruited	1		0		0		1		1		0		0		0		3
		1M	0F	0M	0F	0M	0F	0M	1F	0M	1F	0M	0F	0M	0F	0M	0F	
<b>Chinese</b>	Target	0		0		0		0		0		0		0		0		0
		0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	
	Recruited	0		0		0		0		0		0		0		0		0
		0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	
<b>Other</b>	Target	1		0		0		1		0		0		0		0		2
		1M	0F	0M	0F	0M	0F	1M	0F	0M	0F	0M	0F	0M	0F	0M	0F	
	Recruited	1		0		0		0		0		0		0		0		1
		1M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	0M	0F	

Table 2: Participant Characteristics – Young People Interviews

Code	Gender	Age	Ethnicity	A-SAQ	Condition	Site
Young Person 1	Male	15	White	Positive	Intervention	Kent
Young Person 2	Female	16	White	Positive	Intervention	North East
Young Person 3	Male	16	White	Positive	Control	Kent
Young Person 4	Female	16	White	Negative	N/A	London
Young Person 5	Female	15	White	Positive	Control	North East
Young Person 6	Female	16	Asian	Negative	N/A	Kent
Young Person 7	Female	16	White	Negative	N/A	Kent
Young Person 8	Female	16	White	Positive	Control	Kent
Young Person 9	Female	15	Black	Negative	N/A	London
Young Person 10	Female	16	Black	Negative	N/A	Kent
Young Person 11	Male	16	White	Positive	Intervention	North East
Young Person 12	Female	16	Mixed	Negative	N/A	North West
Young Person 13	Female	15	Asian	Positive	Intervention	Kent
Young Person 14	Male	16	White	Negative	N/A	Kent
Young Person 15	Female	15	White	Positive	Control	North East
Young Person 16	Male	15	Mixed	Positive	Control	North East
Young Person 17	Female	Unknown	Asian	Negative	N/A	North West
Young Person 18	Male	16	White	Positive	Intervention	Kent
Young Person 19	Male	Unknown	Black	Negative	N/A	North West
Young Person 20	Female	15	Black	Negative	N/A	London
Young Person 21	Male	16	White	Positive	Control	North East
Young Person 22	Male	Unknown	White	Positive	Intervention	North West



<b>Young Person 23</b>	Female	16	Black	Negative	N/A	London
<b>Young Person 24</b>	Female	16	Asian	Positive	Control	Kent
<b>Young Person 25</b>	Male	15	Other	Positive	Intervention	North East
<b>Young Person 26</b>	Male	16	White	Positive	Control	North West
<b>Young Person 27</b>	Female	16	Black	Negative	N/A	London
<b>Young Person 28</b>	Male	15	Asian	Negative	N/A	North East
<b>Young Person 29</b>	Female	Unknown	Black	Negative	N/A	North West
<b>Young Person 30</b>	Male	15	Black	Negative	N/A	London
<b>Young Person 31</b>	Female	16	Black	Negative	N/A	London
<b>Young Person 32</b>	Female	15	Black	Positive	Control	North West
<b>Young Person 33</b>	Female	16	Mixed	Positive	Control	London