Drug misuse prevention

NICE guideline

Draft for consultation, July 2016

This guideline covers drug misuse prevention in people who are most likely to start using drugs or who are already experimenting or using drugs occasionally. The guideline makes recommendations on interventions targeting groups at risk that aim to:

- prevent or delay drug use
- prevent people who are already using some drugs from moving on to other drugs
- prevent people moving from using drugs on an experimental or occasional basis to using them regularly and excessively.

Who is it for?

- Local authority and NHS commissioners of drug misuse prevention and drug treatment services
- Providers of services for groups at risk
- Practitioners working in drug misuse prevention and drug treatment services.
- Health and social care professionals, such as youth workers, social workers and probation officers, who come into contact with groups at risk.

It may also be relevant for:

- Owners and staff at venues where drugs may be used (such as gyms, pubs, clubs or music events)
- People who use drugs, their families and carers and the public.

Commissioners of drug misuse prevention services should ensure any service

specifications take into account the recommendations in this guideline when it is finalised.

This guideline contains the draft recommendations, information about implementing the guideline, context, the guideline committee's discussions and recommendations for research. Information about how the guideline was developed is on the guideline's page on the NICE website. This includes the evidence reviews, the scope, and details of the committee and any declarations of interest.

This guideline will update and replace NICE guideline PH4 (published March 2007). See Update information for more details about recommendations from PH4.

1

2

Contents

Recommendations

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

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

1.1 Delivering drug misuse prevention activities as part of existing services

This recommendation is for local authorities and other local decision makers.

1.1.1 Deliver drug misuse prevention activities through a range of existing services for people in groups at risk, including:

- primary care services
- mental health services
- criminal justice services (including adults', youth and family justice services)
- alcohol and drug misuse services
- sexual and reproductive health services
- services for looked-after children and young people
- accident and emergency services
- services for people that are homeless or sleeping rough
- specialist services for sex workers.

1.1.2 Ensure services targeting groups at risk support local activities that may directly or indirectly prevent drug misuse. For more information, see the report from Public Health England on the international evidence on the prevention of drug and alcohol use: summary and examples of implementation in England (2015).

1.2 Assessment

These recommendations are for all health and social care practitioners who come into contact with people at risk.

1.2.1 Assess whether someone in an at-risk group is vulnerable to drug use using a validated or locally agreed approach that is respectful and non-judgemental. This should be done:

- at routine appointments, such as health needs assessments for looked-after children or young people, or a GP or nurse appointment in primary or community care
- opportunistically, for example when someone attends an emergency department as a result of alcohol or drug use or when young offenders come into contact with the criminal justice system.

1.2.2 Assess how a person's personal, social, health, educational or employment circumstances may affect their vulnerability to drug use and potential harm associated with drug use.

1.2.3 Discuss with people in groups at risk what their priorities are. Be aware that for some people who have complex needs and circumstances, discussing their drug use may not be their highest priority at that time.

1.2.4 If after assessment there are concerns that someone is using substances regularly or excessively, refer them to specialist services. See NICE's guidelines on psychosocial interventions and opioid detoxification for drug misuse and alcohol-use disorders.

1.3 Skills training for children and young people who are vulnerable to drug use

These recommendations are for all health and social care practitioners and youth workers involved in drug misuse prevention and competent to provide training in personal and social skills.

1.3.1 Consider skills training for children and young people who are assessed as vulnerable to drug use, and their parents or carers. Any skills training

should be delivered as part of existing services (see recommendation 1.1.1).

1.3.2 Take into account age, developmental stage, presenting vulnerabilities, cultural context, religion, ethnicity and any other specific needs of the child or young person when deciding:

- whether to offer training sessions to children and young people and their parents or carers together, or whether to offer separate sessions
- the content of the skills training
- whether to provide individual or group-based sessions
- the number of sessions needed (a minimum of 2 sessions should be offered)
- where to hold the sessions (for example, in settings in line with the Department of Health's You're welcome)
- how long each session should last.

1.3.3 Discuss and agree a plan for follow-up at the skills training sessions to assess whether additional skills training or referral to specialist services (see recommendation 1.2.4) is needed.

1.3.4 Ensure that skills training for children and young people helps them develop a range of personal and social skills, such as:

- listening
- conflict resolution
- refusal skills
- how to identify and manage stress
- making decisions
- coping with criticism
- dealing with feelings of exclusion (see recommendation 1.3.5)
- how to make healthy behaviour choices.

1.3.5 Ensure that personal and social skills training for looked-after children and young people puts particular emphasis on how to deal with feelings of exclusion.

1.3.6 Ensure that skills training for parents and carers helps them develop a range of skills, such as:

- communication
- relationship skills
- conflict resolution
- problem-solving
- how to use behaviour reinforcement strategies.

1.3.7 Ensure that skills training for foster carers puts particular emphasis on using behaviour reinforcement strategies alongside the other skills listed in recommendation 1.3.6.

1.3.8 Deliver skills training using a non-judgemental approach and tailor the training to the person's health literacy.

1.4 Providing information to adults who are vulnerable to drug use

These recommendations are for all health and social care practitioners working with adults who are vulnerable to drug use.

1.4.1 Offer adults who are assessed as vulnerable to drug use (see section 1.2) the following during their assessment:

- clear information on drugs and their effects
- advice and feedback on their drug use
- information on where to find further advice and support (see recommendation 1.5.2).

1.4.2 Offer information and advice both verbally and in writing. Provide advice in a non-judgemental way and tailor it to the person's cultural preferences, specific needs and health literacy. Ensure it is delivered in line with NICE's guidelines on behaviour change: general approaches, behaviour change: individual approaches and patient experience in adult NHS services: improving the experience of care for people using adult NHS services.

1.4.3 Discuss and agree a plan for follow-up with adults during their assessment.

1.5 Raising awareness about drug use among people not in contact with services

These recommendations are for local authorities and owners and managers of venues attended by people using or at risk of using drugs.

1.5.1 Consider providing information about drug use in settings that people at risk of drug misuse may attend. This could include:

- nightclubs or festivals
- wider health services, such as sexual and reproductive health services or primary care
- gyms (information aimed at people who are taking, or considering taking, image- and performance-enhancing drugs).

1.5.2 Consider providing information in different formats, including web-based information (such as digital and social media) and printed information (such as leaflets). This could include information on:

- local services and sources of advice and support
- drugs and their effects (for example, NHS Choices)
- online self-assessment and feedback to help people assess their own drug use.

1.5.3 Ensure that information provided is in line with NICE's guidelines on behaviour change: general approaches and behaviour change: individual approaches.

Terms used in this guideline

This section defines terms that have been used in a specific way for this guideline. For general definitions, please see the glossary.

Drugs

This term is used to mean any illegal drugs, new psychoactive substances (previously described as 'legal highs'), solvents and image- and performance-enhancing drugs.

Drug misuse

This term is used to mean dependence on, or regular excessive consumption of, psychoactive substances, leading to physical, mental or social problems. It does not refer to occasional or experimental drug use.

Groups at risk

Groups at risk of drug use include:

- people who have mental health problems
- people involved in commercial sex work or who are being sexually exploited
- people who are lesbian, gay, bisexual or transgender
- people not in employment, education or training (including children and young people who are excluded from school or who truant regularly)
- children and young people whose parents use drugs
- looked-after children and young people
- children and young people who are in contact with young offender teams but not in secure environments (prisons and young offender institutions)
- people who are considered homeless
- people who attend nightclubs and festivals.

Groups at risk of drug misuse include:

- all of the groups above, and
- people who are known to use drugs occasionally or recreationally.

Harm reduction

Harm reduction aims to prevent or reduce the negative health effects or other consequences associated with drug use. In harm-reduction approaches it is not essential for there to be a reduction in the drug use itself (although this may be one

of the methods of reducing harm). (National Treatment Agency for Substance Misuse, 2009)

Health literacy

A person's ability to process and understand the information needed to make decisions about their health.

Prevention

This term includes preventing or delaying drug use, preventing people who are already using some drugs from using other drugs, and preventing people who already experiment or use drugs occasionally from using drugs regularly and excessively.

Treatment

This refers to the clinical management of drug use or dependence. This could include, for example, pharmacotherapy, psychosocial therapy or a combination of these.

Vulnerable to drug use

People who are vulnerable to drug use are those in multiple groups at risk, whose personal circumstances put them at increased risk, who may already be using drugs on an occasional basis or may already be regularly excessively consuming another substance, such as alcohol.

Putting this guideline into practice

NICE has produced tools and resources to help you put this guideline into practice.

Putting recommendations into practice can take time. How long may vary from guideline to guideline, and depends on how much change in practice or services is needed. Implementing change is most effective when aligned with local priorities.

Changes should be implemented as soon as possible, unless there is a good reason for not doing so (for example, if it would be better value for money if a package of recommendations were all implemented at once).

Different organisations may need different approaches to implementation, depending on their size and function. Sometimes individual practitioners may be able to respond to recommendations to improve their practice more quickly than large organisations.

Here are some pointers to help organisations put NICE guidelines into practice:

1. **Raise awareness** through a range of different communication channels. These could include digital and social media, alongside regular channels such as email, newsletters, meetings, internal staff briefings and communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.

2. **Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.

3. **Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.

4. **Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.

5. **Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

6. **For very big changes**, include milestones and a business case which will set out additional costs, savings and possible areas for disinvestment. A small project group could develop the action plan. The group might include the guideline champion, a senior organisational sponsor, staff involved in the associated services, finance and information professionals.

7. **Implement the action plan** with oversight from the lead and the project group. Big projects may also need project management support.

8. **Review and monitor** how well the guideline is being implemented through the project group. Share progress with those involved in making improvements, as well as relevant boards and local partners.

NICE provides a comprehensive programme of support and resources to maximise uptake and use of evidence and guidance. See our into practice pages for more information.

Also see Leng G, Moore V, Abraham S, editors (2014) Achieving high quality care – practical experience from NICE. Chichester: Wiley.

Context

The Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016 list all illegal (or controlled) drugs in the UK. According to the Home Office report Drug misuse: findings from the 2014 to 2015 Crime Survey for England:

- Around 9% of people aged 16 to 59 had taken an illicit drug in the past year and around 5% had taken one in the past month. Among young adults aged 16 to 24, this was 19% in the past year and 10% in the past month.
- More than one-third of adults aged 16 to 59 (34.7%) have taken an illicit drug at some point in their lives. Cannabis was the most common, with 6.7% using it in the past year, followed by powder cocaine (2.3%) and ecstasy (1.7%).
- In the same age group 2.2% were defined as frequent drug users (having taken an illicit drug more than once a month, on average, in the past year).
- Among young adults aged 16 to 24, this figure more than doubled to 5.1%.
- Use of any Class A drug was around 10 times higher among those who had visited a nightclub at least four times in the past month (19.2%) compared with those who had not visited a nightclub in the past month (1.8%). A similar pattern was found for those visiting pubs and bars more frequently.

The What About YOUth survey (Smoking, Drinking and Drug Use Among Young People in England 2014) found that:

- 5% of 15 year olds had used cannabis in the last month
- 9% had used cannabis in the last year, and 2% had used it more than a year ago

- 13% said that they had been offered drugs other than cannabis and 2% had tried other drugs.

In April 2013, local authorities, supported by health and wellbeing boards, became responsible for commissioning drug misuse treatment services (Health and Social Care Act 2012). The Home Office's Drug strategy annual review: 2014 to 2015 highlights the key role local authorities play in helping to reduce both the supply of, and demand for, illicit drugs. This includes preventing problematic drug use and helping people to recover from drug addiction by developing their personal and social capital, through providing education, housing, public health and social care services.

The government's national drug strategy for England 2010 sets out plans for helping people to live a drug-free life. The second annual review was published in 2013 (Drug strategy: 2012 to 2013). The Drug strategy 2010: evaluation framework outlines how the strategy's effectiveness and value for money will be evaluated.

The Public Health England and Association of Directors of Public Health Review of drug and alcohol commissioning (2014) identified that in many areas there is a continued desire to improve outcomes, delivery and performance, but service funding may be uncertain. The primary focus for many areas is treatment rather than prevention. Drug services are increasingly integrated with services for alcohol, younger people, criminal justice and local health delivery.

More information

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

The committee's discussion

Evidence statement numbers are given in square brackets. For an explanation of the evidence statement numbering, see the evidence reviews section.

Approach of this guideline

The committee discussed the groups at risk presented in the scope for this guideline. Based on the evidence considered, it agreed that the recommendations should be targeted at these groups. The committee also noted there may be additional groups who have not been considered, such as adults who have been in contact with the criminal justice system, and that some people would be included in more than 1 at-risk group.

The committee understood that the nature of drug use varies within the specified groups at risk. The guideline includes people who are not currently using drugs through to people who are known to use drugs occasionally or recreationally. Recommendations for treating people who are dependent on drugs are outside the scope of this guideline.

The committee discussed that this guideline only covers direct prevention of drug misuse for groups at risk and the evidence base for universal approaches or wider determinants of drug use was not considered. The committee noted the importance of considering the recommendations in this guideline alongside others on preventing and managing drug use (for more information see the NICE pathway on drug misuse).

Wider determinants, such as housing, education and employment opportunities, social support and personal resilience can have a fundamental impact on both the risk of drug use and the effectiveness of drug misuse interventions. The committee developed the recommendations on the assumption that they would be considered alongside other relevant NICE guidance, such as social and emotional wellbeing in primary and secondary education, alcohol-use disorders, looked-after children and young people and community engagement.

Overview of the effectiveness and acceptability evidence

The committee noted that there is limited evidence for effectiveness and acceptability of drug misuse prevention interventions across the groups at risk.

No effectiveness evidence was identified for 3 of the groups at risk in the scope: people involved in commercial sex work [ES1.5] or who are being sexually exploited,

people not in employment, education or training [ES1.9] and people who attend nightclubs and festivals [ES1.25]. There was either no, or limited, effectiveness and acceptability evidence identified for one-to-one skills training, information provision and advice delivered as part of planned outreach activities [ES1.45, ES1.47, ES2.35, ES2.36] or using peer education initiatives [ES1.46, ES2.37, ES2.38].

No acceptability evidence was identified for 4 of the groups at risk in the scope: people with mental health problems [ES2.1, ES2.2], people involved in commercial sex work [ES2.3, ES2.4], people not in employment, education or training [ES2.7, ES2.8], and children and young people whose parents use drugs [ES2.9, ES2.10].

The committee acknowledged that most studies compared an intervention to standard care, assessment only or another intervention rather than no intervention. The committee agreed that data showing no significant difference between the intervention and comparator could be the result of both the intervention and comparator improving the outcome by a similar amount, rather than the intervention not having an effect at all, as shown in the study by Edwards et al. (2006) [ES1.1].

The committee noted that none of the studies reported any adverse effects such as death or overdose. Therefore, it agreed that the interventions in the included studies were unlikely to be harmful, and were likely to be at least as effective as the comparator.

The committee agreed that the acceptability studies found that drug misuse prevention interventions are generally well received.

Overview of the cost-effectiveness evidence

The committee noted that the literature review for cost-effectiveness evidence did not find any studies that were directly relevant to drug misuse prevention in the UK and so health economic modelling was undertaken.

Health economic modelling was undertaken on 7 interventions that were identified in evidence review 1. The committee acknowledged that the health economic modelling did not identify any drug misuse prevention interventions that were cost effective in the base case [ES4.1, ES4.2, ES4.3, ES4.4, ES4.5, ES4.6, ES4.7].

However, the results of the modelling did suggest that some interventions, such as those that are web-based or family-based, could be cost effective if they could be provided at a lower cost and their effects sustained over a longer duration [ES4.2, ES4.3, ES4.6]. Generally, for a drugs misuse prevention intervention to be cost effective it would need to cost less than £100 per person and would need to reduce drug use by 5 percentage points (for example, from 20% to 15% of the population), maintained over 2 years [ES4.8].

The committee acknowledged that there are several reasons why the interventions included in the health economic modelling do not appear to be cost effective. Most of the interventions only have a marginal effect on drug use, and there is no evidence that the interventions maintain any reduction in drug use for more than 1 year. In addition, most of the studies looked at cannabis and ecstasy use, which have lower social costs than more harmful drugs. This means it is difficult to make a large reduction in social costs.

The committee agreed it remains unclear whether there is a causal link between use of 1 substance and other substances (the 'gateway hypothesis') and what the resulting impact a causal relationship might have on costs to the NHS (or society more broadly). So committee members agreed that the relationship should not be assumed within the economic model.

Section 1.1 Delivering drug misuse prevention activities as part of existing services

The discussion below explains how we made the recommendation in section 1.1.

Recommendations 1.1.1 and 1.1.2

The committee noted the difficulty in separating interventions to prevent drug misuse (including harm reduction interventions) and low-level targeted interventions for treating drug misuse. The committee heard expert testimony that the focus of commissioning new drug misuse prevention interventions is changing [EP1]. Many areas are increasingly integrating drug misuse prevention activities with drug treatment or wider health and social care activities, such as sexual health or educational support services to address truancy [EP1].

The committee acknowledged that substance misuse rarely happens in isolation and many people at increased risk of drug use are already in contact with services such as mental health, criminal justice (including youth justice), alcohol and drug misuse, sexual and reproductive health, services for looked-after children, accident and emergency services, and specialist services for sex workers. The committee members heard expert testimony that local authorities are well placed to address some groups at risk, for example, looked-after children [EP1]. However, they also need to collaborate with wider services, such as healthcare services, schools, or police and crime commissioners [EP1].

The committee noted that none of the interventions included in the health economic modelling were cost effective as standalone programmes (see overview of the cost-effectiveness evidence) [ES4.1, ES4.2, ES4.3, ES4.4, ES4.5, ES4.6, ES4.7]. However, they would be cost effective if added to existing programmes of care at an additional cost of less than £100 per person [ES4.9].

Taking into account the changing focus of commissioning, wider determinants of drug use, and the health economic modelling, the committee recommended that drug misuse prevention interventions should be delivered through a range of existing services for people at increased risk.

Section 1.2 Assessment

The discussion below explains how we made recommendations in section 1.2.

Recommendations 1.2.1, 1.2.2, and 1.2.3

The committee discussed assessing people in groups at risk. It noted that an assessment of drug use was a consistent part of effective interventions included in evidence review 1. Studies comparing assessment only with no intervention were not identified, but the committee discussed that where comparator groups were offered assessment, improved drug or other outcomes were consistently reported. The committee also noted evidence from evidence review 2 that assessments of substance use and other risk behaviours may prompt reductions in drug use [ES2.22].

The committee discussed that a targeted approach would be more likely to be cost effective. The committee agreed that drug misuse prevention activities cannot be targeted to people most vulnerable to drug misuse if those people have not been assessed. The committee agreed that it was essential to have an assessment prior to intervention to ensure that appropriate care can be provided. They noted that undertaking assessment prior to an intervention is consistent with the related NICE guideline on drug misuse in overs 16s: psychosocial interventions.

The committee agreed that an assessment should be undertaken before care is offered, to ensure appropriate care is provided and no harm is done. This assessment could be either routine (such as health needs assessments for looked-after children) or opportunistic (such as when someone attends an emergency department as a result of alcohol or drug use, or when young offenders come into contact with the criminal justice system), as many different professionals could be working with people at risk of drug use and they have an important role in drug misuse prevention, even if they do not specifically provide drug misuse prevention activities.

The committee agreed that all professionals who have contact with people in groups at risk, including people working in health services, social care services and the criminal justice system, should be aware of drug misuse prevention and should use every contact to make a difference.

The committee discussed the importance of an assessment considering the wider health and personal impacts of any drug use, such as how a person's social, health and educational or employment circumstances may affect their vulnerability to drug use. They also discussed the importance of assessment addressing the possible harm associated with potential drug use by that person. The committee therefore recommended that routine or opportunistic assessments should be used to assess vulnerability to or existing drug use. It also recommended that people undertaking assessments should be aware that drug use may not be the highest priority of people at risk of drug use, especially if they have complex needs and circumstances.

The committee discussed the nature of the assessment and felt it was not possible to recommend a particular assessment tool because of the wide range of people in

the groups at risk. The committee was aware that in substance misuse interventions for drug misuse prevention in vulnerable under 25s, the Common Assessment Framework was recommended as an assessment tool. But the committee did not believe that this tool is used in existing assessments, so did not think it was appropriate to recommend using it. The committee noted evidence that a non-judgemental approach was more acceptable to participants [ES2.17, ES2.20, ES2.32].

The committee acknowledged that people working with groups at risk need to have an understanding of the potential vulnerabilities to drug use, that people may present with more than 1 vulnerability, and that people who do present with more than 1 vulnerability may be at increased risk of drugs use. The committee noted that existing tools may not fit easily into a routine or opportunistic assessment, but it agreed that best practice would be to use a validated or locally agreed approach. The committee recommended that a respectful and non-judgemental approach is used, but was unable to recommend a specific assessment tool.

Recommendation 1.2.4

The committee agreed that an assessment might identify people who are already misusing drugs and that, as previously discussed, it can be difficult to make a distinction between occasional or recreational use and regular or excessive use. Care for people who use drugs or alcohol regularly or excessively is outside the scope of this guideline, but there are NICE guidelines on psychosocial interventions and opioid detoxification in drug misuse for people aged 16 years and older and also on prevention and management of alcohol-use disorders for people aged 10 years and older. So the committee recommended that if there are concerns about regular or excessive drug use, people should be referred to treatment services.

Section 1.3 Skills training for children and young people who are vulnerable to drug use

The discussion below explains how we made recommendations in section 1.3.

The committee noted that the health economic team modelled 7 interventions that were more intensive than a routine or opportunistic assessment. None of these were cost effective in the base case as a standalone intervention (see overview of the

cost-effectiveness evidence) [ES4.1, ES4.2, ES4.3, ES4.4, ES4.5, ES4.6, ES4.7]. The committee discussed under which circumstances drug use was likely to be reduced by 5 percentage points, therefore making an intervention cost-effective.

The committee agreed that people in the groups at risk whose personal circumstances put them at increased risk could be described as vulnerable to drug use. The committee agreed that a reduction of at least 5 percentage points in the number of people misusing drugs was most likely to occur in people who are vulnerable to drug use.

The committee agreed that not all people in an at-risk group will use drugs, but that drug use is more likely in some people within each at-risk group than others, such as those in multiple groups at risk, whose personal circumstances put them at increased risk, who may already be using drugs on an occasional basis, or may already be misusing another substance, such as alcohol.

Taking into account that intensive interventions are only likely to be cost effective in people who are vulnerable to drug use, the committee recommended that more intensive interventions are prioritised for those with increased vulnerability, such as those in multiple groups at risk, whose personal circumstances put them at increased risk, who may already be using drugs on an occasional basis, or may already be misusing another substance, such as alcohol.

Recommendation 1.3.1

Effectiveness and acceptability of skills training

Evidence for the effectiveness of personal and social skills training for children and young people at risk of drugs misuse in combination with training for their parents and carers came from 4 studies reported in 4 papers [ESc]. Two trials reported a significant reduction in drug use, including a trial undertaken with looked-after children or young people and their foster carers.

Although 1 of these trials reported an increase in cannabis use, it also reported a decrease in the use of drugs other than cannabis. The committee believed this may be a result of participants changing their drug use from other drugs to cannabis during the study. An additional study did not report a significant reduction in drug use

after the intervention; however, in this study, drug use was only measured immediately after the intervention and no longer term data were collected. There was evidence from 3 studies of a significant improvement in personal and social skills after skills training for children and young people and their parents or carers.

The committee noted that there was evidence from evidence review 2 that group-based skills training [ES2.33, ES2.46] and opportunistic skills training, advice and information provision are acceptable to participants [ES2.39]. It agreed that offering skills training to both children and young people and their parents or carers was in line with the integrated approach to drug misuse prevention (see delivering drug misuse prevention activities as part of existing services). However, it also acknowledged that it may not be appropriate to include parents and carers in all cases, such as where children have been sexually exploited.

Personal and social skills training alone for children and young people at risk of drug misuse could not be recommended because the evidence was limited and inconsistent [ESa]. Two studies of the effectiveness of skills training for children and young people showed an inconsistent effect on drug use, with the use of some drugs being significantly reduced but the use of other drugs not changing significantly. A third study reported no difference in drug use after skills training for children and young people.

One study reported a significant improvement in drug refusal skills, problem solving skills, and coping skills after the intervention. Another study concluded that skills training for children had no significant effect on feelings of self-worth, but it did not report data, p values or an effect size. One study reported that the intervention may have affected intention to use drugs, but the data were not reported. Another study reported a statistically significant improvement in knowledge of drugs and their risks after the intervention with peer educators but not with adult educators.

Personal and social skills training alone for parents and carers of children and young people at risk of drug misuse was not recommended because it was not clear that skills training alone had a significant effect on drug use in the children and young people they cared for. Evidence for the effectiveness of skills training for parents or carers came from 4 trials reported in 7 papers [ESb].

One trial and 2 follow-up studies reported no statistically significant difference in drug use. Three trials and a secondary analysis of one of the trials reported significantly reduced drug use after the intervention. However, 2 of the trials that reported significantly reduced drug use included other interventions for the families in addition to skills training, such as case management, weekly family therapy, individual therapy, and motivational interviewing, and it is not clear whether the skills training of the other interventions had a significant effect on drug use.

The committee acknowledged the evidence that family-based interventions have a mixed effect on drug use, with 7 studies showing a significant reduction in drug use, 7 studies showing no significant effect on drug use, and 1 study showing a significant increase in drug use [ES1.50]. However, the committee noted that the evidence base included studies of Multidimensional Treatment Foster Care and motivational interviewing, which are more intensive than skills training alone. The committee was aware that family-based interventions were recommended in NICE's guideline on substance misuse interventions for vulnerable under 25s, but it noted that this recommendation included motivational interviews and family therapy that were very unlikely to be cost effective for the populations included in the current guideline.

Based on the effectiveness and acceptability evidence, the committee agreed that skills training for children and young people as well as for their parents or carers was likely to be an effective way to reduce drug use. It did not believe there was enough evidence to recommend skills training just for children and young people, or just for their parents or carers. The committee reiterated that any skills training should be delivered as part of existing services, as in recommendation 1.1.1.

Cost-effectiveness of skills training

The health economic modelling looked at 3 family-based interventions that included skills training [ES4.1, ES4.3, ES4.7]. None of the interventions were found to be cost effective in the base case scenario, however, the committee noted that these interventions involved more activities than skills training, such as motivational interviewing, which would have made them more costly. The committee noted the results of the modelling showed that 2 of the interventions could be cost effective if the cost of delivering them was lower, and the effects of the interventions could be sustained over 2 years or more [ES4.3, ES4.7]. It also noted that interventions could

be made cost effective if they were added to existing programmes of care at an additional cost of less than £100 per person [ES4.9].

The committee agreed that integrating skills training for children and young people and their parents or carers into existing services could lower the additional cost of the interventions and therefore be a cost-effective way to deliver drug misuse prevention interventions. The committee heard from an expert that integrating skills training into existing services is becoming a more common approach [EP1].

Based on the cost-effectiveness evidence, the committee recommended that skills training for children or young people and their parents or carers should be considered as part of existing services (see discussion section on recommendation 1.2.1).

Recommendation 1.3.2 and 1.3.3

The committee discussed the wide variation in age and developmental stage in the groups at risk. The committee noted that skills training sessions can be used for people of different ages; however, sessions aimed at a young child might not be appropriate for a young adult. So the committee recommended that age and developmental stage should be taken into account when deciding on the details of the skills training sessions.

The committee considered other aspects that might influence the effectiveness of skills training offered to children and young people. It agreed that presenting vulnerabilities, cultural context, religion and ethnicity would be important, and recommended that these be taken into account, along with any other specific needs of the child or young person, when deciding the details of what training sessions to provide. It also noted the evidence that interventions should be made engaging, relevant and creative [ES2.18, ES2.12].

The committee considered whether interventions should be provided one-to-one or in a group-based setting. It acknowledged there was mixed evidence for the effectiveness of group-based behaviour therapy (including skills training) for children and young people [ES1.54] but that it is generally well received [ES2.13]. The committee agreed that group-based skills training is likely to cost less per person, and therefore be more cost effective, than one-to-one skills training. There was little

evidence on the effectiveness of one-to-one skills training but the committee acknowledged that group environments may not be appropriate for everyone in groups at risk. So it recommended taking into account the child or young person's needs when deciding whether sessions should be provided one-to-one or in groups.

The committee considered the number and duration of skills training sessions that should be delivered. It acknowledged that the overall effectiveness of family-based interventions did not appear to vary by the intensity or duration of the intervention [ES1.68]. However, it was not clear whether this was also true for the subset of family-based interventions that included skills training sessions for children or young people and their parents or carers. Studies used different numbers and durations of training sessions, and the committee noted no consistent pattern of effectiveness.

The committee felt unable to recommend a specific number or duration of sessions. However, it acknowledged that skills training is likely to be offered as part of a larger programme, in which skills related to drug misuse prevention may be a small part of each training session. Therefore, the committee recommended that skills training should consist of 2 sessions as a minimum. The committee recommended taking the needs of the child or young person into account when determining the number and duration of skills training sessions. It also recommended discussing and agreeing a plan for future follow-up at the skills training sessions to determine whether additional skills training or referral to specialist services is needed.

The committee also considered where skills training interventions should be delivered. It noted evidence that participants reported having access to a trusted setting in which they are surrounded by likeminded peers could stop them using drugs [ES2.19]. The committee recommended that the settings in which skills training will be delivered should also be considered.

Recommendations 1.3.4, 1.3.5, 1.3.6 and 1.3.7

The committee discussed the content of skills training sessions, noting that different types were used in different studies and that most studies included training on more than 1 type of skill. Skills training interventions for children and young people that successfully reduced drug use and improved personal and social skills included skills such as listening skills, social skills, conflict resolution skills and refusal skills, and

how to identify and manage stress, make decisions, cope with criticism, deal with feelings of exclusion, and how to make behaviour choices [ES1.7, ES1.8, ES1.11, ES1.13, ES1.15, ES1.21, ES1.23].

The committee noted that skills training interventions for parents and carers of children at risk of drug use that successfully reduced drug use and improved personal and social skills included skills such as communication skills, relationships skills, conflict resolution skills, and problem-solving skills, as well as how to use behaviour reinforcement strategies [ES1.11, ES1.13, ES1.15, ES1.17, ES1.21, ES1.23, ES1.57, ES1.58, ES1.60]. So the committee recommended that skills training should develop a range of skills, with the skills used in the studies as examples.

The committee agreed that skills training for looked-after children and their carers needed particular consideration. Successful skills training interventions for looked-after children and young people included social skills and how to deal with feelings of exclusion [ES1.13] and, for foster carers, how to use behaviour reinforcement systems [ES1.13, ES1.14]. So the committee recommended that skills training for foster carers emphasised these skills.

Recommendation 1.3.8

The committee considered factors that may affect the skills training offered to parents or carers of children at risk. It discussed the different levels of understanding about health (health literacy) across groups of people and noted that there is likely to be large variation in the health literacy of parents or carers. The committee also noted that NICE's guideline on patient experience in adult NHS services: improving the experience of care for people using adult NHS services recommends taking people's general literacy levels into account to meet their needs. The committee agreed that the level of health literacy of people receiving skills training needs to be considered to ensure training is effective, and recommended tailoring the training to the person's health literacy.

The committee noted evidence that a non-judgemental approach was more acceptable to participants [ES2.17, ES2.20, ES2.32]. It therefore recommended using a respectful and non-judgemental approach.

Section 1.4 Providing information to adults who are vulnerable to drug use

The discussion below explains how we made recommendations in section 1.4.

Recommendation 1.4.1

The committee was unable to recommend skills training for adults at risk of drug use as the evidence was not strong enough [ESd]. The committee noted that only 1 study of skills training for adults at risk of drug use significantly reduced drug use compared with no intervention, and the same study also reported no significant difference in drug use compared with psychoeducation. The committee acknowledged there was mixed evidence for the effectiveness of group-based skills training as a whole, however, it noted that this evidence included studies in children and young people at risk of drug use, as well as adults [ES1.42].

The committee noted the discussion that motivational interventions are unlikely to be effective, and are not cost effective (see motivational interventions). The committee agreed that, as a whole, motivational interventions were unlikely to be significantly more effective than other interventions or standard care, and cost considerably more. The committee was therefore unable to recommend their use in adults at risk.

The committee agreed it was important to provide guidance on what 'standard care' should involve so that it was clear the committee was not recommending that no action should be taken. The committee considered what components made up 'standard care' in studies where motivational interventions were found to be as effective as standard care [ES1.2, ES1.22, ES1.36, ES1.37], and found that standard care included brief information, education and feedback. The committee agreed that advice and information are likely to be part of standard care in specialist services such as sexual health, although this may not be done in primary care. It recommended that adults who are assessed as vulnerable to drug use should receive these components and also recommended research in this area (research recommendation 5).

The committee considered whether additional components should be added to the care of adults at increased risk of drug use. It agreed that information on sources of advice or support would be helpful for adults at increased risk. The committee

agreed that information and advice should be offered at the time of their assessment (see recommendation 1.2.1).

Recommendation 1.4.2

The committee considered whether the information and advice should be provided in a verbal or written format. The committee acknowledged the evidence from 1 study that participants did not find written information as useful as verbal information [ES2.27] and they thought it was outdated [ES2.31]. However, it noted that this may not be true for all written information and that written information can be useful for people who want to revisit information in their own time. The committee noted the evidence that participants stressed the value of being able to ask questions [ES2.31]. The committee therefore recommended that information and advice is provided in a written and verbal format.

The committee considered factors that may affect the provision of information to adults who are vulnerable to drug use. It discussed the different levels of understanding about health (health literacy) across groups of people and noted that there is likely to be large variation in health literacy among adults who are vulnerable to drug use. The committee also noted that NICE's guideline on patient experience in adult NHS services: improving the experience of care for people using adult NHS services recommends taking people's general literacy levels into account to meet their needs. The committee agreed that health literacy needs to be considered when providing information to adults who are vulnerable to drug use.

The committee noted evidence that a non-judgemental approach was more acceptable to participants [ES2.17, ES2.20, ES2.32]. It therefore recommended using a respectful and non-judgemental approach.

The committee noted that NICE has existing guidance on behaviour change: general approaches and behaviour change: individual approaches, and recommended that information is provided in line with these guidelines.

Recommendation 1.4.3

The committee considered the number of information sessions needed for adults who are vulnerable to drug use. It agreed that the approach used to provide

information will need to vary to account for the wide range of adults who are vulnerable to drug use. So the committee recommended that a plan for future follow-up is discussed and agreed at the time of the person's assessment (see recommendation 1.2.1).

Section 1.5 Raising awareness about drug use among people not in contact with services

The discussion below explains how we made recommendations in section 1.5.

Recommendations 1.5.1 and 1.5.2

The committee discussed the groups at risk that may not present to health or social care services. Committee members heard from an expert that people who use image- and performance-enhancing drugs are less likely to present because they may not identify as drug users [EP2]. They noted that people in some of the groups at risk may not be in contact with existing health or social care services (for example, people who go to nightclubs and festivals) [EP2] or may only be in contact with wider health services, such as sexual and reproductive health services (for example, people who are lesbian, gay, bisexual or transgender). People may also avoid seeking advice because much drug use involves illegal drugs [EP2].

The committee considered what drug misuse prevention services could be offered to people at risk who do not present to health or social care services. Digital technologies can allow access for people who are either unable or choose not to access services, and can offer anonymity. The committee noted the evidence showed that web-based interventions did not significantly reduce drug use [ES1.48] compared with assessment only [ES1.32, ES1.33] or a waiting list control [ES1.34]. However, 1 study did show promising effects of web-based information and advice in a subgroup analysis of those with a family history of drug problems (Lee et al, 2010) and web-based interventions were generally well received [ES2.29, ES2.30, ES2.41].

The health economic modelling did not find web-based interventions to be cost effective in the base case (£329,000 per QALY). If it was delivered at a cost of less than £1 per person, it would be less costly and more effective than a 'do nothing' alternative [ES4.2].

The committee considered that it may be feasible to produce web-based interventions at a low cost and was aware of existing online sources of information, including NHS Choices. The committee therefore recommended that targeted new media, including information on websites, giving reliable information and online self-assessment and feedback to help people assess their own drug use could be provided to people at increased risk, particularly those less likely to be in contact with health and social care services. The committee noted that some people at risk may not be able to access online services and recommended that written information should be made available for people not in contact with health or social care services. The committee also recommended that information given to people not in contact with health or social care services should include information on local services and sources of advice and support.

Recommendation 1.5.3

The committee noted that NICE has existing guidance on behaviour change: general approaches and behaviour change: individual approaches, and recommended that information is provided in line with these guidelines.

Evidence not used to make a recommendation

The committee did not make recommendations for all of the evidence statements. For some interventions, the effectiveness evidence was not strong enough or was too inconsistent to make a recommendation for or against using an intervention [ES 1.1, ES1.7, ES1.10, ES1.12, ES1.14, ES1.17, ES1.18, ES1.20, ES1.67]. Some evidence statements stated that no relevant evidence was identified [ES1.5, ES1.9, ES1.25, ES1.45, ES1.46, ES1.63, ES1.66, ES1.69, ES2.1, ES2.2, ES2.3, ES2.4, ES2.7, ES2.8, ES2.9, ES2.10, ES2.14, ES2.24, ES2.35, ES2.36, ES2.37, ES2.38, ES2.44, ES2.48, ES2.49].

The committee was unable to consider evidence on the acceptability or cost-effectiveness for interventions that were either not effective at reducing drug use or interventions where no effectiveness evidence was identified [ES2.5, ES2.15, ES2.16, ES2.21, ES2.22, ES2.23, ES2.25, ES2.26, ES2.27, ES2.28, ES2.31, ES2.34, ES2.40, ES2.45, ES3.1, ES3.2, ES3.3]. For details of the evidence statements used to make recommendations, see the evidence reviews section.

The committee discussed the different outcomes reported in the studies identified in the evidence reviews. It noted that drug use behaviour does not always reflect attitudes and intentions towards drug use. It was agreed that drug use outcomes were the most important outcomes from the evidence. Therefore, where use was reported, other outcomes were not prioritised when the committee drafted recommendations. Some evidence statements reported on outcomes other than drug use for interventions where drug use outcomes were reported, so were not used to make recommendations [ES1.3, ES1.4, ES1.24, ES1.38, ES1.39, ES1.40, ES1.41, ES1.43, ES1.44, ES1.51, ES1.52, ES1.53, ES1.55, ES1.56, ES1.59, ES1.60, ES1.61].

It was unclear from the evidence whether the effectiveness of an intervention varies by who delivers it [ES1.64, ES1.65]. The committee discussed the importance of the skills and competencies of people delivering assessments and interventions. It agreed that people should have training and continuing professional development to ensure that interventions can be delivered effectively.

The committee noted that little evidence was found for whether the effectiveness of interventions varied by the content and framing of the intervention [ES1.62]. In addition, no evidence was found for whether the effectiveness of interventions varied by mode of delivery [ES1.63], where the intervention was delivered [ES1.66], or the intended recipient of the intervention [ES1.69].

The committee was aware that the evidence review did not find any evidence on drug misuse prevention strategies for image- and performance-enhancing drugs or new psychoactive substances. Committee members heard expert testimony that it is difficult to identify and intervene when people are using these drugs, as they tend not to label themselves as drug users. In addition, image- and performance-enhancing drugs are available online and so can be accessed by a wide range of people. So the committee recommended research is undertaken in this area (research recommendation 7).

Manualised and licensed programmes

Evidence review 1 included evidence for manualised and licensed programmes if the study papers reporting on the programmes met the inclusion and exclusion criteria of

the review. The committee noted that the manualised and licensed programmes identified in the included study papers were Focus on Families [ES1.10], Family Competence Program [ES1.11], Multidimensional Treatment Foster Care [ES1.14, ES1.18], Familias Unidas [ES1.17] and Free Talk [ES1.19].

The committee noted that such programmes are costly, and the studies either showed no significant effect on drug use [ES1.10, 1.19], an inconsistent effect on drug use [ES1.14, ES1.18], or did not report drug use outcomes [ES1.11]. The committee also acknowledged that it may be difficult to find a setting where a programme can be used as it was initially designed and that adapting programmes for use in the UK or to make them shorter or cheaper could lead to them being made less effective. The committee concluded that it could not recommend adapting existing manualised and/or licensed drug misuse prevention programmes for use in the UK.

Motivational interventions

The evidence review identified 3 main types of motivational intervention: 'motivational interviewing', 'brief interventions' and 'motivational enhancement therapy' (see evidence tables for details of the interventions). The committee noted that most studies did not clearly describe the intervention used and used terminology that may not match the committee's understanding. It acknowledged that the programme development group for NICE's guideline on behaviour change: individual approaches noted similar issues, concluding that it was impossible to recommend motivational interviewing because the studies did not specify which principles and components were used. The committee therefore considered the evidence for motivational interventions as a whole.

The committee noted that there were 15 unique trials of motivational interventions (motivational interviewing, brief interventions and motivational enhancement therapy) [ESe, ESf, ESg]. Of these, only 4 trials reported significant reductions in drug use. One trial showed a significant reduction in drug use compared with no assessment or intervention, but no significant reduction in drug use compared with education or information. The committee agreed that, as a whole, motivational interventions were unlikely to be significantly more effective than other interventions (such as skills training) or standard care.

The committee discussed the health economic modelling for motivational interventions. It showed that motivational interviewing was not cost effective in the base case, ranging from £131,000 per QALY gained to £485,000 per QALY gained [ES4.4, ES4.5, ES4.6]. The modelling showed that motivational interviewing would only be cost effective if it could be delivered for less than £190 and could reduce drug use for at least 2 years [ES4.4, ES4.5, ES4.6]. The committee agreed that motivational interventions were unlikely to be cost effective compared with other interventions or standard care.

Taking into account the uncertainty in the terminology, the effectiveness and cost-effectiveness evidence, the committee concluded that it was unable to recommend motivational interventions for groups at risk. The committee recommended that research is undertaken in this area (research recommendation 4).

Digital technologies

The committee considered digital technologies other than web-based interventions that could be used for drug misuse prevention interventions. It acknowledged the evidence that responsive text messaging can reduce the odds of cannabis use in some contexts, but not others [ES1.49], and is generally acceptable to young people [ES2.42, ES2.43]. It noted that the study also involved face-to-face brief motivational enhancement therapy, which is unlikely to be cost effective (see motivational interventions). The committee agreed there was a lack of evidence for the effectiveness of interventions using only digital technologies.

The committee recommended that further research is needed into digital technologies (research recommendation 3).

Limitations of the evidence

Limitations of the effectiveness and acceptability evidence

The committee noted that most of the included studies used small sample sizes, short follow-up times, self-reported drug use and intermediate outcomes (such as knowledge about drugs, rather than change in drug-using behaviour). It was not possible to determine whether some studies were poorly conducted or poorly reported. Some studies may not have been adequately powered to identify

significant differences between groups. In addition, some participants in some studies did not attend any of the intervention sessions, and many studies did not include a true control group. As a result, the efficacy of the intervention could have been underestimated in these studies.

The committee noted that single small studies were presented for more than 1 group at risk, resulting in multiple evidence statements from the same studies. This makes the evidence base look larger and stronger than it actually is.

The committee acknowledged that limited evidence was available on the effectiveness of interventions in the UK. Most interventions considered were undertaken in the US. Although the evidence is likely to be applicable in the UK, the committee discussed that key differences in social norms, education, care, criminal justice and healthcare systems may influence the effectiveness of interventions transferred to UK settings. In addition, the committee noted that the comparators included in the studies may vary from those seen in the UK. It also agreed that 'standard care' was not well defined or consistently reported in the studies and can vary depending on which at-risk group is included in a study, and on the country where the study was conducted.

The committee discussed that some of the interventions in the studies were likely to have been delivered in a research setting, for example, a university research facility. It was felt that the results may have been different if the interventions had been delivered in real-world settings, such as homeless shelters, nightclubs or music events, youth clubs and organisations, or environments where drugs may be used in a sexual context (such as 'chemsex' parties).

The committee agreed that the group 'people who are known to use drugs occasionally or recreationally' represents a diverse population, and although several studies were identified for this group, it is likely that the evidence does not cover the whole target population.

The committee noted that good-quality evidence is still lacking for some groups at risk, despite the research recommendations made in NICE's previous guideline on substance misuse interventions for vulnerable under 25s. Committee members agreed that more evidence from well-designed and adequately powered studies is

needed. The committee recommended that research is undertaken on the effectiveness and acceptability of drug misuse prevention interventions in groups at risk (research recommendations 1 and 2).

The committee noted that studies of pregnant women were excluded from the evidence reviews for this guideline. There is existing NICE guidance on Pregnancy and complex social factors, which includes substance misuse in pregnant women. General antenatal and postnatal care is covered in existing NICE guidance. In addition, it was agreed that studies on drug use in pregnant women are most likely to be studies of treatment for dependent drug users rather than prevention studies.

Limitations of the cost-effectiveness evidence

The studies used in the health economic modelling were identified in the evidence review and therefore the limitations of the studies in the evidence review also apply to the cost-effectiveness evidence.

The committee noted that the impact on someone of having a criminal record was not taken into account in the health economic modelling. It acknowledged that drug use can lead to a criminal record, and that people with a criminal record have difficulties securing employment; therefore, avoiding a criminal record is a potential positive outcome of drug misuse prevention activities. It agreed that including the impact on an individual of having a criminal record in the health economic modelling would have increased the cost-effectiveness of the interventions.

The committee also recognised that the long-term harms and associated costs of cannabis use are mostly unknown. The size of the groups at risk is unknown, and it is not known what percentage of people in these groups will go on to misuse drugs. These factors will affect the accuracy of the health economic modelling. The committee therefore recommended research is done on the long-term consequences of drug use (research recommendation 6).

Terminology

The committee discussed that many terms used in the literature to describe drug use are subjective and often used inconsistently or interchangeably (for example, terms such as ‘use’, ‘misuse’, ‘occasional’ or ‘recreational’, ‘dependency’, and ‘abuse’). It

discussed that the definition of 'recreational' use in particular was subjective. For example, fortnightly use of cannabis by an adult might be considered recreational, but it may not be by a child or young person.

Although treatment for drug misuse fell outside the remit of this guideline, there is an overlap between treatment and harm reduction in this field and some studies of harm reduction interventions may have been misinterpreted as treatment studies, and so would not have been considered in this guideline. The committee noted NICE has a range of products that cover drug misuse, and in particular that treatment has been considered by related NICE guidelines (Drug misuse in over 16s: psychosocial interventions and Drug misuse in over 16s: opioid detoxification).

Existing NICE guidance

The committee was aware of several relevant pieces of NICE guidance.

The committee considered the NICE guideline on behaviour change: individual approaches in the context of the current guideline. That guideline recommends delivering very brief, brief, extended brief and high intensity behaviour change interventions and programmes to people who are at risk of damaging their health through either their behaviour or sociodemographic characteristics.

The committee for that guideline considering the evidence for it noted that, across all interventions, those targeting the general population were more likely to be cost effective than those aimed at vulnerable populations, although it is important to note that evidence directly relating to drug misuse was not included. The committee for that guideline also noted similar difficulties to the committee for this guideline in understanding the terminology used in the studies.

The committee did not think it was appropriate to directly apply the recommendations from 'behaviour change: individual approaches' to the groups at risk in this guideline as the evidence base for that guideline did not include studies of drug misuse interventions. However, it was agreed that those recommendations should be kept in mind when following the recommendations in the current guideline.

The committee considered the NICE guideline on alcohol-use disorders: prevention to be particularly relevant to this guideline as many people who misuse drugs also

misuse alcohol (Klimas et al 2014). This can result in people having multiple issues when they present to healthcare services. However, the committee noted that alcohol misuse is not illegal, allowing data to be collected more easily and for environmental-level interventions to be more easily implemented. The committee agreed that the recommendations for alcohol misuse prevention cannot be directly translated into recommendations for drug misuse prevention because of the lack of data for drug misuse prevention. The committee agreed that, because of the large overlap in the target populations of the current guideline and 'alcohol-use disorders: prevention', the recommendations in 'alcohol-use disorders: prevention' should be kept in mind when providing drug misuse prevention activities.

The committee considered the NICE guidelines on psychosocial interventions and opioid detoxification in drug misuse. It noted that treatment of drug misuse was outside of the scope of this guideline, but acknowledged that it can be difficult to distinguish between prevention and treatment strategies. The committee agreed that people who are drug dependent may be identified during the prevention activities recommended in this guideline, and that NICE's guidelines on psychosocial interventions and opioid detoxification in drug misuse can be used to determine what treatment should be provided. The committee highlighted that the existing NICE guidelines on the treatment of drug misuse do not include recommendations for children and young people under the age of 16.

The committee also noted that NICE's guidelines on child maltreatment, needle and syringe programmes, attention deficit hyperactivity disorder, looked-after children and young people, and dual diagnosis (guideline in development) are relevant to drug misuse prevention, and that this guideline should be considered in the context of this guidance.

Recommendations from 'substance misuse interventions for vulnerable under 25s'

The committee discussed the recommendations and considerations in the guideline being updated: substance misuse interventions for vulnerable under 25s (PH4) and considered the view of the experts in the review decision. It acknowledged that the populations included in the scope for the above guideline differ to some extent to

those included in the current guideline. The current guideline also includes adults aged over 25. The current guideline does not include black, Asian and minority ethnic groups as a specific at risk group as they are no longer considered an at-risk group. The current guideline also did not include people who were considered at risk or vulnerable without further explanation.

The new guidance only includes children and young adults in contact with young offender teams but not in secure environments, in contrast to PH4 which included young offenders per se as an at risk group – so some of the evidence considered for guideline development is likely to differ. Despite this, the committee agreed that it had considered sufficient evidence on effectiveness and cost-effectiveness on the groups at risk for this guideline, along with their wider knowledge of this topic area and current provision, to make a judgement on the recommendations from PH4.

The committee agreed that recommendation 1 and recommendation 2 from 'substance misuse interventions for vulnerable under 25s' should be withdrawn because they are now covered in the implementation section of the current guideline.

It also agreed that recommendation 3 should be replaced with the current recommendations. The committee discussed that although the family-based interventions that it had considered were effective, they were not shown to be cost effective. Similarly, the intensive family-based intervention as described in PH4 recommendation 3 is highly unlikely to be cost effective, particularly given that the committee agreed that motivational interventions were unlikely to be significantly more effective than other interventions, such as skills training.

The committee discussed that recommendation 1.3 in the current guideline would be likely to be cost effective if delivered through existing services. It discussed that the elements included in recommendation 1.3 in this guideline did cover aspects of PH4 recommendation 3, and, while not a family-based programme, encouraged involvement of parents and carers. The committee did not consider the original evidence base for PH4. However, it was made aware that PH4 recommendation 3 was based on evidence from 4 studies that all targeted 'high risk' groups (the groups were not more specifically described) and only 2 of which reported drug related outcomes.

Recommendation 4 in PH4 covers persistently aggressive and disruptive children. This target group are included in the current guideline but no evidence was identified. The committee agreed that the recommendation was now covered by the recommendations on child-focused programmes in the NICE guideline on conduct disorders

The committee agreed that recommendation 5 is out of the scope of the current guideline because it refers to people who are dependent on drugs. The committee agreed that for young people aged over 16, the recommendation could be replaced by NICE guidelines on drug misuse in over 16s: psychosocial interventions and drug misuse in over 16s: opioid detoxification. The committee noted that there is currently no guideline on treatment of children and young people aged under 16.

Evidence reviews

Details of the evidence discussed are in evidence reviews, reports and papers from experts in the area.

All of the evidence statements are presented in the paper Evidence statements from all reviews. The paper also includes overarching statements which summarise the evidence across the groups at risk.

The evidence statements are short summaries of evidence. Each statement has a short code indicating which document the evidence has come from.

Evidence statement (ES) letter 'a' indicates that the linked statement is lettered 'a' in Evidence statements from all reviews. **Evidence statement (ES) number 1.1** indicates that the linked statement is numbered 1 in evidence review 1. **ES2.1** indicates that the linked statement is numbered 1 in evidence review 2. **ES3.1** indicates that the linked statement is numbered 1 in the health economic evidence review. **ES4.1** indicates that the linked statement is numbered 1 in the health economic modelling report. **EP1** indicates that expert paper 1 is linked to a recommendation. **EP2** indicates that expert paper 2 is linked to a recommendation. **EP3** indicates that expert paper 3 is linked to a recommendation.

If a recommendation is not directly taken from the evidence statements, but is inferred from the evidence, this is indicated by **IDE** (inference derived from the evidence).

Recommendation 1.1.1: ES4.1, ES4.2, ES4.3, ES4.4, ES4.5, ES4.6, ES4.7, ES4.9; EP1

Recommendation 1.2.1: ES2.17, ES2.20, ES2.32; IDE

Recommendation 1.2.2: IDE

Recommendation 1.2.3: IDE

Recommendation 1.2.4: IDE

Recommendation 1.3.1: ESc, ES1.50, ES2.33, ES2.39, ES2.46, ES4.1, ES4.3, ES4.7

Recommendation 1.3.2: ES1.54, ES1.68, ES2.12, ES2.13, ES2.18, ES2.19; IDE

Recommendation 1.3.3: IDE

Recommendation 1.3.4: ES1.7, ES1.8, ES1.11, ES1.13, ES1.15, ES1.21, ES1.23, ES1.53

Recommendation 1.3.5: ES1.13

Recommendation 1.3.6: ES1.11, ES1.13, ES1.15, ES1.17, ES1.21, ES1.23, ES1.57, ES1.58, ES1.60

Recommendation 1.3.7: ES1.13, ES1.14

Recommendation 1.3.8: ES2.17, ES2.20, ES2.32; IDE

Recommendation 1.4.1: ES1.2, ES1.22, ES1.36, ES1.37, ES2.27, ES2.31; IDE

Recommendation 1.4.2: ES2.17, ES2.20, ES2.23; IDE

Recommendation 1.4.3: IDE

Recommendation 1.5.1: EP2, EP3; IDE

Recommendation 1.5.2: ES1.32, ES1.33, ES1.34, ES2.29, ES2.30, ES2.41, ES 4.2; IDE

Recommendation 1.5.3: IDE

Gaps in the evidence

The committee's assessment of the evidence on drug misuse prevention identified a number of gaps. These gaps are set out below.

1. The variation in the effectiveness of interventions to prevent drug misuse in groups at risk according to the content and framing of the message.

(Source evidence review 1)

2. The variation in the effectiveness of interventions to prevent drug misuse in groups at risk according to the mode of delivery.

(Source evidence review 1)

3. The variation in the effectiveness of interventions to prevent drug misuse in groups at risk according to where the intervention is delivered.

(Source evidence review 1)

4. The variation in the effectiveness of interventions to prevent drug misuse in groups at risk according to the intended recipient of the intervention.

(Source evidence review 1)

Recommendations for research

The advisory committee has made the following recommendations for research.

1. Effectiveness and cost-effectiveness of drug misuse prevention interventions for groups vulnerable to drug use

What is the effectiveness and cost-effectiveness of drug misuse prevention interventions for groups vulnerable to drug use in the UK?

Why this is important

We identified limited evidence of effectiveness or cost-effectiveness for interventions for groups vulnerable to drug use in the UK. In particular, no evidence on the effectiveness and cost-effectiveness of drug misuse prevention interventions for people involved in commercial sex work or who are being sexually exploited; people not in employment, education or training, and people who attend nightclubs and festivals.

The differential impact on groups at risk needs to be established, particularly for people with multiple vulnerabilities. The accuracy of tools for assessing vulnerability to drug use also needs to be determined. Interventions of interest include one-to-one skills training, information and advice as part of planned outreach activities.

Most of the evidence identified comes from studies in the US. Furthermore, it was unclear which components of interventions were essential for effectiveness and cost-effectiveness.

Primary outcomes of interest include a direct measure of drug use. Longer term outcomes (longer than 1 year) from longitudinal studies would also be useful. Research on location-based interventions, for example at nightclubs or festivals, would provide prevention data for hard-to-reach groups and those who do not access existing services. Research could also consider prevention in people with multiple vulnerabilities and the use of new psychoactive substances.

2. Acceptability of drug misuse prevention interventions for groups at risk

How acceptable are drug misuse prevention interventions among groups vulnerable to drug use in the UK? How can acceptability be improved?

Why this is important

We identified little evidence on the acceptability of drug misuse prevention interventions for groups vulnerable to drug use. The evidence that was available was limited by the small number of studies and participants, and in the overall quality of the studies.

Studies are needed on interventions that are acceptable to people with different levels of health literacy. It is also important to know which interventions are more acceptable to particular groups and practitioners. Research on the framing of messages, such as harm reduction-based approaches, is needed because some ways of framing interventions may be more acceptable than others to people in groups at risk. Research is also needed on who delivers the interventions, as this may also affect the acceptability of an intervention.

3. Effectiveness of digital technologies

How effective and cost effective are digital technologies, such as web-based interventions or targeted new media, for drug misuse prevention among groups at risk in the UK?

Why this is important

We identified limited evidence on digital interventions and targeted new media, with existing studies focusing on web-based and text messaging interventions. Digital interventions are potentially more cost effective than interventions delivered face to face and could be used for prevention activities in groups at risk who are harder to reach or who do not present to services. Digital interventions could also allow people to use sources of support anonymously and help maintain engagement.

Research is needed on effectiveness, cost-effectiveness and acceptability of digital interventions. Studies could compare digital interventions with face-to-face interventions.

4. Key components and delivery of effective motivational approaches

What are the key components of effective and cost effective motivational approaches for preventing drug misuse in groups at risk in the UK? How should motivational approaches be delivered to groups at risk in the UK?

Why this is important

We identified limited evidence on the key components of effective motivational approaches (such as motivational interviewing, motivational enhancement therapy, and skills training or brief interventions focusing on motivation to change) in groups

at risk. The evidence found was generally poorly reported, with unclear terminology. High-quality studies are needed to assess which parts of these interventions are effective and cost effective in groups at risk. Studies need to define the intervention and comparator used, and provide enough detail on the intervention and comparator for the study to be replicated It is important to determine whether the effectiveness of approaches differs for the different groups at risk, and which approach is most effective for each group.

5. Mapping existing practice and provision

What drug misuse prevention activities are currently used in the UK as standard practice for groups at risk of drug use?

Why this is important

It is unclear what standard practice is for drug misuse prevention in groups at risk in the UK. Studies in the current review showed that 'standard care' is often as effective as an active intervention for drug misuse prevention. However, it is not clearly defined. In addition, there is a lack of UK-based studies and it is not clear whether the interventions in the studies are applicable to the UK population. Mapping existing practice and provision will allow new drug misuse prevention activities to be compared to standard care, and to identify gaps in current provision.

6. Long-term consequences of drug use

What are the long-term consequences of drug use?

Why this is important

The health economic modelling for this guideline was difficult because little evidence was identified on the long-term consequences of drug use. More understanding about this would enable more accurate modelling of the costs of drug use. This would in turn allow more accurate modelling of the cost-effectiveness of drug misuse prevention interventions.

7. Image- and performance-enhancing drugs

What are the most effective and cost effective interventions for the use of image- and performance-enhancing drugs?

Why this is important

No evidence was identified for interventions to reduce the use of image- and performance-enhancing drugs. People using these drugs may not identify as drug users, making it difficult to provide preventative interventions. In addition, image-and performance-enhancing drugs are available online and can be accessed by a wide range of people.

Update information

This guideline is a full update of substance misuse interventions for vulnerable under 25s and will replace it.

1 *Recommendations that have been deleted or changed*

2 Recommendations to be deleted

Recommendation in 2007 guideline Substance misuse interventions for vulnerable under 25s	Comment
Who is the target population? Any child or young person under the age of 25 who is vulnerable and disadvantaged. **Who should take action?** Local strategic partnerships. **What action should they take?** • Develop and implement a strategy to reduce substance misuse among vulnerable and disadvantaged people aged under 25, as part of a local area agreement. This strategy should be: – based on a local profile of the target population developed in conjunction with the regional public health observatory. The profile should include their age, factors that make them vulnerable and other locally agreed characteristics – supported by a local service model that defines the role of local agencies and practitioners, the referral criteria and referral pathways. (Recommendation 1)	This recommendation has been withdrawn because it is covered in the implementation section of the current guideline.
Who is the target population? Any child or young person under the age of 25 who is vulnerable and disadvantaged. **Who should take action?** Practitioners and others who work with vulnerable and disadvantaged children and young people in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. In schools this includes teachers, support staff, school nurses and governors. **What action should they take?** • Use existing screening and	This recommendation has been withdrawn because it is covered in the implementation section of the current guideline.

assessment tools to identify vulnerable and disadvantaged children and young people aged under 25 who are misusing – or who are at risk of misusing – substances. These tools include the Common Assessment Framework and those available from the National Treatment Agency. • Work with parents or carers, education welfare services, children's trusts, child and adolescent mental health services, school drug advisers or other specialists to: – provide support (schools may provide direct support) – refer the children and young people, as appropriate, to other services (such as social care, housing or employment), based on a mutually agreed plan. The plan should take account of the child or young person's needs and include review arrangements. (Recommendation 2)	
Who is the target population? Vulnerable and disadvantaged children and young people aged 11–16 years and assessed to be at high risk of substance misuse. Parents or carers of these children and young people. **Who should take action?** Practitioners and others who work with vulnerable and disadvantaged children and young people in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. In schools this includes teachers, support staff, school nurses and governors. **What action should they take?** • Offer a family-based programme of structured support over 2 or more years, drawn up with the parents or carers of the child or young person and led by staff competent in this area. The programme should: – include at least 3 brief motivational interviews (see	This recommendation has been replaced by recommendations 1.3.1 to 1.3.8. 1.3.1 Consider skills training for children and young people who are assessed as vulnerable to drug use, and their parents or carers. Any skills training should be delivered as part of existing services (see recommendation 1.1.1). 1.3.2 Take into account age, developmental stage, presenting vulnerabilities, cultural context, religion, ethnicity and any other specific needs of the child or young person when deciding: • whether to offer training sessions to children and young people and their parents or carers together, or whether to offer separate sessions • the content of the skills training • whether to provide an individual or group-based intervention • the number of sessions needed (provide a minimum of 2 sessions)

glossary) each year aimed at the parents/carers – assess family interaction – offer parental skills training – encourage parents to monitor their children's behaviour and academic performance – include feedback continue even if the child or young person moves schools. Offer more intensive support (for example, family therapy) to families who need it. (Recommendation 3)	• where to have the sessions (for example, in settings in line with the Department of Health's You're welcome) • how long each session should last. 1.3.2 Discuss and agree a plan for follow-up at the skills training sessions to assess whether additional skills training or referral to specialist services (see recommendation 1.2.4) is needed. 1.3.4 Ensure that skills training for children and young people helps them develop a range of personal and social skills, such as: • listening • conflict resolution • refusal skills • how to identify and manage stress • making decisions • coping with criticism • dealing with feelings of exclusion • how to make healthy behaviour choices. 1.3.5 Ensure that skills training for looked-after children and young people includes particular emphasis on social skills and how to deal with feelings of exclusion. 1.3.6 Ensure that skills training for all parents and carers helps them develop a range of skills, such as: • communication • relationship skills • conflict resolution • problem-solving • how to use behaviour reinforcement strategies. 1.3.7 Ensure that skills training for foster carers includes particular emphasis on using behaviour reinforcement strategies alongside the other skills in recommendation 1.3.6. 1.3.8 Deliver skills training using a non-judgemental approach and tailor the training for the person's health literacy.
Who is the target population?	This recommendation has been withdrawn because it is covered by the

Children aged 10–12 who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse. Parents or carers of these children. **Who should take action?** Practitioners trained in group-based behavioural therapy. **What action should they take?** • Offer the children group-based behavioural therapy over 1 to 2 years, before and during the transition to secondary school. Sessions should take place once or twice a month and last about an hour. Each session should: – focus on coping mechanisms such as distraction and relaxation techniques – help develop the child's organisational, study and problem-solving skills – involve goal setting. • Offer the parents or carers group-based training in parental skills. This should take place on a monthly basis, over the same time period (as described above for the children). The sessions should: – focus on stress management, communication skills and how to help develop the child's social-cognitive and problem-solving skills – advise on how to set targets for behaviour and establish age-related rules and expectations for their children. (Recommendation 4)	NICE guideline on conduct disorders.
Who is the target population? Vulnerable and disadvantaged children and young people aged under 25 who are problematic substance misusers (including those attending secondary schools or further education colleges). **Who should take action?** Practitioners trained in motivational interviewing. **What action should they take?**	This recommendation has been withdrawn because it is out of scope for this guideline. Management of people aged 16 and over is covered by the NICE guideline on Drug misuse in over 16s: psychosocial interventions.

• Offer one or more motivational interviews (see glossary), according to the young person's needs. Each session should last about an hour and the interviewer should encourage them to: – discuss their use of both legal and illegal substances – reflect on any physical, psychological, social, education and legal issues related to their substance misuse – set goals to reduce or stop misusing substances. (Recommendation 5)	

Glossary

Brief interventions

This can comprise either a short session of structured brief advice or a longer, more motivationally-based session (that is, an extended brief intervention). Both aim to help someone reduce their drug use and can be carried out by non-drug specialists.

Dependent [on drugs]

A person who is dependent on drugs has a strong desire or sense of compulsion to take a substance, a difficulty in controlling their drug use, a physiological withdrawal state, tolerance of the use of the drug, neglect of alternative pleasures and interests and persistently uses the drug, despite harm to themselves and others (adapted from WHO, 2006).

Foster carers

People who care for looked-after children. This includes long-term care, emergency overnight care, and short-term care

Looked-after children and young people

Children and young people looked after by the State where the Children Act 1989 applies, including those who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care. It includes residential care, foster care, young offender or other secure institutions or boarding

school, or with birth parents, other family or carers, and including placements out of the area.

Motivational interviewing

A brief psychotherapeutic intervention. For substance misusers, the aim is to help people reflect on their substance use in the context of their own values and goals and motivate them to change. (adapted from McCambridge and Strang, The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people, 2004).

Psychoeducation

Education sessions for people affected by mental illness and their families and carers. Psychoeducation uses shared learning to empower people to cope better.

Skills training

The teaching of specific verbal and nonverbal behaviours (including personal and social skills) and the practising of these behaviours by the person receiving the training.

Substance misuse

Intoxication by – or regular excessive consumption of or dependence on – psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances).

For other public health and social care terms see the Think Local, Act Personal Care and Support Jargon Buster.