Drug misuse prevention

Consultation on draft guideline
Stakeholder comments table

20/07/16 to 07/09/16

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7	SH	Bristol Drugs Project	Full	General	General	**Question 1 & 3**. We are concerned that the greatest impact on practice and cost implications will vary dependent on areas, their present investment, threat to cuts in funds and forward thinking nature of agencies and commissioners around drug prevention. Bristol's experience allowing at present: - A dedicated young person's substance use Early Intervention service (BYL) - LA led training for CYPS (4YP) - BDP service providing targeted responses for IPED - BDP providing internal training schedule and support to external services capacity building (responding to emerging needs and promoting the identification and inclusion of substance users) - BDP engagement and assertive outreach approach harmonising direct provision with specialist service partnership working/ co working. (clinical sexual health services for MSM, Brook for YP, 125 Sex Worker support service, Early Help for family provision and delivering from primary care). - BDP additionally delivering assertive outreach at , festivals , community celebrations/ attractions and settings (homeless , LGBT, CYPS, street) - Dedicated non opiate responses (group and one to one), ketamine, NPS, Cannabis, Chem sex etc.; alert to emerging needs - Barriers reduced through partnerships, community / in reach-/ outreach settings , varying/ multimedia approaches, out of hours, community ambassadors or champions ; older people , polish speaking, Somali, LGBT to meet identified and changing needs	Thank you for providing this information.
11	SH	NHS	Full	General	General	Many thanks for this - my biggest concern is that there is no mention	Thank you for this comment. This group

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		Birmingham South and Central CCG				of Domestic Abuse. The following is taken from Guidance for domestic abuse and alcohol and drugs services in Lanarkshire published by Lanarkshire Alcohol & Drug Programme 2011. Some women experiencing domestic abuse do turn to drugs or alcohol as a form of self-medication and relief from the pain, fear, isolation, and guilt associated with their abuse. Evidence also shows that male partners often introduce women to illicit drug abuse. A UK study of 60 women using crack cocaine found that 40% reported being regularly physically assaulted by a current partner and 75% being physically assaulted by a current or past partner. A study of inner London treatment agencies showed that 30% of women reported physical abuse from their current partner, a likely underestimate given fear and reluctance to disclose abuse. Women who use alcohol or drugs are not responsible for the abuse, although their substance use is often blamed. Perpetrators' substance use is often (falsely) blamed as the cause of the abuse. There is considerable stigma against women experiencing domestic abuse, compounded if she is also using drugs or alcohol; it is seen as socially unacceptable	would not have been excluded if they were included within an identified at risk group (as defined in the guideline glossary). To note that NICE has published guidance on domestic violence (PH50 https://www.nice.org.uk/guidance/ph50). This guideline makes specific reference to people who misuse alcohol or drugs and are affected by domestic violence. We will ensure that this guidance on domestic violence is linked within the pathway for this guideline.
12	SH	CoramBAAF Adoption and Fostering Academy	Full	General	General	This response is being submitted on behalf of the CoramBAAF Health Group, which is also a special interest group of the Royal College of Paediatrics and Child Health (RCPCH). The Health Group was formed to support health professionals working with children in the care system, through training, the provision of practice guidance and lobbying to promote the health of these children. With over 500 members UK-wide, an elected Health Group Advisory Committee with representation from community paediatricians working as medical advisers for looked after children and adoption panels, specialist nurses for looked after children, psychologists and psychiatrists, the Health Group has considerable expertise and a wide sphere of influence. Our area of concern is the particularly vulnerable group comprised of looked after and adopted children and young people.	Thank you for this comment.
19	SH	CoramBAAF Adoption and Fostering	Full	General	General	**Question 2:** As mentioned above there are significant resource implications involved in undertaking comprehensive assessment of vulnerability and in provision of skill training and the guidance	Thank you for providing this information.

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		Academy				should address. However in our view and given the generic nature of the skill training described, investment in skill training could lead to improved outcomes in other areas such as mental health, sexual health, relationships and educational attainment.	
20	SH	CoramBAAF Adoption and Fostering Academy	full	General	General	**Question 6:** We are uncertain whether there are any existing services for LAC which currently offer the described skills training by either social care or health. Some of this will be addressed, usually by a specialist LAC nurse as part of health promotion at statutory health assessments. We would therefore like some clarity as to whether it is envisioned that health or social care might develop such programmes. We have already noted that additional resources would be required for development.	Thank you for this comment. The updated guideline makes clear that drug misuse prevention activities should be delivered through a range of existing statutory, voluntary or private services.
21	SH	Department of Health	Full	general	general	The extension of the age-range, from the previous guideline (vulnerable under-25) to all adults in (or at least perceived to be in) at-risk groups is a big change in scope, which could have a big impact in practice/services.	Thank you for this comment. The recommendations all focus on integrating activities through existing services so that the resource impact is reduced. The resource impact of the recommendations is also considered throughout the discussion section of the guideline.
22	SH	Department of Health	Full	general	general	We do have concerns about the term 'health literacy', as it appears to be labelling some individuals with a language that suggests degrees of health illiteracy. While we assume a positive point is intended by its use, (e.g. as a reminder to practitioners that they should talk to patients and present information/advice in an appropriate way to that individual, their needs and supports their own decision-making about their health), we think that the term 'health literacy' does not actually achieve this. For example, professionals should always start with an assumption that all adults are capacitous in making decisions about their own health; and this language could appear to undermine that legal and ethical principle. It is only meaningful if it is to be used to respond to degrees of 'health illiteracy' and so also appears to risk labelling individuals as having a deficit, perhaps because they look at their health decisions in a different way to some professionals, or because they may not prioritise the same kind of knowledge as professionals. We certainly do not think this is the intention of the authors but if there is a more explicit definition of 'health literacy' that corrects this interpretation it would really be helpful to provide this - as the current definition does	Thank you for this comment. The term 'health literacy' has been removed from the updated guideline. The guideline now refers to tailoring information according to a person's preferences, needs and level of understanding about their health (please see recommendations in section 1.4 of the guideline).

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						not seem to do this. If the intention is simply to identify those with lesser degrees of knowledge about health, then a lack of literacy would not be a suitable equivalent term.	
29	SH	Department of Health	Full	General	General	1. Which areas will have the biggest impact on practice and be challenging to implement? Please say for whom and why. – It is unclear how extensively the expansion of this guidance to all adults will be taken up (not least given the limitations of the evidence base identified in the guidance), and given a lack of clarity about level of implementation of the previous recommendations it is difficult to assess the additional impact of this new guideline - but it appears this might have a substantial impact on assessment of at risk adults in primary care if pursued specifically and could require changes in services supporting at risk children and their families if they do not have skills education in place already. Identifying suitable assessment tools or approaches to trigger specific responses seems a challenge given the apparent lack of a clear consensus on this.	Thank you for this comment and raising this issue. The updated guideline makes clear that drug misuse prevention activities should be delivered through a range of existing statutory, voluntary or private services. The updated guideline is clearer about the approach that should be taken to assessment and the fact that this should be undertaken as part of statutory, routine or opportunistic appointments. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems.
30	SH	Department of Health	Full	General	General	2. Would implementation of any of the draft recommendations have significant cost implications? As the draft guideline notes there are costs involved in implementing drug misuse prevention activities and it would be for local authority public health directors and their teams to manage these costs.	Thank you for this comment.
31	SH	Department of Health	Full	General	General	3. What would help users overcome any challenges? (For example, existing practical resources or national initiatives, or examples of good practice.) Examples and sharing of good practice would be helpful.	Thank you for this comment. NICE has a database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).
32	SH	Department of Health	Full	General	General	4. Are there any validated or locally agreed approaches that could be used as examples in recommendation 1.2.1? If so, which ones are you aware of? We would defer to insights/recommendations of clinical/research drugs prevention experts.	Thank you for this comment.
33	SH	Department of Health	Full	General	General	5. Is recommendation 1.2.4 (If after assessment there are concerns that someone is using substances regularly or excessively, refer them to specialist services.) likely to result in a large number of referrals to treatment services? A referral to a treatment service requires the informed consent of the individual. If there are concerns that someone was using excessively that should	Thank for this comment. The wording of this recommendation has been amended to be clear that any referral should be in discussion with the individual.

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						be discussed with the individual and a referral offered only if appropriate; and such a referral should then only be made if informed consent is obtained. A referral is not normally appropriate for those simply using regularly in the absence of concerns about this use so referring to regular use is potentially confusing. The phrase 'using substances regularly or excessively' is subjective and difficult to quantify/standardise for all individuals. If there are cases of diagnostic uncertainty for the professional about whether regular use may be excessive and in need of further assessment or treatment, that uncertainty should be discussed with the person/patient - but no referral should be made unless they give informed consent. Such referral is not without potential harm, as well as the potential benefit, so this guideline would be better to be more precise in this recommendation. Assuming normal consent is obtained, the recommendation would probably have little impact on inappropriate referrals to treatment services (but if this were misunderstood to be encouraging referral to assist the assessing professional's diagnosis it could lead to a waste of resources and be inappropriate for the person). The numbers of referrals could rise if more older at risk adults are identified in this process than previously - but it seems likely that they would be individuals who were anyway showing more clear evidence of harmful or dependent use than younger individuals at risk who were the focus of the earlier NICE guideline. Broadening to all adults may have some impact on numbers of vulnerable adults from at risk groups being referred for assessment by treatment services but if 'appropriate' referrals are made of those needing such specialist assessment by treatment services we would not anticipate a large increase. May be better to amend to "If after assessment there are concerns that someone is using substances excessively, or regularly to an extent that it is negatively affecting them, and the person gives their informed consent to specialist assessment, refer to specialist services."	
34	SH	Department of Health	Full	General	General	6. What costs are involved in skills training interventions? Who would typically carry out the training? How long would a session generally last? We would expect local authority public health directors and their teams to commission, and providers to deliver, any such intervention within suitable clinical governance frameworks. We do not have any estimated costs –which would	Thank you for this comment. The intention is that the training would be delivered as part of existing practice and would therefore not excessively increase costs. This issue is considered in detail in the committee discussion section of the guideline.

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						depend on the scale of delivery as well as the nature of the programme and follow-up, which does not appear to be fully established for this recommendation. We wonder whether this may be estimated from the data collected on cost-effectiveness by the NICE expert group.	
35	SH	Department of Health	Full	General	General	7. When should follow-up after a skills training intervention, as recommended in recommendation 1.3.3, take place? We would expect local authority public health directors and their teams to commission, and providers to deliver, any such intervention within suitable clinical governance frameworks.	Thank you for this comment.
36	SH	Department of Health	Full	General	General	8. When and where should follow-up after assessment of adults at risk of drug misuse, as recommended in recommendation 1.4.3, take place? We would expect local authority public health directors and their teams to commission, and providers to deliver, any such intervention within suitable clinical governance frameworks. We would note that it is probably not clear whether such follow-up should be offered equally to those simply identified at risk of future use/misuse and to those identified as already using and agreeing a need to reduce their use whose follow-up may partly depend on any goals agreed. Despite this, it would appear to be appropriate to offer follow-up for all such groups within 1-6 weeks based simply on common sense principles of supporting some immediacy for further reflection or for support for aimed for changes. However, this is not based on specific evidence. It may be helpful if the NICE experts were able to add any information on this from the literature they reviewed.	Thank you for this comment. Updated section 1.2 of the guideline (covering assessment) states if the person is already misusing drugs, see NICE's guidelines on psychosocial interventions and opioid detoxification for drug misuse in people aged 16 years and older, needle and syringe programs, and diagnosis and management of alcohol-use disorders. IN addition, the recommendation for adults has been amended for clarity, noting to refer to psychosocial interventions as necessary.
37	SH	Department of Health	Full	General	General	9. What examples are there of online self-assessment and feedback tools would be appropriate to include in recommendation 1.5.2? We would defer to insights/recommendations of clinical/research drugs prevention experts.	Thank you for this comment.
38	SH	Department of Health	Full	General	General	10. Which research recommendations should be prioritised? Which research recommendations should not be prioritised? All the research recommendations are of value, and we would not argue strongly for the precise order and might well defer to insights of clinical/research drugs prevention experts – but from a policy perspective we suggest prioritising them (in relation to improving prevention) as follows:	Thank you for this comment. The included research recommendations have been amended in line with responses from stakeholders.

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						1. Effectiveness and cost-effectiveness of drug misuse prevention interventions for groups vulnerable to drug use 2. Acceptability of drug misuse prevention interventions for groups at risk 3. Mapping existing practice and provision 4. Image- and performance-enhancing drugs 5. Effectiveness of digital technologies 6. Key components and delivery of effective motivational approaches 7. Long-term consequences of drug use	
39	SH	LGBT Foundation / National LGB&T Partnership	Full	General	General	The National LGB&T Partnership recommends that organisations monitor both sexual orientation and trans status. This will help organisations create a baseline of how they currently fare in supporting LGBT communities (note that an estimated 5-7% of the population identify as lesbian, gay or bisexual, and an additional 1% doesn't identify with the gender they were assigned at birth). This will also be important to identify those who are in multiple groups at risk; we know for example that 1 in 4 homeless youths identify as LGBT. Monitoring sexual orientation and trans status also enables effective improvement of access and will also help address the lack of evidence on what are effective prevention techniques for LGBT people. Guidance on how to monitor sexual orientation and trans status can be found on LGBT Foundation's website: http://lgbt.foundation/som?professionals	Thank you for this comment.
48	SH	LGBT Foundation / National LGB&T Partnership	Full	General	General	It is very encouraging that LGBT people are recognised as a high risk group. However, service providers and other users of these guidelines must recognise that the LGBT community is not a singular, homogenous group of people. Lesbian, gay, bisexual and trans people that are at risk of drug misuse have differing needs and experiences, and as targeted interventions must be implemented separately. For example, whilst there is only limited evidence, studies nonetheless suggest that approximately 52% of trans people exhibited at least one indicator of drug abuse, with 10% indicating severe drug abuse (The Rainbow Project, 2012). Similarly, according to the CSEW drug use was similarly higher among	Thank you for raising this issue. The committee discussed this and a point about the broad membership, and the differing needs and experience of individuals within all the at risk groups has been added to the committee discussion section in relation to the importance of assessment.

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						lesbian and bisexual women, being approximately four times higher than among heterosexual women (22.9% and 5.1% respectively). The Equality Impact Assessment mentions that trans people should be specifically discussed, and it would be useful for the guidance to reference the need for further research around prevention work with trans communities. Some existing targeted work that targets LGBT people is actually created based on only the specific needs of gay, bisexual and other Men who have Sex with Men (MSM), and does therefore not support the entirety of the LGBT community. Whilst the needs of MSM are very well evidenced, this should not detract from the needs of the rest of the community. It is likely that if this distinction is not made clear, targeted interventions will not consider the differing needs and experiences within lesbian, gay, bisexual and trans communities.	
51	SH	Mentor Foundation UK	Full	General	General	Question 3 We believe that a key role in helping users overcome challenges is played by giving access to credible prevention and education information and resources. For instance, we run two programmes called ADEPIS and CAYT (see more info at http://mentor-adepis.org/), which are relevant examples of how staff in existing services can have access to best practice guidelines on drug prevention.	Thank you for providing this information. We would also encourage you to consider whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).
53	SH	Mentor Foundation UK	Full	General	General	Question 6 Mentor has recently piloted a life-skills, evidence- based intervention called Unplugged in secondary schools (mainstream, SEN and PRUs) across the north of England. We are currently in the evaluation process and would be happy to share any relevant information after September 2016. The cost involved in the delivery of this type of intervention is an average of £70 per student. The cost for this type of intervention is inversely proportional to the number of students, meaning that the higher number of students participating in the programme would significantly reduce associated costs. This is mainly due to the fact that associated cost for programmes like Unplugged are mainly used to cover teacher training, printing and distribution of resources,	Thank you for providing this information. Universal approaches are outside the scope of this guideline.

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						and logistics. The Unplugged programme is in fact aimed to be delivered by teachers in the school, following attendance of a two (or two and a half) days training delivered by EUDAP certified trainers (external provider). Teachers are asked to deliver the programme as part of the existing school curriculum, meaning that there is no additional cost associated to programme delivery. This programme can also be delivered to more vulnerable students. We will be able to provide results in relation to delivery in PRU settings following completion of the programme evaluation. Teacher training is normally delivered by a qualified (EUDAP) trainer. The life-skills programme (training) is delivered by teachers to students (12-14 years old). The programme is composed by 12 modules. Each module should ideally be delivered in 50 minutes; however these can also be adapted to fit the timetable.	
54	SH	Mentor Foundation UK	Full	General	General	Question 9 An online self-assessment and feedback tool we are aware of is the Drinks Meter developed by Dr Adam Winstock, founder of the Global Drug Survey. According to Dr. Winstock, the app (The Drinks Meter) "is designed to allow people to think about their alcohol use and compare themselves to other people like them. It aims to nudge people to be safer and wiser, and to provide them with some simple tools to reduce the risk of harms related to their use and flag up when their use might be causing them problems. It places no judgment. It does not tell a person what to do. It reflects back to them what they have shared with Drinks Meter. It reinterprets that information based on the way I think about drug use and the way it affects different people". The website also provides relevant information about alcohol, standard drinking, binge drinking and other information aimed at discouraging related risky behaviours (such as sex and alcohol, or driving and alcohol). We are mindful of the present guideline being focused on drug misuse but we believe that a similar tool to self-assess and ultimately self-regulate drug consumption can be developed.	Thank you for this comment. The final guideline is clearer about the approach that should be taken to assessment and the fact that this should be undertaken as part of statutory, routine or opportunistic appointments. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems. Further information about the committee's deliberations on assessment tools is included in the committee discussion section of the guideline.
63	SH	NHS England	Full	General	General	Question 5 Recommendation 1.2.4. Shouldn't increase referrals and impact on capacity within secure environments as routine assessments include drug misuse/at risk people with referral processes already in place.	Thank you for this comment. To note that prescribed drugs were within scope for this guideline but no evidence was identified. The terms used definition of drug misuse has been

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						Referrals may already be increasing due to the impact of NPS and the evolving referral for people dependent on prescribed medicines. This is creating a capacity and cost pressure for services already- the guideline alone won't increase this further.	updated in the guideline to include a reference to misuse of prescribed or over the counter drugs.
64	SH	NHS England	Full	General	General	Question 7: When should follow-up after a skills training intervention, as recommended in recommendation 1.3.3, take place? Question 8: When and where should follow-up after assessment of adults at risk of drug misuse, as recommended in recommendation 1.4.3, take place? For both of these questions, • for people that are assessed within the community, who then are admitted into a secure environment, then the follow-up will be handled by services within the secure environment. • For people assessed in one secure environment and then transferred to another, their care should continue in the second and subsequent environments. • For people released from a secure environment, their care should be followed up by community service providers and community-based criminal justice/offender teams.	Thank you for providing this information. Please note that secure settings are excluded from the scope for this work.
73	SH	NHS England	Full	General	General	While there is a general reference to criminal justice settings it does not fully reflect the level of risk. We know some prisoners start using drugs in prison including NPS and diverted medicines. The prevalence of prior drug use is much higher than the general population and that drugs are potentially quite available. There is a high prevalence of chronic pain and other comorbidities including low mood etc that may lead to self-medication with drugs and there are fewer alternative coping options compared to the community. e.g the Groups at risk of drug use or misuse does not include prisoners 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	Thank you for this comment. Prison and young offender institution settings were outside of the scope of this guideline. People in prison in the UK are already in part of an existing prevention / rehabilitation scheme. NICE has recently published guidance on the physical health of people in prison (see https://www.nice.org.uk/guidance/ng57). Guidance is also in development on mental health of adults in contact with the criminal justice system (see https://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726).

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						- 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. It also does not refer to the commissioning of SMS services in prisons only the community arrangements. It is useful to thread prevention into wider service provision for primary health and substance misuse services.	
74	SH	Public Health Wales	full	General	General	Public Health Wales welcome this draft guidance on drug misuse prevention and recognise the challenges in evidence of effectiveness and cost-effectiveness stated.	Thank you for this comment.
75	SH	Public Health Wales	Full	General	General	There is a need to include misuse of prescription only medicines (POMs) and Over-the-Counter (OTC) medications alongside 'illegal drugs, new psychoactive substances (previously described as 'legal highs', solvents and image and performance enhancing drugs.	Thank you for this comment. Prescribed drugs were within scope for this guideline. The terms used definition of drug misuse has been updated in the guideline to include a reference to misuse of prescribed or over the counter drugs.
84	SH	Public Health Wales	Full	General	General	Whilst it is recognised that this guidance document is for drug misuse prevention for individuals in at risk groups, the document would benefit from inclusion of those at risk from experiencing harm or increased vulnerability from drug use of others	Thank you for this comment. One of the included at risk groups is children and young people whose carers or families use drugs.
88	SH	Public Health England	Full	General	General	Could include a note saying that, although this is drug specific guidance, many of the principles apply to alcohol for children and young people.	Thank you for this comment. The NICE alcohol pathway will be linked to the pathway for this guideline on the NCE website once the final guideline is published.

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104	SH	Royal College of General Practitioners	Full	General	General	The paper is admirable in its recommendations but admits the lack of evidence and the detailed epidemiology of this population. There are occasional users to confirmed addicts with different health trajectories. The harm to health, the cost to society and the misery of addiction are hard to quantify Transient, occasional use is so common as to be almost normal, in particular where alcohol is regularly used in the parent society. Human beings seem naturally drawn to addictive behaviour, this is normal and not readily preventable. Drug taking has the added glamour of "forbidden fruit" Primary prevention is about information, teaching and helping young and impressionable people make better choices. Education, information and non-judgemental help are important in secondary prevention and in tertiary prevention-the long term care of the heroin addict. Fiscal policy, legislation and supervised prescription are factors in helping the chaotic life style and criminality of the heroin addict to be turned around and offered an alternative life style. The attitudes of society towards drugs and drug use-occasional, regular and escalating are important in determining the political dynamic in funding, treating and preventing (PS)	Thank you for raising these issues.
108	SH	Royal College of Nursing	Full	General	General	The Royal College of Nursing welcomes the invitation to comment on the draft guidelines for Drugs Misuse Prevention. The RCN invited members who work with and care for people in this area. The comments below include the views of our members.	Thank you for this comment.
109	SH	Royal College of Nursing	Full	General	General	The draft guidelines are comprehensive.	Thank you for this comment.
55	SH	Mentor	Full	40-43		Question 10	Thank you for this comment. The included

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		Foundation UK				Jamila and I have found it very subjective. Though we have identified two recommendations for research that should be prioritised (1 and 6) and one that should not be prioritised (n.5).	research recommendations have been amended in light of stakeholder comments.
15	SH	CoramBAAF Adoption and Fostering Academy	Full	6-7	18	Use of the term 'ensure' is problematic. Even the most excellent skills training can only be offered - the outcomes cannot be ensured.	Thank you for this comment. The guideline committee did not consider the use of the term 'ensure' problematic. The committee considered that it was clear that the recommendation was referring to the action which needs to be taken to deliver skills training and that the listed factors were associated with its effectiveness, based on the evidence considered.
16	SH	CoramBAAF Adoption and Fostering Academy	Full	6-7	20-30	Our members would like clarity as to whether provision of skills training for LAC and their parents or carers would be provided by social care or health, as this has implications for funding.	Thank you for this comment. The committee discussed that skills training may be provided by trained health or social care practitioners. Provision would be a local decision; local funding issues are outside the remit of NICE.
45	SH	LGBT Foundation / National LGB&T Partnership	Full	28-29	General	The guidance suggests that web-based interventions are not cost effective in the base case, whilst also suggesting it is feasible to produce web-based interventions at low cost that is particularly beneficial for people at increased risk. Evidence from LGBT Foundation's *Part of the Picture* report supports the benefit of web-based interventions, and the guidance could be clearer to avoid dismissing web-based interventions before they are fully explored. Part of the Picture found that a third of respondent had sought information, advice or help about their substance use, with the internet being the most popular source of information for LGB people. This suggests that websites must have the best quality of LGB specific information possible. As discussed elsewhere, there are barriers to accessing physical services for LGBT people so relevant web-based solutions are extremely relevant for the LGBT community. It therefore might be appropriate to include a recommendation that web-based solution are further explored.	Thank you for this comment. Research recommendation 5 in the guideline has been made to highlight the gap in the evidence on effective and cost effective digital technologies such as web based interventions or targeted new media in groups at risk. This research recommendation notes that such interventions have the potential to be cost effective.
65	SH	NHS England	Full	1		As you are speaking about CYP as well as adult, Youth offending	Thank you for this comment, the text has

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						team/worker should be added as adults see probation.	been amended in line with your comment.
89	SH	Public Health England	Full	1	2	The decision not to address universal prevention interventions means that it would be more accurate to describe these guidelines as "Targeted and indicated drug misuse prevention".	Thank you for this comment. There was an error in the title on the guideline document that went out for consultation and the title for this guideline has been updated to state that it is 'Drug misuse prevention: targeted interventions'
8	SH	NHS Birmingham South and Central CCG	Full	Section 1.2.1	General	Using a validated or locally agreed approach Guidance is needed with this as to current validated approaches and recommendations to support commissioning	Thank you for this comment. The final guideline is clearer about the approach that should be taken to assessment and the fact that this should be undertaken as part of statutory, routine or opportunistic appointments. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems.
9	SH	NHS Birmingham South and Central CCG	Full	Section 1.2.4	General	Referral without specific agreement from client? Will this have a huge impact on services i.e DNA and non engagement	Thank you for this comment, the text has been amended to make clear that referral should be considered following discussion with the person, carer or family.
10	SH	NHS Birmingham South and Central CCG	Full	1.3.5	General	Who is responsible for this training Health? Local authority? Lack of responsibility makes accountability and movement to act difficult	Thank you for this comment. The wording of this recommendation has been revised to be clearer that training should be commissioned and delivered as part of existing services and that training should be delivered by people competent to provide it. Recommendation 1.1.1 lists services through which activities may be delivered. The introduction to the guideline notes that it is for • Local authorities and NHS commissioners • Providers of services for groups at risk • Practitioners working in drug misuse

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							prevention and specialist drug treatment services • Health and social care professionals, such as health visitors, school nurses, youth workers, social workers, youth justice workers and probation officers, who come into contact with groups at risk • Owners and staff at venues attended by people using or at risk of using drugs (such as gyms, pubs, clubs or music events) • People responsible for educational governance Provision would be a local decision; local funding issues are outside the remit of NICE.
67	SH	NHS England	Full	4	13	Although the glossary defines Looked after children and young people as those under sec 20 Children Act, it is confusing in document as they are usefully defined as LAC, this appears to exclude all other vulnerable children especially those at risk or in contact with the youth justice system.	Thank you for this comment. The definition of looked-after-children (LAC) has been amended and broadened in the guideline. Children, young people and adults in contact with the criminal justice system (not in secure environments) are also identified as a specific at risk group in the guideline. While the guideline does not exclude other vulnerable children and young people, it focusses on the 10 at risk groups identified by the public health advisory committee. These are given in the *Terms used in this guideline* section on page 9 of the guidance. These 10 groups were identified to support targeted approaches towards drug misuse prevention for those who are anticipated to be most at risk of drug misuse. Vulnerable groups per se were not considered an at risk group for this guideline but are implicitly considered in the 10 at risk groups which were identified in the guideline.

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77	SH	Public Health Wales	full	4	15	Suggest amendment to read 'services for people that are unstably housed, homeless or sleeping rough'	Thank you for your comment. The wording has been amended to say 'services for people who are in unstable accommodation, homeless or sleeping rough'.
49	SH	Mentor Foundation UK	Full	4	17	Question 1 Recommendation number 1 (*Delivering drug misuse prevention activities as part of existing services*). We believe that the main challenge will be the training of staff in services for young people who are in groups at risk and embedding drug prevention in a range of existing services; it requires significant investment of time and resources, and specialist consultancy. It is vital that existing services seek out (or are provided) expert advice from specialist prevention organisations, or else they risk providing information and pursuing strategies that are ineffective. It is also important to avoid implementing isolated early interventions and scare tactic practices. Evidence-based programmes have proven their effectiveness in reducing drug use amongst young people as well as in raising awareness about risks associated with psychoactive substances. According to Mentor's experience, the two main obstacles to overcome are practicability, scalability and coordination of all the services available, both for providers and recipients. Ideally, we should aim to build a shared and connected network that brings together all actors and works towards common solutions.	Thank you for this comment. Staff competence and training are outside the scope of this guideline but updated recommendation 1.3.2 states that training is delivered by people competent to provide skills training'. We would also encourage stakeholders to see whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).
57	SH	NHS England	Full	4	4	We are concerned that the audience for this recommendation excludes other commissioners of substance misuse services. In health and justice residential/prescribed places of detention such as prisons, immigration removal centres and the children and young people secure estate, NHS England directly commissions substance misuse services for people in these secure settings (i.e. not local authorities). Please consider adding "other commissioners" before the words "and other local decision makers". This also clarifies that the local authorities are commissioners in the context of this recommendation (and not providers).	Thank you for this comment. Prison and young offender institution settings were outside of the scope of this guideline. People in prison in the UK are already in part of an existing prevention / rehabilitation scheme. NICE has recently published guidance on the physical health of people in prison (see https://www.nice.org.uk/guidance/ng57). Guidance is also in development on mental health of adults in contact with the criminal justice system (seehttps://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726).
66	SH	NHS England	Full	4	4	Include NHS Commissioners are responsible for the provision of Substance misuse services to the CYPSE	Thank you for this comment. The wording of recommendation 1.1.1 has been amended to

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							include health services, such as primary care services, community-based health services, mental health services, sexual and reproductive health services, drug and alcohol services, and school nursing and health visiting services.
50	SH	Mentor Foundation UK	Full	4 6	5 3	Question 2 The presence of effective preventive interventions is not sufficient for a sustainable universal prevention. Such an effort also requires worthwhile action from policy-makers, because any large-scale project involves use of considerable resources. Given that the total costs for supporting effective interventions could exceed the resources that are available, we see a need, therefore, to be able to evaluate and choose among a variety of potential interventions. As a result, the choice may be focused on deciding among interventions that address an issue identified as a priority for prevention. For instance, if drug misuse prevention is the priority, the relevant programmes may be compared on both how much they cost to implement and how much they tend to decrease rates of misuse. However, the choice may be more complex, because a preventative intervention must be compared with initiatives largely unrelated to health, such as investments in education, job training, or construction. Even though these various investments try to achieve substantially different outcomes, they are in the running for the same resources, and the decision regarding which one to support requires a thorough comparison on common outcomes. In this case, economic analysis could provide a systematic tool for making such comparisons, and ultimately enabling more informed decisions. Also, for these recommendations to be fulfilled, it requires a significant investment in training of staff in a range of existing services, so they have the knowledge and skills to recognise young people at risk and to either deliver drug education and prevention as part of their other responsibilities or signpost to other relevant services.	Thank you for raising these issues. The committee's considerations on the economics and resource impact of the recommendations have been expanded within the discussion section of the guideline. It is not envisioned that implementation will have a significant resource impact as the recommendations focus on delivery through existing services.
90	SH	Public Health England	Full	4	5	Suggest add 'youth support services'	Thank you for this comment. Recommendation 1.1.1 has been updated to include youth justice services. The committee did not think that youth services per se should

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							be added to the recommendation.
23	SH	Department of Health	Full	4	5 - 16	In the list of services, we would suggest explicitly mentioning LGBT services, including non-sexual health related LGBT services, given that the prevalence of drug use, compared to the general population, is high amongst the lesbian, gay, bisexual and trans (LGBT) and men who have sex with men (MSM) communities.	Thank you for this comment. Services for people who are lesbian, gay, bisexual or transgender have been added to the list of services in recommendation 1.1.1.
114	SH	University of West London	Full	4	5/6 and 8	Question 1: delivering drug prevention activities through existing services is challenging if services are not evaluated according to relevant outcomes. For example, in relation to mental health services, despite the high prevalence of co-morbidity is well documented, drug missue is often seen as a separate issue and delegated to drug treatment services. When clients are not already identified as problematic drug users, drug is not a priority. I have been involved in training mental health nurses for many years and there a knowledge gap with regard to substance use/misuse, drug effects and drug interactions, as a result staff working in mental health services are often not confident to discuss drug problems with their clients, especially if there are not clustered as "dual Diagnosis" cases (cluster 16). However, when talking about "prevention" interventions should be delivered to all mental health clients because of their vulnerability and increased risk of developing a drug problem. Another issue is attitude, a lot of work needs to be done with regard to challenging stereotypes and moralistic /judgemental attitudes towards people who use illegal substances, in particular injecting drug users.	Thank you for this comment. Recommendation 1.3.2 has been updated to state that training should be delivered by people competent to provide skills training. Section 1.2 of the guideline stresses taking a non -judgemental approach.
40	SH	LGBT Foundation / National LGB&T Partnership	Full	4	5-16	It is important that Voluntary & Community Sector (VCS) organisations are recognised for their role in providing drug and alcohol services and prevention work for people who are using or at risk of using drugs. As discussed throughout the document, lesbian, gay, bisexual and trans (LGBT) communities are a high-risk group in regards to drug use. LGBT VCS organisations specifically are therefore in a crucial position in raising awareness about drug use within communities and providing drug and alcohol services. Local Authorities should be	Thank you for this comment. This recommendation has been amended to make clear that drug misuse prevention services should be commissioned through a wide range of services and that sexual and reproductive health services are given as an example of these.

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						working closely with VCS organisations to raise awareness and make this critical link. It is significant to recognise that co-locating drug and alcohol services with sexual health services is likely to be particularly relevant to gay, bisexual and other Men who have Sex with Men (MSM) communities. The Chemsex Study (Sigma, 2014) indicates strong acceptability by MSM for GUM and sexual health services to receive drug information and prevention interventions. It also indicates widespread satisfaction from specialist services like Antidote, GMI Partnership and GMFA, underlining the importance of the expertise found within the LGBT VCS. The Neptune study of club drug use in LGBT communities (2016) suggested specialist LGBT drug services are necessary to attract gay, bisexual and other MSM into treatment and to retain them in treatment, and an element of this is that staff in such spaces are more likely to be familiar with HIV risk behaviours related to drug use and more likely to be perceived as credible sources for culturally appropriate HIV prevention messages. LGBT Foundation's *Part of the Picture* (2012) indicated that LGB people are experiencing barriers in relation to recognising they may have a substance problem which needs attention, and in accessing services where they feel comfortable and confident in the services provided. Where services were accessed, respondents commonly referred to the experience of being an 'outsider' related to sexual orientation, and service structures and even ethos created barriers to access and completion of treatment; as did a failure to address complex needs such as mental health issues (diagnosed and undiagnosed) with substance dependency. The role of the Voluntary & Community Sector in therefore breaking down these access barriers to offer alternative services is key.	
76	SH	Public Health Wales	full	4	7-16	Need to include support services for Lesbian, Gay, Bisexual, Transgender (LGBTX) groups	Thank you for this comment. This recommendation has been amended to make clear that drug misuse prevention services should be commissioned through a wide range of services and services for people who are lesbian, gay, bisexual or transgender are

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							given as an example of these.
105	SH	Royal College of General Practitioners	Full	5	1	Consider what screening tools would useful in primary care. Consider using a 2 item brief screening instrument in primary care developed in Canada. The screening instrument has 2 questions. The first is, "How many days in the past 12 months have you used drugs other than alcohol?" Patients meet that criterion with a response of 7 or more days. The second question asks, "How many days in the past 12 months have you used drugs more than you meant to?" A response of 2 or more days meets that criterion. http://archinte.jamanetwork.com/article.aspx?articleID=2301378 Another option is an audio computer-assisted self-interview version of the Alcohol, Smoking and Substance Involvement Screening Test (ASSIST) in primary care patients http://www.tandfonline.com/doi/abs/10.1080/08897077.2015.1062460 (MH)	Thank you for this comment. The final guideline is clearer about the approach that should be taken to assessment and the fact that this should be undertaken as part of statutory, routine or opportunistic appointments. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems.
120	SH	Renaissance at Drugline Lancashire	Full	5	10	Definitely when someone attends A&E or is admitted to hospital as a result of drug or alcohol misuse, there needs to a direct referral to the substance misuse service. For example in Blackpool, a referral would be made to the Assertive Outreach Team within the substance misuse service, so patients can be seen while in the hospital and also upon discharge, with an appointment made for them to attend substance misuse services as soon as they are ready and able. Referrals are also being sent through for New Psychoactive Substances. There needs to be a good working relationship and clear pathways between the hospital and the substance misuse service. We have over 10 years experience in delivering Information and Brief Advice training to front line workers coming into contact with drug users, to equip them with the tools to provide information and refer to services. We also use Sexual Health Outreach, Netreach and co-delivery with Sexual Health Nurses to target LGBT drug using community.	Thank you for providing this information. We would also encourage stakeholders to see whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).
58	SH	NHS England	Full	5	11	We are concerned that the recommendation explicitly excludes adult offenders- services to offenders for drug misuse prevention should be delivered to all age groups at any point in the criminal justice pathway. Consider removing the word "young" from line 11.	Thank you for this comment. Recommendation 1.1.1 includes community-based criminal justice services (including adult, youth and family justice services).

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							Prison and young offender institution settings were outside of the scope of this guideline. People in prison in the UK are already in part of an existing prevention / rehab scheme. NICE has recently published guidance on the physical health of people in prison (see https://www.nice.org.uk/guidance/ng57). Guidance is also in development on mental health of adults in contact with the criminal justice system (seehttps://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726).
59	SH	NHS England	Full	5	11	We are concerned that this recommendation makes no mention of the soon to be published NICE guidelines on physical health in prisons which is due for publication in Oct 16. Can this guideline be referenced in your final publication? Please also note the following guideline is currently under consultation and may be relevant to the recommendations: *UK guidelines on clinical management' has published its draft for consultation with stakeholders. Details of the consultation, which runs until 15 September, and how to contribute are on the clinical guidelines page at www.nta.nhs.uk/guidelines.aspx*	Thank you for this comment. The guideline on the physical health of prisoners has been referenced in the final guideline and will be linked in the NICE pathway for this guideline.
69	SH	NHS England	Full	5	11	Young offender in the community are in contact with youth justice system	Thank you for this comment. References to community-based criminal justice services/ system within the guideline refer to services for adults, young people and families. This has been made clear in recommendation 1.1.1
24	SH	Department of Health	Full	5	11 - 12	Would suggest amending "…when young offenders come into contact…" to "…when young or adult offenders come into contact…"	Thank you for this comment. References to community-based criminal justice services/ system within the guideline refers to services for adults, young people and families. This has been made clear in recommendation 1.1.1;

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91	SH	Public Health England	Full	5	13	Add 'youth justice workers'	Thank you for this comment. Recommendation 1.1.1 has been updated to include community-based criminal justice services (including adult, youth and family justice services).
107	SH	Royal College of General Practitioners	Full	5	19	Recommendation 1.2.4: Although the mechanisms of referral pathways are ideally agreed at locality level, taking into account relevant local factors, would it be helpful to local commissioners to be provided, either in this guideline or elsewhere, with examples and advice about best practice? (LL)	Thank you for this comment; the implementation aspects of referral are outside the scope of this guideline. However, we encourage stakeholders to submit examples of best practice to be included on the NICE database of local practice to share learning and it may be that some examples will be listed here in future (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies)
79	SH	Public Health Wales	Full	5	20	Need to amend to ... regularly or excessively, **discuss and** refer them to specialist services...' In Wales the treatment data indicate a high number of non-attendances following referral to specialist services. When this was investigated as part of a research project, it was clear that some referrals, particularly those made by primary care were not even discussed properly with the patient/client. Report available at: http://www2.nphs.wales.nhs.uk:8080/BloodBorneVirusesDocs.nsf/public/BEE22A0587B6A00D802576F0003CCD13/$file/Influences%20and%20implications%20%20of%20unplanned%20drop%20out.pdf	Thank you for this comment. The text of the recommendations has been amended to ''discuss with the person what their priorities are and take into account how these might affect next steps or referral to other services'.
2	SH	Bristol Drugs Project	Full	5	23- 12 1.3	Bristol has experience of delivering such approaches under Youth Links Specialist Youth Work Service. It has from 2013 to present; targeted 9-19, offered dedicated time limited (6-8 sessions) harm reduction , informed decision making, resilience and coping strategies focused one to one , with target group workshops (1 hour, 1-3 times))in education and youth settings. This has allowed a consistency in knowledge and skills, credibility with young people and their families and complementing generic teacher and youth worker initial contact and general drug and alcohol educative approaches. Work governed by the local young people friendly award, reactive to emerging substances and pockets of use-(NPS to Somali young people) and offering consultancy to generic young people's worker to keep substance use live on competing agendas	Thank you for providing this information. We would also encourage stakeholders to see whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).

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						and promote referrals at the earliest possible juncture. Parental and carer education offered one to one, supported with school based awareness, LA online resource (4YP) with suggested option for standardised online learning and resources to reduce attrition at live events. Such approaches offered in light of reducing funds, where preventative approaches remain harder to demonstrate their impact.	
112	SH	Re-Solv	Full	5	29	Similar to the point above, we would encourage the wording to explicitly include solvent and volatile substance abuse, as in "…young people who are assessed as vulnerable to drug use INCLUDING SOLVENT AND VOLATILE SUBSTANCE ABUSE, and their parents…"	Thank you for this comment. Volatile substances have been added to the definition of drugs, therefore any reference to drugs in the guideline would include solvents and volatile substances.
52	SH	Mentor Foundation UK	Full	5	4	Question 4 We are aware of nationally validated tools that could be used at routine appointments, such as general paediatric settings. These are the CRAFFT and the Personal Experience Screening Questionnaire (PESQ).	Thank you for this comment. The final guideline is clearer about the approach that should be taken to assessment and the fact that this should be undertaken as part of statutory, routine or opportunistic appointments. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems.
68	SH	NHS England	full	5	4	An important group is missing those held in the CYPSE	Thank you for this comment; children and young people in secure environments are outside the scope for this work.
111	SH	Re-Solv	Full	5	4	As the UK National charity working toward the prevention of volatile substance abuse (VSA), we feel that VSA is often missed in assessments as, due to its legality, some users do not see it as a 'drug'. We encourage services to ask specifically if their clients use or have used solvents or volatile substances. In this document we would recommend including the wording, "assess whether someone in an at-risk group is vulnerable to drug use, INCLUDING SOLVENT OR VOLATILE SUBSTANCE ABUSE, using a validated…"	Thank you for this comment. Volatile substances have been added to the definition of drugs, therefore any reference to drugs in the guideline would include solvents and volatile substances.
1	SH	Bristol Drugs Project	Full	5	4-22 1.1 & 1.2	**Question 4, 5 & 6** We are concerned that the recommendation may imply greater ability, resource and commitment to such approaches exists than is actually present; noting particularly the recent	Thank you for raising these issues. Staff training was outside the scope of this guideline.

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						evidence challenging the value of IBA [identification and brief advice] approaches. Recognising there are some IBA and screening approaches in practice; the majority appear focused to alcohol (and other health issues) not drugs. There appears a lack of parity in approaches; generic services can be time restrictive, there may be differing approach from workers (based on their own interest in substance use , skills and confidence to have difficult conversations and quality of training in the subject and best ways to approach people), a difference in priority in services to highlight the subject when competing with information they require for their key delivery and may not be easily received or engaged with by the service user (denial based through stigma or not why they were there and most important need to them at that moment). Referring to drug and alcohol agencies again based on worker knowledge and interest or at times competing with a preciousness to hold onto clients. Training of generic workers having a cost and time impact, it can be offered cost effectively by online courses but can impact on the quality and governance of onward delivery. Training sources from drug and alcohol agencies to LA public health sources or local training providers (1/2 to 1 day). Extent of referrals to services dependant on the quality of training; may increase inappropriate referrals or attrition of service users if not well executed. Additionally the risk of the generic worker wanting to utilise their newly gained knowledge and undertake a substance use intervention themselves beyond their level of expertise Services should factor in possible increases if concerns of low area saturation into drug communities or emerging substances are being identified. Earlier referrals as part of a prevention strategy may allow for more time limited interventions and less long term demand; proving more cost effective and less impacting on services in the long run.	However, the final recommendations are clearer that targeted prevention activities should be delivered as part of existing services and practice and would therefore not excessively increase costs. Furthermore, recommendations on assessment are aimed at ensuring that intervention is targeted at the most vulnerable groups and therefore likely to be more cost effective. These issues are considered in detail in the committee discussion section of the guideline. The text of the recommendations has been amended to 'discuss with the person what their priorities are and take into account how these might affect next steps or referral to other services'.
78	SH	Public Health Wales	Full	5	4-6	Suggest amendment to 'Assess whether someone in an at-risk group is vulnerable to drug use using a **standardised and validated** approach that is respectful and non-judgemental...	Thank you for this comment. The updated guideline is clearer about the approach that should be taken to assessment and the fact

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						Whilst it is recognised that different assessment tools may be used, standardisation ensures equity of access to services that would otherwise not be met. The process then would be fully auditable and comparable across areas. At present there is too much variability leading to a lack of transparency in the process and as a result unmet need.	that this should be undertaken as part of statutory, routine or opportunistic appointments. It is also advocates that a respectful and non-judgemental approach is taken. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems.
115	SH	University of West London	Full	5	5-9	Question 1: I have been involved in delivering training in mental health services with the aim to enhance assessment of substance misuse, however there has been strong resistance from some of the most senior staff against introduce routine assessment using standardised tools. The main reasons provided were that they thought there is a risk that it might become another "ticking box" exercise. They also thought that the tool can become a barrier between the clinician and the client and that the clients may not be willing to talk about their drug use. Trainees feedback that substance use is not the priority, especially when the clients present with serious psychiatric symptoms. There is also a common understanding that most of psychiatric patients use substances, but mental health staff generally they do not feel that it's their responsibility to assess and discuss this issue. Another challenge is lack of knowledge and competence in dealing with Novel Psychoactive Substances, training is very much needed to enhance confidence on this matter. Question 3. Training and example of good practice could certainly help overcome some of the aforementioned challenges, for example in terms of knowledge, confidence and attitude. More resources are also needed; as mental health services have been drastically cut and very little funding is allocated to address co-morbidity, staff are not willing to include additional preventative interventions and assessment tools in their practice when they struggle with their case load.	Thank you for raising these issues. Staff training is outside of the scope for this guideline. The updated guideline is clearer about the approach that should be taken to assessment and the fact that this should be undertaken as part of statutory, routine or opportunistic appointments. It also advocates that a respectful and non-judgemental approach should be taken. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems. NICE also encourage stakeholders to submit examples of best practice to be included on the NICE database of local practice to share learning and it may be that some examples will be listed here in future (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).

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14	SH	CoramBAAF Adoption and Fostering Academy	Full	5	7 - 8	We agree that it is extremely important to carry out an assessment of vulnerability, however the resource implications of assessing vulnerability should be acknowledged here. For example, while this is something which should be considered at every statutory LAC health assessment, when combined with consideration of the wide range of other physical and mental health issues and health promotion which must also be addressed, these assessments require sensitivity and time.	Thank you for this comment. The updated guideline is clearer about the approach that should be taken to assessment and the fact that this should be undertaken as part of routine or opportunistic appointments. It also advocates that a respectful and non-judgemental approach is taken. The committee agreed that assessment can enable interventions to be targeted at the most vulnerable groups and therefore likely to be more cost effective. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems.
106	SH	Royal College of General Practitioners	Full	5	8	Recommendation 1.2.1: Should there be clarification and specification of what skill sets are required by GPs and nurses to undertake these assessments, and how training to acquire these skills should be delivered locally (with appropriate quality assurance)? (LL)	Thank you for this comment. Staff training and competences are outside the scope of this guideline. However, recommendation 1.3.2 has been updated to be clear that skills training should be delivered by people competent to provide skills training.
92	SH	Public Health England	Full	6	12	Say "where to hold the sessions (for example, in settings in line with the Department of Health's You're welcome **quality criteria for young people friendly health services".** It may also be worth noting that these are currently being updated.	Thank you for highlighting this.
3	SH	Bristol Drugs Project	Full	6	15-17 1.3.3	**Question 7** The Bristol experience promoting as timely a follow up as possible, with BYL an appointment within the next week offered in school or other education or deemed safe space; this appointment allowing progression of an early intervention approach (6-8 sessions) and as needed a supported referral to younger people's treatment services.	Thank you for providing this information. We would also encourage stakeholders to see whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).
80	SH	Public Health Wales	Full	6	20-27	Need to include negotiation, self-efficacy and confidence building skills	Thank you for this comment. The list is not intended to be exhaustive and the examples are based on the evidence considered by the

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							public health advisory committee.
17	SH	CoramBAAF Adoption and Fostering Academy	Full	6	20-30	Again there are significant resource implications in offering skill training for looked after children and young people. Most will probably have experienced trauma and loss and they may also have mental and emotional health issues which might need to be addressed either as part of skills training or to lay the foundation for it; CAMHS may be best placed to offer this. While it may be possible to address skill training with some young people as part of health promotion during statutory LAC health assessments, for many others it may be necessary to develop a specific programme to deliver training in these skills. It must also be noted that these are generic skills that will be useful in other aspects of life and may assist in preventing other types of harm.	Thank you for this comment. The recommendation does not preclude looked-after-children or other young people being referred to other services to address wider concerns in relation to their health or circumstances. To note that NICE has also issued guidance specifically on looked after children and young people – please see https://www.nice.org.uk/guidance/ph28 To note that staff training and competencies are outside the scope of this guideline. However, recommendations in section 1.3 of the guideline have been updated to be clear that any skills training should be delivered by people competent to provide it.
41	SH	LGBT Foundation / National LGB&T Partnership	Full	6	26	The section discussing skills training for children and young people is particularly relevant to LGBT children and young people. As mentioned, skills training can help them with 'dealing with feelings of exclusion', which LGBT children and young people are particularly at risk at. For example, METRO's *Youth Chances: Summary of First Findings* report (2014) showed that LGBT young people report lacking emotional support to help them when they are coming out as LGB or trans. Similarly, the report showed significantly higher levels of mental health problems including depression and anxiety, self-harm and suicidal thoughts than the general population. Effective prevention work with LGBT children and young people before the age of 18 is crucial, i.e. before they join with the heavy drinking culture prevalent in the LGBT community, which anecdotally helps LGBT individuals feel less excluded.	Thank you for providing this information.
81	SH	Public Health Wales	Full	6	30	Need to add '... feelings of exclusion, **loss, bereavement/grief'**	Thank you for this comment. The current wording is based on the evidence identified and discussed by the committee. Therefore, this change has not been made to the

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							guideline.
93	SH	Public Health England	Full	7	16	Consider adding "or who are at risk of their current drug use becoming problematic"	Thank you for this comment. The committee considered that the point made is already covered in the definition of 'vulnerable to drug use'.
We w18	SH	CoramBAAF Adoption and Fostering Academy	Full	7	1-7	Similarly the skills listed here are generic skills which may improve the relationship between parent/carer and child as well as having a positive impact on family functioning.	Thank you for this comment.
56	SH	Mentor Foundation UK	Full	7	1-7	We think it would be good to include and highlight the effectiveness of parental supervision, monitoring and effective discipline, including the ability of setting, and expecting compliance with clear rules and values for appropriate behaviour. Research shows that parents and carers who are supportive, encourage children to be independent, but expect compliance with rules, and are consistent and fair in their discipline, have children who are more resilient than others (UNODC Guide to implementing family skills training programmes for drug abuse prevention). Moreover, Recent Australian research shows that parents with more restrictive views can reduce levels of binge drinking. We would also stress the need to convey information/education. Besides skills training, it is vital to provide credible information about risks, normative education, and related harms. Although this does not work in isolation, it does form a key part of prevention. An example of evidence-based intervention that uses the respect of common ground rules (not only at family level, but also at community level by targeting communities of parents) is Effekt, also known as Orebro Prevention Programme. For further information on the programme, please visit CAYT: http://cayt.mentor-adepis.org/publication/orebro-prevention-program-effekt-2/	Thank you for this comment. The wording reflects the evidence identified. Some evidence was identified on behaviour reinforcement strategies but specific evidence was not identified on parent's supervision, monitoring and discipline. Please see the evidence reviews section in the guideline for further information. To note that universal approaches are outside the scope of this guideline.
121	SH	Renaissance at Drugline Lancashire	Full	8	8	In Blackpool, we hold Harm Reduction clinics in the Hostels within the town, providing drug and alcohol harm reduction advice, needle exchange provision, and a referral pathway into substance misuse service if required.	Thank you for providing this information. We would also encourage stakeholders to see whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).

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122	SH	Renaissance at Drugline Lancashire	Full	8	12	Having a harm reduction clinic in the gyms once a month or every 6 weeks is a good way of engaging with SIPED users and providing harm reduction advice.	Thank you for providing this information. We would also encourage stakeholders to see whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).
5	SH	Bristol Drugs Project	Full	8	1.5.2 14-20	**Question 9** The recommendation may be challenging in practice for those non competent or having IT access for on line self-assessment tools (recent benefit changes to Universal Credit highlighting this) but not negated as we see the benefit of online tools as Breaking Free Online. For preventative purposes and less complex substance users, exclusion challenges averted and easily be a chosen option for those where daily information sharing on line is 'normalised'. The Bristol experience highlighting social media and use of email for advice and information, it harnessed for cost effective campaigns, reach into differing demographics and initial contact purposes. Most recently including a dedicated email for target reach with the PRISM service for LGBT+, complementing agency web space, social media, the in-reach and satellite provision on the 'scene' and events as Pride. Breaking barriers to contact and winning hearts and minds of differing individuals and the credibility of a substance use agency to meet their needs.	Thank you for providing this information. We would also encourage stakeholders to see whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).
94	SH	Public Health England	Full	8	10	May be worth specifying HIV clinics	Thank you for this comment. The text has not been amended as sexual and reproductive health services are already included.
4	SH	Bristol Drugs Project	Full	8	1-2 1.4.3	**Question 8** This may be challenging to implement recognising the differing settings of first contact (gym to club to festival to agency etc.). Support to be a timely response (1-3 weeks maximum) and as the Bristol with Brief Interventions offering both an assessment and intervention within one process, rather than waiting for a more formal assessment process and referral on within service. Additionally recognising what can be done in situ at the setting, the PRISM LGBT response allowing support in a dedicated 'scene' premises to challenge concerns with accessing the general premises. Where, dependent on the person and agency; GP	Thank you for providing this information.

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						practice to agency base or satellite venue to other community safe space identified by the individual. Non face to face options considered as netreach, email or phone support. Such approaches utilising lessons from BI and EBI for duration of contact (3-6 sessions)	
25	SH	Department of Health	Full	8	18	We would suggest including Talk to Frank (http://www.talktofrank.com/) as a source of information	Thank you for this comment. We have not included a specific link to Talk to Frank as we understand that this programme is being re-focused. There is a link to it from the NHS Choices link in the guideline. This will ensure any future changes to the Talk to Frank link will not be broken.
42	SH	LGBT Foundation / National LGB&T Partnership	Full	8	3-7	There's strong indication that delivery in sexual health settings is beneficial in prevention. For example, Antidote locates workers in several GUM settings, meaning they're able to access MSM who would not consider attending drug services and who do not experience their substance use as problematic. Initiating conversations about drug use and offering information where MSM are attending for STI screening or PEP allows Antidote to provide prevention interventions, and identify where structure treatment may be indicated. Similarly, the weekly Reach Clinic based in the Hathersage Integrated Contraception, Sexual Health and HIV Service in Manchester provides support for people engaging in Chemsex. The Reach Clinic was recently reviewed (July 2016) and 100% of respondents attending the clinic reported that they felt they were more aware of how to reduce risks to their health when using drugs during Chemsex. This is an indicator of the importance of operating services jointly between Sexual Health and drugs services. The report also noted that men who attended Reach tended to use drugs in a way which is significantly more likely to harm their mental and physical health (in particular increasing their risk of drug dependence and of contracting a blood-borne virus), indicating that sexual health settings is a crucial place for drug prevention services to be situated.	Thank you for providing this information.
60	SH	NHS England	Full	8	5	As in recommendation 1.1, the inclusion of other substance misuse	Thank you for this comment. Secure settings

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						service commissioners is needed in addition to local authorities. This will ensure the commissioners for services in residential secure environments will act on these recommendations.	were excluded from the scope for this guidance. People in prison in the UK are already in part of an existing prevention / rehabilitation scheme. NICE has recently published guidance on the physical health of people in prison (see https://www.nice.org.uk/guidance/ng57). Guidance is also in development on mental health of adults in contact with the criminal justice system (seehttps://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726).
95	SH	Public Health England	Full	8	5	The line in 1.5 "These recommendations are for local authorities and owners and managers of venues attended by people using or at risk of using drugs." Doesn't really work, as the bullet on line 10 is "wider health services, such as sexual and reproductive health services or primary care" so more specific to CCGs.	Thank you for this comment. The heading sections across the recommendations have been removed as the recommendations have been re-drafted to ensure that it is implicit from the recommendations who the recommendations are for.
82	SH	Public Health Wales	Full	8	7,14	The recommendations with regards to raising awareness use the term 'Consider' providing information... This term will allow no action to be taken and does not indicate any confidence in the recommendation being made. Suggest removal so that recommendations 1.5.1 and 1.5.2 read 'Provide information about drug use.... ' and 'Provide information in different formats....'	Thank you for this comment. The use of the term 'consider' reflects the strength of the evidence identified, in line with the NICE manual section 9 (please see https://www.nice.org.uk/media/default/about/what-we-do/our-programmes/developing-nice-guidelines-the-manual.pdf)
96	SH	Public Health England	Full	9	10	'groups at risk' – there is no specific mention of men who have sex with men and who are involved in chem sex. Seems an omission throughout, to have no mention of chem sex.	Thank you for this comment. No specific evidence on chem sex among men who have sex with men was identified. This issue is highlighted within the updated committee discussion section of the guideline.
62	SH	NHS England	Full	9	18	We are very concerned that this group explicitly excludes children & young people not in secure settings. Adults and young people in secure environments are clearly at risk of using drugs for the first time as well as continuing irregular use initiated in the community. The impact of NPS in secure environments evidences this vulnerability. As a result of this and the potential of diversion of prescribed medicines in prisons, we ask the GDG to consider	Thank you for this comment. Residential secure environments were excluded from the scope for this guidance. People in prison in the UK are already in part of an existing prevention / rehab scheme. NICE has recently published guidance on the physical health of people in prison (see

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						including children and young people in held on youth justice or welfare grounds within the children and young people's secure estate including Young Offender Institutions (under 18), Secure Training Centres and Secure Children's Homes. All children and young people held in the estate are screen and assessed using the Comprehensive Health Assessment Tool, which includes a substance misuse section, all CYP with a need will be seen by the SM section of healthcare including early intervention and prevention. The intercollegiate healthcare standards and NHSE core outcome specifications all include SM weaved throughout and have separate SM sections.,	https://www.nice.org.uk/guidance/ng57). Guidance is also in development on mental health of adults in contact with the criminal justice system (seehttps://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726).
70	SH	NHS England	Full	9	19	Children and young people are not held in prison, they are either remanded or sentenced to young offender institutions, secure training centres and secure children's homes. Not sure why excluded??	Thank you for this comment. Residential secure environments were excluded from the scope of this guidance. People in prison in the UK are already in part of an existing prevention / rehabilitation scheme. NICE has recently published guidance on the physical health of people in prison (see https://www.nice.org.uk/guidance/ng57). Guidance is also in development on mental health of adults in contact with the criminal justice system (seehttps://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726).
97	SH	Public Health England	Full	9	20	It would be helpful to make specific reference to children who run away from home. The Hard Edges report on people with multiple needs shows that 42% of those experiencing the most severe multiple disadvantage (including substance misuse problems) had run away from home as children.	Thank you for this comment. We did not identify specific evidence on children who have run away from home. We did identify a number of interventions focusing on homeless young people, but they did not elaborate on their circumstances. Further information on the choice of at risk groups is included in the linked evidence reviews undertaken to support the development of this guideline.
98	SH	Public Health England	Full	9	22	Not sure the distinction between 'groups at risk of drug use' and 'groups at risk of drug misuse' really works, or adds anything other than stating the obvious.	Thank you for this comment. The terms used section of the guideline has been amended for clarity. The definitions for the terms 'drugs', 'groups at risk' and 'vulnerable to drug

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							misuse' are clearly distinguished.
61	SH	NHS England	Full	9	2-4 and 6-8	We are concerned that the omission of "prescribed medicines" in the definition of "Drugs" and "Drugs Misuse" misses a key population who have dependency on prescribed medicines including opioids, gabapentin and pregabalin. The dependency arises due to un-intentionally acquired dependency on their prescribed medicines, or an intentional dependency on prescribed medicines diverted or traded. This is a recognised dependency by the Advisory Committee on the Misuse of Drugs (ACMD) but substance misuse services do not consistently recognise or offer services for these people. This guidance offers an opportunity to include this cohort of people within the scope of drug misuse and thus services to treat them. This population falls within the at risk group in the guideline (page 1) that "prevent people who are already using some drugs from moving on to other drugs"	Thank you for this comment. The exclusion of prescribed drugs and over the counter drugs was an omission; this has been amended in the updated version of the guideline.
done 26	SH	Department of Health	Full	12	11 - 12	This section refers to the 2014/15 Crime Survey for England, but the Survey covers England and Wales and 205/16 data has recently been published (https://www.gov.uk/government/statistics/drug-misuse-findings-from-the-2015-to-2016-csew)	Thank you for this comment, this text has been updated, using this more up-to-date reference.
99	SH	Public Health England	Full	12	22	It would be worth making clear that CSEW as a household survey has some weaknesses in measuring the prevalence of Class A drug use; it doesn't, for example, collect data from homeless people, or those in the criminal justice system.	Thank you for this comment. As this section of the guideline is intended to give a concise summary of the context for drugs misuse prevention, further methodological information on the Crime Survey for England and Wales has not been added to this section of the guideline.
100	SH	Public Health England	Full	12	26	What About YOUth and Smoking, Drinking and Drug Use Among Young People in England - are 2 different surveys.	Thank you for this comment, the different surveys have now been distinguished from one another in this section of the guideline.
27	SH	Department of Health	Full	12	26 - 27	The reference "The What About YOUth survey (Smoking, Drinking and Drug Use Among Young People in England 2014)" is incorrect, it should be "The Health and Wellbeing of 15-year-olds in England - Main findings from the What About YOUth? Survey 2014"	Thank you for this comment. The reference has been corrected in the final guideline.
28	SH	Department of Health	Full	13	11	The National Drug Strategy for England 2010 was published by the previous Coalition Government and not the current Government. It might also be helpful to reference the 2014/15 review of the Strategy (https://www.gov.uk/government/publications/drug-strategy-annual-	Thank you for this comment. The updated guideline notes that the third annual review of this strategy was published in 2015.

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						review-2014-to-2015)	
13	SH	CoramBAAF Adoption and Fostering Academy	Full	4 and 9	13 and 17	We welcome the specific inclusion of looked after children and young people in the guidance to highlight their at risk status. Not all those who come into contact with them will understand their vulnerability and background risk factors.	Thank you for this comment.
113	SH	Re-Solv	Full	13	2	Would add in a further point on young people's drug use: 11-13 year olds were twice as likely to use volatile substances as cannabis. Or some similar point highlighting that VSA is a significant issue in the 11-13 year old age groups.	Thank you for this information The context section of the guideline has been updated to note that of 11 to 13 year olds who reported some drug use in the past year, 53% reported using volatile substances. In addition, volatile substances have been added to the definition of drugs, therefore any reference to drugs in the guideline would include solvents and volatile substances.
101	SH	Public Health England	Full	17	19	The problem with the way that 'drug misuse prevention' is discussed in section 1.2 is that it doesn't really relate to young people. It still feels like the document hasn't established what 'prevention' means for young people. The evidence base suggests that effective prevention is not substance misuse specific, but this doesn't really come across here. It comes across as if 'drug misuse prevention' is just a thing that everyone needs to do…	Thank you for this comment. The recommendations apply to all ages within at risk groups, other than where an age is clearly stated (recommendations in section1.3 are for children and young people under the age of 18 assessed as vulnerable to drug misuse). To note that this guideline focuses on targeted approaches. Universal approaches to prevention are outside the scope for this work. Recommendation 1.1.2 has been amended in the updated guideline to recommend the following: 'Ensure activities targeting groups at risk are integrated with any population-level (universal) activities aimed at preventing drug misuse.
102	SH	Public Health England	Full	17	19	Section 1.2 also doesn't feel very relevant for young people, where, in particular, factors around risk, protective factors and safeguarding will be key – but these aren't reflected here.	Thank you for this comment. A recommendation around safeguarding has been added to section 1.2 and further information on this has been added into the committee discussion section of the guideline.
83	SH	Public Health	Full	18	17-20	Public Health Wales welcome the statement that all relevant	Thank you for this comment. Staff training and

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		Wales				professionals be aware of drug misuse prevention and should make every contact count (MECC) – this is in line with the national (MECC) aims within Public Health Wales. However, the **competence and credibility** of the professional is paramount. Many health and social care professionals may present a lack of knowledge or moral opinion - this is detrimental to outcomes for the at risk groups. As such, health, social care and criminal justice professionals should undertake training and assessment of competence prior to engagement with individuals in relation to MECC and drug misuse prevention messages and assessment.	competence is outside the scope of the guideline. However, recommendation 1.3.2 emphasises that training should be delivered by people competent to provide skills training.
43	SH	LGBT Foundation / National LGB&T Partnership	Full	19	24-25	The wording of this sentence should be amended to reflect the complexity of the issue and poorer rates of engagement with groups at risk. It would be better to say 'people should be referred and supported to engage with treatment services'.	Thank you for raising this issue. However as treatment (and related engagement across groups) is outside of the scope of this guideline, the committee have not considered this issue. Therefore, we are unable to amend the wording as suggested.
71	SH	NHS England	Full	19	3	Community Comprehensive Health Assessment Tool http://www.ohrn.nhs.uk/OHRNResearch/CHAT	Thank you for this comment. The updated guideline is clearer about the approach that should be taken to assessment and the fact that this should be undertaken as part of statutory, routine or opportunistic appointments. It also advocates a respectful and non-judgement approach. The updated guideline provides an example of assessment linking to practice standards for young people with substance misuse problems. We would also encourage stakeholders to see whether these examples are eligible to be included on the NICE database of local practice to share learning (see https://www.nice.org.uk/about/what-we-do/into-practice/local-practice-case-studies).
85	SH	Public Health Wales	Full	21	26	Public Health Wales recognise the importance and efficacy of use of Peer Educators in drug misuse prevention and wider harm reduction interventions both within the community and in custodial settings. Peer educators can provide highly credible and competent engagement with at risk individuals and groups, far better in many	Thank you for this comment. Limited evidence was identified on peer educators and the committee were therefore unable to make a recommendation on this. Please see the linked evidence reviews, which supported the

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						cases than that provided by health and other professionals in relation to making every contact count. Further examination of the potential of peer educators would be welcomed in this guidance.	development of this guideline.
86	SH	Public Health Wales	Full	23	26-31	It is our experience that group work will be offered in the first instance as it is cheaper to provide. It is vital that the decision to provide 1-1 or group work lies with the at-risk individual and not limited by the provider organisation on the grounds of finance – this can have detrimental effect on engagement with at-risk individuals and on retention to services.	Thank you for this comment.
103	SH	Public Health England	Full	25	12	Why single out looked after children? Wouldn't this be the case for all vulnerable young people (i.e. those in the youth justice system)?	Thank you for this comment, the text has been amended for clarity. The discussion section has been amended to clarify that there was clearer evidence of the success of skills training in children who are looked after compared with other groups.
87	SH	Public Health Wales	Full	26	23-25	In our experience, the assumption that advice and information are likely to be part of standard care is NOT borne out in reality.	Thank you for this comment.
44	SH	LGBT Foundation / National LGB&T Partnership	Full	26	General	Limited evaluation has been carried out into the effectiveness of techniques in providing information to adults that identify as LGBT who are vulnerable to drug use. LGBT drug and alcohol services use a range of established techniques (brief interventions, motivational interviews, CBT and counselling), and throughout all the importance is the cultural knowledge and the place-based setting where LGBT people express greater comfort, trust and confidence. Anecdotally from data gathered at Antidote's service that predominantly see's non-opiate and/or crack users, LGBT people may often have more recovery capital than the more traditional entrenched problematic opiate or crack users who structured treatment is aimed at. This means that the treatment (i.e. tier 3) work done with them is sometimes difficult to distinguish from the education and motivation interventions used in prevention work; it can be difficult to draw a clear line between the two.	Thank you for providing this information. The committee considered that the recommendations, context, discussion and terms used were all clear on the scope of the guideline in relation to prevention and that there was clear signposting to other NICE guidelines on treatment. Recommendation 1.1.2 in the guideline states 'Ensure activities targeting groups at risk are integrated with any population-level (universal) activities aimed at preventing drug misuse.

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						It is therefore important to note that prevention doesn't happen in isolation but is part of wider services around harm reduction, early intervention and semi-structured treatment/low – intensity treatment. In order to understand the best way to support LGBT people, as a group at high risk of substance misuse and dependency, it would be useful for the guidance to have clear boundaries and clearly define prevention from wider substance misuse services.	
46	SH	LGBT Foundation / National LGB&T Partnership	Full	30	11-15	As part of professional development and wider training, staff delivering assessments and interventions should have LGBT awareness training. London Friend's *Out of Your Mind* report (2014) recommends that to improve drug and alcohol services for LGBT people commissioners and providers of services should subcontract and work in partnership with targeted LGBT organisations. This ensures that necessary specialist services are funded, whilst also helping towards skills development and capacity building for the mainstream provider.	Thank you for this comment. Staff training and competence are outside the scope of this guideline. However, recommendation 1.3.2 emphasises that training should be delivered by people competent to provide skills training.
110	SH	Royal College of Nursing	Full	30	21	With regards to the comment on lack of evidence on the New Psychoactive Substances (NPS), the developers may be aware that there is Public Health England (PHE) guidance (A toolkit for substance misuse Commissioners) which is great but an increasing problem in prisons to implement.	Thank you for providing this information.
47	SH	LGBT Foundation / National LGB&T Partnership	Full	33	22-23	It's very positive that Chemsex is specifically identified as an environment that requires more research and targeted interventions. The success of the Reach Clinic at the Hathersage in Manchester is discussed earlier in comment no. 2.	Thank you for providing this information.
123	SH	Renaissance at Drugline Lancashire	Full	33	23	Recommendations would be welcome on interventions delivered in real-world settings for people using drugs in a sexual context.	Thank you for this comment. No evidence was identified on this issue.
72	SH	NHS England	Full	38	10	This also appears in other places. No reference to either secure or community guidance http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_106431 http://webarchive.nationalarchives.gov.uk/20130107105354/http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/Publications	Thank you for this comment. Residential secure environments are excluded from the scope of this guidance. People in prison in the UK are already in part of an existing prevention / rehabilitation scheme. NICE has recently published guidance on the physical health of people in prison (see

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						PolicyAndGuidance/DH_106433	https://www.nice.org.uk/guidance/ng57). Guidance is also in development on mental health of adults in contact with the criminal justice system (seehttps://www.nice.org.uk/guidance/indevelopment/gid-cgwave0726).
6	SH	Bristol Drugs Project	Full	40	19+	**Question 10** Prioritised: 3. Effectiveness of Digital Technologies 7. Image and Performance Enhancing drugs 1. Effectiveness and costs effectiveness of drug misuse prevention interventions for groups vulnerable to drug use	Thank you for this comment. The included research recommendations have been amended in light of stakeholder comments.
116	SH	University of West London	Full	40	21	Question 10. It is important to evaluate effectiveness and cost-effectiveness of drug prevention intervention in order to focus our efforts in the right directions, however, conducting good longitudinal well designed studies require a long time and resources, I believe that in the meantime, based on the available evidence (even with its limitations), changes need to be implemented to improve the care for vulnerable groups.	Thank you for this comment. The order of the research recommendations have been amended in light of stakeholder comments.
117	SH	University of West London	Full	41	2	Question 10 It is essential to understand and enhance the acceptability of drug misuse prevention interventions in staff who are supposed to deliver them, they will not be implemented otherwise. Challenges/obstacles need to be acknowledged and systems should be put in place to overcome them.	Thank you for this comment. A research recommendation (4) has been added on the acceptability of drug misuse prevention interventions.
118	SH	University of West London	Full	42	8	Exploring the effectiveness of new technologies could offer valuable cost effective interventions.	Thank you for this comment.
119	SH	University of West London	Full	43	8	Question 10. Mapping existing practice is essential to be able to identify and share good practice as well as identify training development needs	Thank you for this comment. Research recommendation 2 focuses on identifying current practice and provision.
In January 2017, the Local Government Association and a number of local authority contacts were asked to comment on a most recent draft of the Drugs Misuse Prevention guideline recommendations. This was to ensure NICE had sufficient feedback from commissioning organisations on the content and potential impact of the guideline recommendations. Feedback which was received is shown below.							
	SH	Local Government Association	Guideline recommendations			I read through the recommendations and I couldn't see anything that gave us cause for concern.	Thank you for providing this feedback.
	Indivi	Hackney	Guideline			Thank you for the opportunity to review these NICE guidelines prior	Thank you for providing this feedback and

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	dual	Council	recommendations			to publication. Some brief comments on the guideline recommendations are below, I hope these are helpful in your preparations. • We wondered if the distinction between "Groups at risk" and "vulnerable to drug misuse" could potentially cause some confusion, and whether these sections could be combined (or reframed)? For example, definition of 'drug misuse' excludes occasional / experimental use, but such use is cited as a risk factor for misuse; e.g. gyms are mentioned as a 'risk' because of PIEDs. There may also be potential for some of the 'at risk' definitions to be possibly stigmatising eg LGBT, and 'people who attend nightclubs and festivals'. These groups are at risk inasmuch as prevalence of drug misuse is higher, but that doesn't mean that all people in these groups are at risk. • As part of the section on Assessment, the focus on health services is appropriate, as staff are likely to have skills and experience required to work with people in the way outlined in 1.2.2 to 1.2.5. However if assessments are to be conducted in 'community-based criminal justice system' (ie police and probation?), then it would be helpful if there were references to such competences, eg using specialist drug and alcohol workers. • More information on what constitutes effective 'skills training' in reference to children and young people would be helpful. Section 1.3 (C&YP) refers to skills training as part of increasing resilience and reducing risk across a range of behaviours, not just drug misuse in isolation. Although implicit in this section, greater reference to the value of increasing skills/resilience of young people around drug misuse would be helpful to prevent this getting lost in more generic 'skills training' offers. • In addition, in section 1.3 greater reference to PSHE as well as diversionary activities and work to delay first use would be helpful in this context. • Section 1.4 (adults) focuses on drug-specific advice - it may be appropriate to also include more information the value of	highlighting potential challenges for implementing the guideline recommendations. Groups at risk' and 'vulnerable to drug misuse' are defined in the 'terms used' section following the recommendations. The guideline committee did review these definitions and felt they were sufficiently clear. The equality issue highlighted is very important. Further information on the guideline committee's considerations around this can be found at the start of the committee discussion section of the guideline. They agreed that there would be variation in risk within each of the 'at risk' groups based on a person's circumstances. It was not possible to say anything further on the competencies of staff undertaking drug misuse prevention assessments in community-based criminal justice services, as staff training and competencies fell outside of the scope for the guideline. However, the guideline does include a link to the NICE guideline on anti-social behaviour, which does include recommendations on the training and competencies of staff working with children and young people. Due to the limitations of the evidence base, it was not possible to give more information on the constituency of effective skills training in the guideline recommendations. However, it is hoped that the breadth of the recommendations about this will allow flexibility in how skills training is provided based on the needs of the local population. It was not within the scope of the guideline to

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						refering people to welfare / housing / training services to address possible stressors that are causing drug misuse, otherwise they remain at-risk/vulnerable. • Greater reference to harm reduction (in addition to the reference of needle and syringe programmes) would strengthen the guidelines.	consider broader, universal activities to prevent drugs misuse or to consider harm reduction approaches. For this reason, the guideline does not make reference to personal and social health and education or referrals to other services such as housing and welfare. However, the guideline committee did recognise the importance of wider socio-economic determinants and these are highlighted in the committee discussion section of the guideline.
	Individual	Doncaster Council	Guideline recommendations			Recommendation: 1.2.4. needs may be complex and this may necessitate multi-disciplinary action to address risk 1.4.1 advice and feedback on risks of any existing drug use	Thank you for providing this feedback and highlighting potential challenges when implementing these guideline recommendations.
	Individual	Southend-on-Sea Borough Council	Guideline recommendations			Recommendations : 1.1.1 Why only community-based? Why not prison for example? Or in custody? 1.2.1 Does this need further expansion? I assume we are referencing the idea that the 'messages' in be must be consistent with the other, but inevitably given the different audiences, the methods and thus the nuancing of the message may legitimately be different. 1.2.1 Despite the definition provided, we'd suggest this is wide open to observer-bias, for example, some teachers we work with seem to feel that a pupil who discloses that they have tried cannabis will be using heroin within weeks, whereas perhaps others view cannabis as utterly harmless. We see this across different professions. Also, why just community based criminal justice? 1.2.3 Not just single type, but also if there is any 'poly use', which of course multiplies risk. As well as how used, circumstances of use – where, with whom (set and setting) 1.3.2 Will there be standards formulated by which to judge this	Thank you for providing this feedback. Prison and custodial settings were outside the scope of the guideline. Universal approaches to drug misuse prevention were also outside of the guideline scope but the committee wanted to ensure that targeted interventions were consistent with universal activities. However, this does not preclude people working in drug misuse from using their professional judgement to tailor drugs misuse prevention messages as part of targeted interventions. While the guideline is intended to provide recommendations on best practice, it is not intended to replace professional judgement. Some variation in a drugs misuse prevention assessment is anticipated and will vary dependent on professional experience and the particular situation or setting.

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						1.3.3 Add: Developing individual- and family-based resilience? 1.3.4 Why don't other parents and carers get this? 1.4.1 Does this miss the opportunity for an early intervention where appropriate, or is this captured sufficiently in bullet 2? 1.4.2 Should this also reflect possible digital platforms (websites, social media etc.)? 1.4.3 The previous issue about subjective interpretation of risk applies – we often see inappropriate referrals from schools and other professional settings, where referred clients do not need specialist intervention, but the panic of the referrer kicks in. 1.5.1 what about schools here...? Certainly pupil referral units or other specialist education units dealing with excluded young people, but why aren't schools in general on this list. However, really pleased to see nightclubs and festivals included here. 1.5.2 Why is this included here but not in the adults' section above? 1.5.3 Again, should we make more of the link to 'advice as brief intervention'? Terms used: Drugs - Is there a separate set of parallel guidance for alcohol? Drug misuse - How are we defining excessive? We have no CMO guidelines on this? Prevention - Is there scope within this for something relating to preventing those who already use drugs regularly from regular use of these through harmful means of administration, e.g. injecting? Young people - Why starting from 10? There is a reasonably well established view that preventive approaches should begin significantly earlier	It was not within the scope of the guideline to consider staff training and competencies to provide skills training. Therefore it has not been possible to provide any further information on this in the recommendations. However, the guideline does include a link to the NICE guideline on anti-social behaviour, which does include recommendations on the training and competencies of staff working with children and young people. The recommendations are based on the evidence that was available. Combined individual and family based resilience interventions were not found to effective or cost effective. There was particular evidence demonstrating that behaviour reinforcement strategies were particularly important for skills training provided to foster carers, which is why this was highlighted in the recommendations. The examples given in section 1.5 of the guideline recommendations were specifically linked to the defined 'at risk' groups within the guideline. For this reason schools were not included here. The intention of these particular recommendations was to capture 'at risk' groups that may be difficult to make contact with, for example people who attend nightclubs and festivals and people without permanent accommodation. NICE has existing guidelines on preventing alcohol use disorders (PH24). There is also a NICE guideline update in development on alcohol in schools and existing guidance on the treatment and management of alcohol use

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							disorders. 'Excessive' in the context of drugs misuse is a subjective term but the guideline defines 'drugs misuse' as dependence or regular consumption that would lead to physical, mental or social problems. Defining excessive drug use would be based on professional judgement taking into consideration the impact that known drug use may be having on the person. It was outside of the scope of this guideline to consider the progression of drug use in those who are already using drugs regularly. The guideline does include children younger than 10 years but this age was identified as the lower band for the definition of young people.
	SH	Calderdale Council	Guideline recommendations			My overall view is that implementation of these guidelines whilst very worthy would be very challenging in the current environment where resources are being cut. To implement this locally would be a big project working across most directorates and external partner agencies. Assessment tools are silo based so initial intensive work would be needed to bring partner agencies on board who are currently focused on maintaining delivering essential services. Locally we would have to develop holistic assessment tools or agree additional questions on a range of assessment tools would pull upon already stretched public health resources. Calderdale for example has one post across the whole council looking at drugs and alcohol treatment and prevention all ages. We have experienced similar challenges trying to develop GP screening in GP practises, the work involved tweaking system one (IT system) and the training required for both GPs and practise staff.	Thank you for providing this feedback and for highlighting potential challenges with implementing the guideline recommendations. The initial assessment recommended in the guideline is not intended to be an intensive assessment, particularly as it would be delivered through routine appointments and opportunistic contacts with statutory and other services. Working with the guideline committee and based on feedback from stakeholders at consultation, the resource impact team at NICE anticipate that the guideline will have a low resource impact. Children and young people whose carers or families use drugs are identified as an at risk group in the guideline. The full list of at risk groups can be found in the 'terms used'

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						Training on basic identification would need to be a cross council project, current experience tells us that it is difficult to attract frontline staff to courses when they are struggling with stretched caseloads, senior management buy in would be key to making this happen. Our current specialist contracts have been reduced to essential delivery and are at risk of further cuts, including training within the service spec would mean difficult decisions about what we don't do… I would have expected that children of drug users in treatment would have been another target group alongside Care leavers and Looked after Children, these groups are easy to identify and with our limited resources may be a good starting place, in terms of vulnerable adults in Calderdale we have had difficulty in progressing work in this area due to personal change and differing priorities. The broader drugs information and prevention initiatives, targeting specific groups, i.e. Young people attending festivals and gyms are easier to develop particularly using social media and council resources.	section of the guideline following the recommendations.