NATIONAL INSTITUTE FOR HEALTH AND CARE EXCELLENCE

HEALTH AND SOCIAL CARE DIRECTORATE

QUALITY STANDARD CONSULTATION

SUMMARY REPORT

1 Quality standard title

Drug misuse prevention

Date of quality standards advisory committee post-consultation meeting:
9 January 2017.

2 Introduction

The draft quality standard for Drug misuse prevention was made available on the NICE website for a 4-week public consultation period between 9 August and 7 September 2017. Registered stakeholders were notified by email and invited to submit consultation comments on the draft quality standard. General feedback on the quality standard and comments on individual quality statements were accepted.

Comments were received from 12 organisations, which included service providers, national organisations, professional bodies and others.

This report provides the quality standards advisory committee with a high-level summary of the consultation comments, prepared by the NICE quality standards team. It provides a basis for discussion by the committee as part of the final meeting where the committee will consider consultation comments. Where appropriate the quality standard will be refined with input from the committee.

Consultation comments that may result in changes to the quality standard have been highlighted within this report. Comments suggesting changes that are outside of the process have not been included in this summary. The types of comments typically

not included are those relating to source guidance recommendations and suggestions for non-accredited source guidance, requests to broaden statements out of scope, requests to include thresholds, targets, large volumes of supporting information, general comments on the role and purpose of quality standards and requests to change NICE templates. However, the committee should read this summary alongside the full set of consultation comments, which are provided in appendix 1.

3 Questions for consultation

Stakeholders were invited to respond to the following general questions:

1. Does this draft quality standard accurately reflect the key areas for quality improvement?

2. Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be to be for these to be put in place?

3. Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them? Please describe any resource requirements that you think would be necessary for any statement. Please describe any potential cost savings or opportunities for disinvestment.

7. Do you have an example from practice of implementing the NICE guideline(s) that underpins this quality standard? If so, please submit your example to the NICE local practice collection on the NICE website. Examples of using NICE quality standards can also be submitted.

Stakeholders were also invited to respond to the following statement specific questions:

4. For draft quality statement 1: Do stakeholders think that an assessment of vulnerability to drug misuse could be done as part of the annual health plan review of

looked-after children or young people, or should this be at a different point in the wider care planning process?

5. For draft quality statements 1, 2 and 3: The College Centre for Quality Improvement's practice standards for young people with substance misuse problems suggest CRAFFT as a potential tool for assessing risk of drug misuse. Do stakeholders think this is suitable to suggest as a potential tool for assessment of risk of drug misuse for children and young people?

6. For draft quality statement 4: As this statement is quite broad in its focus, is there a specific aspect of providing advice and support for adults assessed as at risk of drug misuse that it should focus on for quality improvement?

4 General comments

The following is a summary of general (non-statement-specific) comments on the quality standard.

- The quality standard takes a sensible and pragmatic approach to drug misuse prevention, with the focus on high risk groups, prevention and care covering the core elements of quality improvement.
- Mixed comments about the key groups that are the focus of the quality standard. Stakeholders commented positively that looked-after children and care leavers are identified as a priority group, however some considered that other vulnerable groups should also be included (highlighted in section 6 of this summary).
- Additional settings were highlighted that should be included in the quality standard (highlighted in section 6 of this summary).
- It was suggested that solvent and volatile substance use should be included within the definition of drug misuse.

Consultation comments on data collection

- Stakeholders generally agreed that the assessments highlighted in statements 1-3 could be used as a point to ask questions about drug misuse, however some stakeholders expressed concerns that this could become a "tick-box" exercise.

- Stakeholders considered that some additional resources will be required for data collection. There was concern that linking of data systems and joint monitoring would be required.
- Clarity was requested over responsibility for data collection and monitoring.

Consultation comments on resource impact

- Stakeholders commented that some measures are achievable using existing resources.
- Concern was expressed about the availability of services for young people once they are identified as vulnerable to drug misuse.

5 Summary of consultation feedback by draft statement

5.1 Draft statement 1

Looked-after children and young people are assessed for vulnerability to drug misuse at their annual health plan review.

Consultation comments

Stakeholders made the following comments in relation to draft statement 1:

- Self-reporting through use of questionnaires means issues might not be identified
- Referrals to drug misuse services could be measured
- Important to be aware of safeguarding issues around vulnerability to drug misuse when carrying out assessments
- Examples were given of services that are already using screening tools
- Systems do not routinely record drug risk so further data collection required.

Consultation question 4 - ***Do stakeholders think that an assessment of vulnerability to drug misuse could be done as part of the annual health plan review of looked-after children or young people, or should this be at a different point in the wider care planning process?***

Stakeholders made the following comments in relation to consultation question 4:

- Assessment of vulnerability to drug misuse could be done/already is done as part of the annual health plan and should form part of ongoing assessment/planning
- Might be more appropriate for social workers to complete questions to assess vulnerability to drug misuse.

Consultation question 5 ***- The College Centre for Quality Improvement's practice standards for young people with substance misuse problems suggest CRAFFT as a potential tool for assessing risk of drug misuse. Do stakeholders***

think this is suitable to suggest as a potential tool for assessment of risk of drug misuse for children and young people?

Stakeholders made the following comments in relation to consultation question 5:

- Although CRAFFT might be appropriate for some groups it would not suit all children and young people, and other tools should be considered.

5.2 Draft statement 2

Care leavers are assessed for vulnerability to drug misuse at their health assessment.

Consultation comments

Stakeholders made the following comments in relation to draft statement 2:

- Care leavers have increased vulnerability due to independent living. It would be useful to include housing-related questions within the assessment.
- Health assessments completed with young people up to 18th birthday, so clarity after this is required. Extra resources may be needed for this group.
- Referrals to drug misuse services could be measured
- Important to be aware of safeguarding issues around vulnerability to drug misuse when carrying out assessments
- Examples were given of services that are already using screening tools.

Consultation question 5 - *The College Centre for Quality Improvement's practice standards for young people with substance misuse problems suggest CRAFFT as a potential tool for assessing risk of drug misuse. Do stakeholders think this is suitable to suggest as a potential tool for assessment of risk of drug misuse for children and young people?*

Stakeholders made the following comments in relation to consultation question 5:

- Overall it was suggested that although CRAFFT might be appropriate for some groups it would not suit all children and young people, and other tools should be considered.

5.3 Draft statement 3

Children and young people having a young offender assessment are assessed for vulnerability to drug misuse.

Consultation comments

Stakeholders made the following comments in relation to draft statement 3:

- Examples given of where youth offending support workers currently screen for drug misuse.

Consultation question 5 - *The College Centre for Quality Improvement's practice standards for young people with substance misuse problems suggest CRAFFT as a potential tool for assessing risk of drug misuse. Do stakeholders think this is suitable to suggest as a potential tool for assessment of risk of drug misuse for children and young people?*

Stakeholders made the following comments in relation to consultation question 5:

- Overall it was suggested that although CRAFFT might be appropriate for some groups it would not suit all children and young people, and other tools should be considered.

5.4 Draft statement 4

Adults assessed as vulnerable to drug misuse are given information and advice.

Consultation comments

Stakeholders made the following comments in relation to draft statement 4:

- Very difficult to measure in its current format. A numerical process measure may not be appropriate.
- Support and advice for people at risk of injecting drug use needs to be readily accessible, where they are likely to encounter healthcare professionals
- Welcome the inclusion of LGBT people as a vulnerable group, other suggestions of groups to include
- Quality and tone of information is important. It should be tailored to the local area and individual needs.
- New patterns of drug use should be considered, e.g. chemsex
- Suggestions for content of information
- Welcome the inclusion of sexual and reproductive health services. Sexual health services are already meant to ask and report on drug use through GUMCAD
- Should be person-centred. Cultural competence is important when asking sensitive questions of particular groups.

Consultation question 6

Stakeholders made the following comments in relation to consultation question 6:

- Characteristics of vulnerability need to be more specific for measurement, as "at risk" is too broad
- Could measure delivery of brief interventions programmes
- Additional vulnerable groups suggested, including people in prison, people in the criminal justice system, people engaged in chemsex, and body builders.

6 Suggestions for additional statements

The following is a summary of stakeholder suggestions for additional statements:

- Drug preventions being delivered in the context of wider approaches to increase resilience
- Referral for a comprehensive assessment, if brief assessment suggests vulnerability to drug misuse
- Safe supply of drugs
- Social support, for example to find work or housing.
- Testing of street drugs for their contents
- Various additional populations were suggested, including:
  - Children excluded from/refusing to attend school
  - Children affected by parental substance misuse
  - Children affected by domestic violence
  - Homeless young people
  - Young people at risk from sexual exploitation
  - Young people in gangs/at risk of gang recruitment
  - Schools as a setting, health visitors, children's centres, Jobcentre Plus for adults
  - Children with mental health difficulties
  - Children and young people in the secure system.

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Appendix 1: Quality standard consultation comments table – registered stakeholders

ID	Stakeholder	Statement number	Comments[1]
1	Blenheim CDP	1	**Do stakeholders think that an assessment of vulnerability to drug misuse could be done as part of the annual health plan review of looked-after children or young people, or should this be at a different point in the wider care planning process?** Blenheim's view that assessing vulnerability to drug misuse could be done as part of the annual health plan review of looked after children however it should form part of the ongoing assessment and care planning.
2	CoramBAAF	1	Assessment of vulnerability to drug use already forms part of annual health assessments for LAC but should also be part of the ongoing care planning process. It may be more appropriate for a social worker to complete screening tool with young person at times other than the annual health assessment.
3	NHS England	1	**Question 4 For draft quality statement 1: Do stakeholders think that an assessment of vulnerability to drug misuse could be done as part of the annual health plan review of looked-after children or young people, or should this be at a different point in the wider care planning process?** – I would question a focus on single assessments as a mechanism for capturing vulnerability to drug misuse. Do we really think it likely that the assessor would build sufficient rapport with the YP to have them reveal something of this nature within the annual health assessment? Or do we need to build in other points of contact for this, either by asking the YP's support network (bearing in mind obvious confidentiality questions) in the way the SDQ is triangulated with teachers' reports, or alternatively taking a 'continuous assessment approach' and considering other pathways and assessment mechanisms beyond the AHR which can help pick up risk of drug misuse. It seems odd that schools are not in this.
4	Re-Solv	1	We would like to ensure that solvent and volatile substance misuse is included in any assessment for looked after children. In addition we would like to ensure good quality prevention information regarding solvent and volatile substance misuse is available for all looked after young people and professionals working with them.

[1]PLEASE NOTE: Comments received in the course of consultations carried out by NICE are published in the interests of openness and transparency, and to promote understanding of how quality standards are developed. The comments are published as a record of the submissions that NICE has received, and are not endorsed by NICE, its staff or its advisory committees.

ID	Stakeholder	Statement number	Comments[1]
5	Re-Solv	1	'Commissioners' – We would like to ensure that the definition of 'drug misuse' contains an explicit reference to solvent and volatile substance misuse. VSA is the most misused drug in the 11-13 age range as measured by the Smoking, drinking and drug use in England report. Young people may not see solvent and volatile substance misuse as 'drug-misuse' so we would like to see services assess for the issue directly.
6	South Gloucestershire Council Public Health and Wellbeing Division	1	In South Gloucestershire there is an agreed brief valid questionnaire used annually at health plan review. This data is collectable. However, this process is based on self-report and is therefore open to accuracy in the numbers of young people who disclose substance use. All young people within care are vulnerable to substance misuse. Locally an allocated Looked After Children's nurse and Paediatrician complete annual health reviews and currently ask CRAFFT questions alongside a locally designed screening tool to assess substance misuse and facilitate a structured conversation around behaviours. Questions 1-5: Yes
7	Association of Directors of Public Health	1 & 2	Monitoring could be undertaken against the referrals young people's substance misuse services receive from LAC nurses / social care. Locally, services are regularly promoted with local nurses that provide annual health checks with LAC. Social care professionals are asked to use DUST – Drug Using Screening Tools. Safeguarding networks at hospitals use DUST and young people's substance misuse services are present at weekly psychosocial paediatrics meetings. Awareness of "County Lines" – and other safeguarding issues such as CSE are important.
8	London Borough of Hackney	1 & 2	Monitoring could be undertaken against the referrals young people's substance misuse services receive from LAC nurses / social care. Locally, services are regularly promoted with local nurses that provide annual health checks with LAC. Social care professionals are asked to use DUST – Drug Using Screening Tools. Safeguarding networks at hospitals use DUST and young people's substance misuse services are present at weekly psychosocial paediatrics meetings. Awareness of "County Lines" – and other safeguarding issues such as CSE are important.
9	Association of Directors of Public Health	1-3	We would encourage some flexibility in the screening tools recommended for use, for example, many local authorities use the 'Drug Use Screening Tool' instead of CRAFFT
10	Association of Directors of Public Health	1-3	Increased screening and referral of young people at risk of substance misuse is positive. We would like to ensure this is proportionate and achievable though for services who may be carrying out assessments and screening. For example, this may mean that services such as Youth Justice or LAC Health Services carry

ID	Stakeholder	Statement number	Comments[1]
			out brief screening and refer to young people's substance misuse services where there is an indication of potential need, so that these specialist substance misuse services can carry out full assessment.
11	Blenheim CDP	1-3	**Does this draft quality standard accurately reflect the key areas for quality improvement?** Generally we would agree that the looked after children, care leavers and those in contact with the criminal justice system are key risk groups and welcome the fact that these are covered in the quality standards. However, at Blenheim we know that a major group at risk of substance use are those excluded from or refusing to attend school and we would like to see this reflected in the guidance. Below is evidence for the risk related to school exclusion, many of which quoted on NICE evidence website. There is a wealth of research on this issue and specialist young people's projects at Blenheim confirm the need for this group to be target for prevention/intervention. • https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/633365/SFR35_2017_text.pdf • http://www.tandfonline.com/doi/abs/10.1080/13575270220000040390 • http://www.rapt.org.uk/sites/default/files/1/RAPt%26Place2Be%20Report%20-%20May%202015%20%28FINAL%29%20%28Small%20for%20Email%29.pdf • http://www.scie-socialcareonline.org.uk/exclusion-and-marginalisation-in-adolescence-the-experience-of-school-exclusion-on-drug-use-and-antisocial-behaviour/r/a1CG0000000GSkcMAG • https://www.evidence.nhs.uk/search?q=School%20exclusion Other key significant groups appear to be missing from the Quality Standard • **Children affected by parental substance misuse** https://www.nspcc.org.uk/preventing-abuse/child-protection-system/case-reviews/learning/parents-misuse-substances/ https://link.springer.com/article/10.1186/1471-2458-9-377 • **Children affected by domestic violence** http://www.rcpsych.ac.uk/healthadvice/parentsandyouthinfo/parentscarers/domesticviolence.aspx • **Homeless young people**

ID	Stakeholder	Statement number	Comments[1]
			http://www.drugsandhousing.co.uk/Youth%20Homelessness%20and%20Substance%20Use.pdf • **Young people at risk from sexual exploitation** http://youth-spark.org/resources/research/sexual-exploitation-and-drug-use/ • **Young people in gangs or at risk of gang recruitment** http://www.nuffieldfoundation.org/sites/default/files/files/Children_young_people_gangs.pdf This is not an extensive list of the research available but shows that there is evidence to support these additional risk groups.
12	Blenheim CDP	1-3	**Do stakeholders think that CRAFFT is a suitable tool for assessment of risk of drug misuse for children and young people?** Blenheim's view is that CRAFFT is one of many drug screening tools. We think that the reference to the CARFFT assessment tool should be removed or extended to mention other tools such as DUST, funded by Department of Health, and is used extensively across the UK. DUST was designed for the UK context by a range of agencies across Kent. Here is a link to the original research and development report which is available on the Unicef website (we declare an interest in that Blenheim CEO was on the development team). https://www.unicef.org/eca/DUST_report_Neil_Hunt_UK_Drug_Use_Screening_Tool.pdf Blenheim also sought advice from Professor John Marsden BSc, MSc, PhD Professor of Addiction Psychology, a leading expert in this area, who suggested Assist-lite - https://assistportal.com.au/eassist-lite/ Further advice could be sought from PHE Director of Drugs, Alcohol and Tobacco, Rosanna O'Connor.
13	CoramBAAF	1-3	CRAFTT tool may be a useful tool for practitioners, however it may not be appropriate for all young people eg ,considering a young persons, communication.and social skills.
14	CoramBAAF	1-3	Concern that completion of the CRAFFT tool at a LAC health assessment could become a required " tick box exercise"
15	London Borough of Hackney	1-3	Increased screening and referral of young people at risk of substance misuse is positive. We would like to ensure this is proportionate and achievable though for services who may be carrying out assessments and screening. For example, this may mean that services such as Youth Justice or LAC Health Services carry

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			out brief screening and refer to young people's substance misuse services where there is an indication of potential need, so that these specialist substance misuse services can carry out full assessment.
16	London Borough of Hackney	1-3	We would encourage some flexibility in the screening tools recommended for use, for example, many local authorities use the 'Drug Use Screening Tool' instead of CRAFFT
17	NHS England	1-3	**Question 5 For draft quality statements 1, 2 and 3: The College Centre for Quality Improvement's practice standards for young people with substance misuse problems suggest CRAFFT as a potential tool for assessing risk of drug misuse. Do stakeholders think this is suitable to suggest as a potential tool for assessment of risk of drug misuse for children and young people?** – We would need more time to consult with our clinical advisors on this, if NICE would like further input on this we are very happy to go away and collate further feedback.
18	Public Health England	1-3	Standard 4 is clear that adults vulnerable to drug misuse are given information and advice on the harms of drugs AND where to get help. However, standards 1-3 do not specify the information on where to get help for vulnerable young people. We suggest that statement 1-3 includes care pathways for vulnerable young people.
19	Re-Solv	1-3	Is the CRAFFT tool able to assess for a wider definition of drug misuse including the misuse of solvents and volatile substances? With looked after children in particular the risk of solvent and volatile substance abuse (VSA) is increased.
20	Re-Solv	2	Similar to comments above, we would like to ensure that within any assessment process for care-leavers that there is an explicit reference to solvent and volatile substance abuse and that professionals working with this group have access to training on how to assess for solvent and volatile substance abuse.
21	South Gloucestershire Council Public Health and Wellbeing Division	2	See above. Care leavers in South Gloucestershire receive the same package of care including annual health reviews. Care leavers have an increased level of vulnerability due to independent living. The inclusion of housing related questions within the health assessment around housing would be useful.
22	Association of Directors of Public Health	3	Guidelines seem reasonable and proportionate. Locally, YOS workers regularly screen for substance misuse issues which also includes screening and referring to our dealing interventions worker.
23	London Borough of Hackney	3	Guidelines seem reasonable and proportionate. Locally, YOS workers regularly screen for substance misuse issues which also includes screening and referring to our dealing interventions worker.
24	Re-Solv	3	Similar to comments above, we would like to ensure that within any assessment process for children and young people having a young offender assessment that there is an explicit reference to solvent and volatile

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			substance abuse and that professionals working with this group have access to training on how to assess for solvent and volatile substance abuse.
25	South Gloucestershire Council Public Health and Wellbeing Division	3	In South Gloucestershire there is a Substance Use Specialist within the Youth Offending Team. Young Offenders are assessed at entry into the Youth Justice System so that questions around substance use are included. The YOT may benefit from using CRAFFT. Questions 1-3: Yes, Question 4: NA, Question 5: Yes
26	Association of Directors of Public Health	4	The guidelines in relation to assessment of adults vulnerable to drug misuse need further work and would be very difficult to measure in their current format. The characteristics of those who are vulnerable to drug misuse is not specific enough to be measured, and the groups who are assessed as ‘at risk’ are too broad to be meaningful. For example, screening and recording outcomes for all those who are in ‘multiple groups at risk’ (e.g. those who identify as LGBT and/or unemployed and/or who attend nightclubs or festivals) is not realistic, proportionate, or likely to be a good use of resources. Furthermore identifying the number of unique individuals who have received information and advice is unlikely to be possible to arrive at the process indicator required. It is suggested that a numerical process measure may not be appropriate for this standard, and rather evidence that the standard is met could take alternative forms.
27	Blenheim CDP	4	**As this statement is quite broad in its focus, is there a specific aspect of providing advice and support for adults assessed as at risk of drug misuse that it should focus on for quality improvement?** The risk groups in Standard 4 need to include prisoners, those in the criminal justice system and those engaged in chem-sex (who are in significant risk). It may also be worth considering body builders who are at risk of misusing and injecting steroids.
28	Care quality Commission- Medicines Optimisation Team	4	I am unsure as to how you would be able to provide evidence that the information around drug misuse was being given to adults.
29	London Borough of Hackney	4	The guidelines in relation to assessment of adults vulnerable to drug misuse need further work and would be very difficult to measure in their current format. The characteristics of those who are vulnerable to drug misuse is not specific enough to be measured, and the groups who are assessed as ‘at risk’ are too broad to be meaningful. For example, screening and recording outcomes for all those who are in ‘multiple groups at risk’ (e.g. those who identify as LGBT and/or unemployed and/or who attend nightclubs or festivals) is

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			not realistic, proportionate, or likely to be a good use of resources. Furthermore identifying the number of unique individuals who have received information and advice is unlikely to be possible to arrive at the process indicator required. It is suggested that a numerical process measure may not be appropriate for this standard, and rather evidence that the standard is met could take alternative forms.
30	NAT (National AIDS Trust)	4	With regards to the process of measuring outcomes for quality standard 4, while we agree that the measurement should be the proportion of adults assessed as vulnerable to drug misuse who are given information and advice, we believe that a second measurement should be added. This measurement should be along the lines of 'the proportion of adults who are assessed to ascertain whether they are vulnerable to drug misuse'. The current denominator needs to a measurement of effectiveness in itself. Otherwise, an organisation may be giving a large proportion of the adults assessed as vulnerable information and advice, but if the organisation is only actually assessing a small number of adults, then overall, they are not being that effective with regards this quality standard. While we agree with the fact that services should be providing information and advice to people vulnerable to drug misuse, a key question is how do you ensure quality of the written and oral information and advice? Quality could be prone to wide variation. We suggest that NICE recommend all information should be in line with standards for assessment as set out in the Department of Health's *Drug Misuse and dependence: UK Guidelines on clinical management* Chapter 2.2 (while this is quite focused on assessing for whether someone requires treatment, some of the advice will still apply to prevention). Similarly, for New Psychoactive Substances follow Neptune's *Guidance on the Clinical Management of Acute and Chronic Harms of Club Drugs and Novel Psychoactive Substances.* Other such standards should be sought, particularly ones focused on prevention. Another such document that might be useful is *European drug prevention quality standards* produced by European Monitoring Centre for Drugs and Drug Addiction.
31	NAT (National AIDS Trust)	4	We agree that providing information and advice to adults thought to be at high risk of drug misuse is a good intervention to support people to either not take drugs, or do so with minimal harm. However, we believe it is vital to include information related to harm reduction, not just information and advice to deter people from taking drugs altogether. It must be recognised that some people will end up taking drugs regardless of the advice given to them, so information should support them to do so more safely. We would advise rewording the rationale for quality standard 4 to say 'it is important that adults who have been assessed as vulnerable to drug misuse are provided with clear information and advice on the harms of drugs, how to reduce those harms, and where to get help'.

ID	Stakeholder	Statement number	Comments[1]
			Harm reduction should be emphasised within this quality standard, so that information and advice given by organisations does not end up solely focused on abstinence, to the detriment of efforts to minimise the harms drugs may have on someone deemed at high risk. The information should be based in evidence of what type of advice works. Public Health England have stated that 'the evidence tells us that education-only approaches, which focus on scare tactics…are not effective on their own at reducing drug use and harm.' This again could be achieved by having documents to reference for standards for organisations to use when authoring information. Harm reduction initiatives can include information on how to take a drug/groups of drugs more safely, information on needle and syringe programmes for people who inject drugs (PWIDs) which are proven to support a reduction in transmission of blood-borne viruses and empowers them to be able to protect themselves from HIV and Hepatitis C, where to obtain naloxone for opiate users, and where to access drug support services that can provide clinically supervised harm reduction initiatives such as Opioid Substitution Therapy (OST). Knowing where to turn for more comprehensive support seems like vital information to include with any advice on drug misuse. Information and advice should be tailored to the local area, and include information on where to access drug and alcohol services, helplines, or wider support (on housing, employment and mental health services for example). The advice also needs to take into consideration the wider determinants that affect health and likelihood to misuse drugs. The drivers of drug misuse are complex and when authoring written information, the wider reasons why some people choose to engage in drug use should be taken into consideration; whether this be just for recreational and social purposes, or are a result of escapism from hardship, economic instability or poverty, unemployment, or mental health issues. Information on where to turn for economic support or mental health services could be included in both verbal and written material. We welcome the description that advice 'should be provided in a non-judgemental way and tailored to the person's preferences, needs and level of understanding about their health'. This is important, as the cause of someone's vulnerability to drug misuse may be complicated and will require an understanding approach.

ID	Stakeholder	Statement number	Comments[1]
			It may be worth making clearer in the quality standard that any written information itself needs to be non-judgemental, factual, and not solely focused on scare tactics about a certain drug/group of drugs. It may also be worth taking into consideration that any conversation with someone considered at risk needs to not just be non-judgemental, but person-centred, allowing that individual to be an equal partaker in conversations about their health, empowered to make decisions from themselves. For example, in the NICE Quality Standard 'Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services', NICE look to 'promote person centred care that takes into account service users' needs, preferences and strengths'. This approach should be adapted to the needs of people at risk of drug misuse.
32	NAT (National AIDS Trust)	4	One such harm that information and advice should be available on is around the transmission of blood-borne viruses, mainly HIV and Hepatitis. The prevalence of HIV within the community of people who inject drugs remains low. As it stands, in the UK around 1 in 100 people who inject drugs is living with HIV. The continuing success of low rates of transmission of HIV through injecting drug use can only be assured if people are aware of the risks of sharing injecting equipment, and have knowledge of and are able to access needle and syringe programmes. Support and advice for people who are at risk of injecting drug use needs to be readily accessible and given in contexts where they are likely to encounter healthcare professionals, whether that be at drug treatment services, GP surgeries, within prisons or by a probation officer, or when accessing wider support for housing and employment or mental health services. We only have to look to the recent outbreak of HIV in Glasgow among people who inject drugs to demonstrate the need for information on injecting drug use to be easily accessible, with information on accessing needle and syringe programmes given concurrently. The outbreak in Glasgow in 2015 saw a marked increase in new HIV diagnoses, which has only been curtailed by informing the at-risk population of addiction services, and increasing provision of needle and syringe programme.
33	NAT (National AIDS Trust)	4	We welcome the inclusion of LGBT people as a group to be targeted by this quality standard. We know, from the official statistics from the National Crime Survey 2013/14, which analysed the prevalence of drug misuse by sexual orientation, that LGBT people are more likely to take drugs. For example, if we compare gay/bisexual men with heterosexual men, use of any drug in the last year is around three times higher (33% and 13.3% respectively).

ID	Stakeholder	Statement number	Comments[1]
			An issue that should be taken into consideration are new patterns of drug use, such as the use of drugs in sexualised settings by men who have sex with men (MSM), colloquially known as 'chemsex'. Neptune offer detailed guidance on how to best do brief interventions with people considered at risk of drug misuse in relation to 'chemsex' drugs: http://neptune-clinical-guidance.co.uk/wp-content/uploads/2015/03/NEPTUNE-Guidance-March-2015.pdf Advice and information related to 'chemsex' could be accessed at sexual health clinics, where most of the programmes supporting people with problematic Chemsex drug use are taking place. Having information that could be readily distributed to MSM at sexual health clinics could be vital in educating people on the harms of the Chemsex drugs and also advice on how to reduce the harms associated with these drugs. However, it also seems vitally important that drug treatment services, who have less experience of working with the MSM community, have information readily available to support where people with problematic sexualised drug use may present. We acknowledge that this point is more focused on treatment than prevention, so might be outside the scope of this consultation. Examples of good local practice in this area are 56 Dean Street, the sexual health clinic, and the interventions led by David Stuart. We welcome the inclusion of sexual and reproductive health services as a service provider for whom this quality standard is relevant. Sexual health services are well placed to give information and advice to people with regards drug use, particularly when used within sexualised settings. Many are also places well trusted by LGBT people, in comparison to other services (such as drug treatment for example), and also offer an opportunity to give information and advice as a brief intervention early on, before someone ends up needing to access drug services. Sexual health services should be in a good position to record information on drugs. They are already meant to ask and report on drug use through GUMCAD (Genitourinary medicine clinic activity dataset), which is the mandatory reporting system providing data on sexual health services and STI diagnoses from all commissioned Level 3 and Level 2 sexual health services in England. While information and advice given to LGBT + adults seems to be a good way to inform, cultural competency when addressing the issues of LGBT people and the higher prevalence of drug misuse within this community must be assured. For example, in our 'HIV and Injecting Drug Use' report (2013), we note

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			that 'within sexual health clinics, it was reported that staff often do not have adequate training or awareness to ask appropriate questions about problematic recreational drug use and provide support' with regards to MSM. Traditional terms such as 'injecting drug user' which many associate with opiate use, may not always fit the description of how someone on the 'chemsex' scene injecting crystal meth or mephedrone may see themselves. Staff must be trained and supported to give non-judgemental advice that draws from terminology that will resonate with someone potentially at risk of drug misuse within the LGBT community. You can find our report here: http://www.nat.org.uk/sites/default/files/publications/HIV_and_Injecting_Drug_Use_Report_2013.pdf London Friend have also produced a report on drugs within the LGBT community, which includes advice to commissioner's on how to include the needs of LGBT communities within services. Their report 'Out of Your Mind' found poor representation of LGBT health needs generally within published Joint Strategic Needs Assessments on London Local Authority websites, with very poor inclusion of LGBT needs in relation to drugs. To ensure services are considering the needs of LGBT people, more work is needed so that commissioners are including drug misuse prevention initiatives targeted at LGBT people within contracts with providers. Their report can be found here: http://londonfriend.org.uk/wp-content/uploads/2014/06/Out-of-your-mind.pdf
34	Public Health England	4	We're unsure about the broadness of statement 4. Statements 1-3 are focused on recognised vulnerable groups. Statement 4 is for all adults, and it's not clear how these adults are going to be assessed as vulnerable. We are concerned about the lack of evidence or good practice in how this might be done (e.g. what screening tools to use, what advice to give, sources of information). In the definitions of terms, adults at risk of drug misuse is broad, and many health and social care staff will have contact with people who fit into one or more of these categories. Would we, for instance, be comfortable recommending asking every LGBT person whether they use drugs? Obviously, some clinician sense is required, but the standard doesn't bring any clarity to these circumstances.
35	Re-Solv	4	We would like to ensure that any assessment for the risk of drug misuse also explicitly includes an assessment for solvent and volatile substance abuse, and that advice and support on solvent and volatile substance abuse is routinely available

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36	Re-Solv	4	Similar to comments above, we would like to ensure that within any assessment process for adults who are vulnerable to drugmisuse that there is an explicit reference to solvent and volatile substance abuse and that professionals working with this group have access to training on how to assess for solvent and volatile substance abuse.
37	South Gloucestershire Council Public Health and Wellbeing Division.	4	Question 1: Yes. Locally South Gloucestershire can provide training to front line services including community & voluntary sector around identifying adults vulnerable to substance use. However, at present CRAFFT is not included but could be requiring no further resources. Questions 2: Signposting for adult services is in place with a single point of contact for triage. Collection of data for adults at risk of substance use outside of that collected at triage by substance use services would be challenging due to services not using the same data collection management system. Question 3: Yes. Information and advice can be offered to any adult assessed as vulnerable to substance use however the effectiveness of these interventions are challenging to monitor. Questions 4&5: NA Question 6: A specific aspect could be the delivery of brief intervention programmes being delivered by service providers working with vulnerable adults with initial training to deliver this from specialist substance use providers. Some of the adults identified within the draft standards are not necessarily accessing services e.g. those attending festivals and nightclubs. More guidance needed on how to collect data on these groups.
38	Blenheim CDP	Data sources	**Are local systems and structures in place to collect data for the proposed measures? If not how feasible would it be to put them in place?** There is no problem collecting data in relation to the first 3 quality standards as systems and structures are in place or easily amendable to capture data. Data collection for quality standard 4, while possible in individual organisations, would be difficult to have an overview given the sheer diversity of potential delivering agencies.
39	CoramBAAF	Data sources	Annual health assessments for LAC will include some discussion , assessment of substance misuse. Some areas use screening tools. Although data re completion of LAC health assessments is collected in a standardised format this data does not routinely include information re whether a substance misuse screening tool has been completed. Therefore further data collection systems would be required.
40	NHS England	Data sources	**Question 2 Are local systems and structures in place to collect data for the proposed quality measures? If not, how feasible would it be for these to be put in place? –** this needs some work to

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			look into and needs input from a range of data leads from across DfE, DH, MoJ, HO. In current draft it appears unduly burdensome and seems to suggest a bespoke local data collection (though unclear who would pay for this and which providers would input) for each element of the quality statements. To answer the second question, this is likely to be burdensome for providers and may require linking datasets at a local level (which is not always feasible) and joint working to maintain and monitor the outputs. It is not clear from the data sections which agency/ies are the lead for which data collections, who is responsible for monitoring those collections, whether the data needed is a new bespoke collection or can be pulled out of existing published data reports. There is also the question of what is meant by 'local' in 'local data collection' – across what footprint, which agencies, and collected at what frequency? I think a more detailed piece of work is needed on this before it is published because, as currently drafted, it may be difficult for commissioners and providers from across health and social care to put this into action.
41	Royal College of Nursing	Data sources	We consider the data is available, and could be obtained from a range of sources, for example, local authorities will have some elements of data. However, what is required is for key organisations to share information more effectively that they currently hold at a local level, for example local authority and health will need to share data as they are likely to have different information about the same people. This also will benefit from accessing information held by mental health trusts who may encounter at risk young people, including liaison and diversion and youth offending teams.
42	Blenheim CDP	General	**Case Study – Insight Southwark (young people's service)** Girl A, aged 19, came from a family known to Social Services and had a history of mental health, anxiety and self harming. At 13 years old she started dating boys who were affiliated to a gang. There had been reported incidents from the Police that Girl A was filmed having sexual intercourse with a gang and was at risk of being sexually exploited by the gang. She was forced to have sex with 5 gang members and told to sell drugs. It was then that girl A wanted to leave the gang and as a result they targeted her and her family, threatening to send the footage to her father and post on social media. Girl A's life then started to descend into a downward spiral and her drug use became problematic. It was at this point that she was referred to Insight Southwark where we helped her to leave the gang, reduce her smoking and she started college studying for hair and beauty. She now has a positive social network, improved family relationships and has built her confidence and self-esteem.

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43	CoramBAAF	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 care leavers
44	CoramBAAF	General	The quality standard focus"s on very specific groups of vulnerable young people. It is positive that LAC and care leavers are identified as priority group, however other vulnerable groups could benefit from specific attention,eg children not in school , children with mental health difficulties, , children exposed to parental substance misuse in their home.
45	NHS England	General	General feedback • **General:** Surprised to find that these focus on only LAC, youth offending and care leavers, and no mention of other groups (e.g., those at risk of joining gangs, CYP with parents who abuse substances, CYP in the secure system (particularly if singling out YOT, and so on. Surely we need a broader approach that considers a range of factors that could increase vulnerability to drug misuse? E.g. 1) That assessments are in place with appropriate markers to signal vulnerability to drug misuse, where groups/populations are more likely to be vulnerable (e.g. LAC annual health plan review, care leavers assessment, young offender assessment); 2) that there is a clear local protocol following these assessments to provide information, advice and, where appropriate, further support to the person and those around them (e.g. foster carers, schools, parents/carers); 3) that these assessments are constructed in a way that supports the agency and dignity of the person at risk and keeps them fully involved in decision-making. • **Services and staff covered:** Staff in schools are a critical actor here in spotting vulnerability to drug misuse, and are also a key partner to engage in tackling drug misuse and spreading information and advice. If the QSs are focusing on key points of detection for vulnerability to drug misuse, surely they ought to include places like schools, health visitors, children's centres,

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			Jobcentre Plus for adults, etc? It seems particularly remiss to exclude schools if the standard is intended to cover the prevention or delay of drug misuse for CYP. • **Equalities:** There doesn't appear to be an 'equalities and diversity concerns' section in any of the CYP quality statements, but this is present for adults. Surely these issues need flagging for CYP too – including any communication difficulties (sensory, language, etc) or additional needs.
46	NHS England	General	Consultation questions Quality standard **Question 1 Does this draft quality standard accurately reflect the key areas for quality improvement**? – It does highlight some key at-risk groups for CYP, but feels narrow in scope and appears to be based on selecting a very small number of high risk groups rather than taking a step back to consider factors influencing vulnerability. For example, LAC are pointed out here as a group with heightened vulnerability to drug misuse. Are there not other groups with heightened vulnerability we should also be flagging – e.g. those with a neurodevelopmental disability, or with mental or physical health needs commonly associated with misuse of drugs? CYP with parents who misuse drugs? I wonder if LAC is actually a proxy for these groups as both are disproportionately represented in the LAC population, in which case this approach would collect a large proportion but possibly not all and it would merit wider thinking of contact points for CYP at risk. (E.g. all CYP with a family history of drug misuse as opposed to only LAC). At present this QS feels unduly narrow in its scope, and yet in parts lacks the detail to be put into practice (see below re data).
47	Public Health England	General	We would like to reiterate the importance of all drug preventions being delivered in the context of wider approaches to increase resilience. This way it will be possible to assess and address the needs of vulnerable groups in a wider context, rather than a narrow drugs specific focus.
48	RCGP	General	A sensible and pragmatic document concentrating on high risk groups, a prevention and caring/treatment service. The epidemiology is inadequate to make an assessment of the problem and the likelihood of recreational use, developing into addiction. The natural history of the problem, the links with poor social support, the use of alcohol and associated criminality are very difficult to gauge what interventions and treatments work best is uncertain.

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			A proportion of young men and women will mature, and move on and settle into society, a proportion will develop severe addiction and risk severe sickness and death. A proportion will become chronic users. A supporting and caring approach, the willingness to pilot different models of care and a non-judgemental approach is essential. The problems around the law and its enforcement for possession or supplying are difficult to gauge when there is much controversy. Probably the safe supply of drugs, short/medium term, the testing of street drugs for their contents and social support to find work, housing etc.is the best strategy as more evidence becomes available. The population approach in terms of information, alternatives, advice and help for teachers and parents needs to be part of the overall approach. The importance of peer pressure, the real opportunity for other activities and celebrity endorsement all play a part.
49	RCGP	General	Do we know that any steps taken to prevent drug misuse are effective? I'm not familiar with this topic so cannot comment, but I would be surprised if GPs were good at it. In the absence of any evidence, what is the purpose of this quality standard? It is the kind of thing which, if implemented, would result in doctors & nurses asking questions in a pointless way that simply ticks the box, and diverts them from other, potentially more useful activity.
50	Royal College of Nursing	General	The standard reflects the key areas for development, as these are the core elements of quality improvement and t ithey are well identified in the document
51	Blenheim CDP	Resources	**Do you think each of the statements in this draft quality standard would be achievable by local services given the net resources needed to deliver them?** Blenheim's view is that they would be achievable. Statement 4 might be difficult to evidence on a population level but possible by individual agencies.

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52	CoramBAAF	Resources	Where vulnerability to substance misuse is identified there need to be accessible and available services for young people. There is some concern that these resources are not necessarily available There needs to be some clarity about care leavers. Health assessments are only completed with young people up to 18th birthday. Therefore clarity about careleavers post 18 is required. It is envisaged that extra resources may be required for this particular group. Extra resources would be required for data collection processes
53	Royal College of Nursing	Resources	We do not have an example, at present, but we are aware that liaison and diversion teams are looking to work more closely with young people who are deemed at risk. Local areas may also have vulnerable people panels, or equivalent, which may provide good evidence base to support this work.
54	Department of Health	NONE	Thank you for the opportunity to comment on the draft for the above quality standard. I wish to confirm that the Department of Health has no substantive comments to make, regarding this consultation.

Registered stakeholders who submitted comments at consultation

- Association of Directors of Public Health
- Blenheim CDP
- CoramBAAF
- Care quality Commission - Medicines Optimisation Team
- London Borough of Hackney
- National AIDS Trust
- NHS England
- Public Health England
- Re-Solv

- Royal College of General Practitioners
- Royal College of Nursing
- South Gloucestershire Council Public Health and Wellbeing Division