



Drug misuse prevention: targeted interventions

NICE guideline

Published: 22 February 2017

www.nice.org.uk/guidance/ng64

Your responsibility

The recommendations in this guideline represent the view of NICE, arrived at after careful consideration of the evidence available. When exercising their judgement, professionals and practitioners are expected to take this guideline fully into account, alongside the individual needs, preferences and values of their patients or the people using their service. It is not mandatory to apply the recommendations, and the guideline does not override the responsibility to make decisions appropriate to the circumstances of the individual, in consultation with them and their families and carers or guardian.

Local commissioners and providers of healthcare have a responsibility to enable the guideline to be applied when individual professionals and people using services wish to use it. They should do so in the context of local and national priorities for funding and developing services, and in light of their duties to have due regard to the need to eliminate unlawful discrimination, to advance equality of opportunity and to reduce health inequalities. Nothing in this guideline should be interpreted in a way that would be inconsistent with complying with those duties.

Commissioners and providers have a responsibility to promote an environmentally sustainable health and care system and should assess and reduce the environmental impact of implementing NICE recommendations wherever possible.

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This guideline is the basis of QS165.

Overview

This guideline covers targeted interventions to prevent misuse of drugs, including illegal drugs, 'legal highs' and prescription-only medicines. It aims to prevent or delay harmful use of drugs in children, young people and adults who are most likely to start using drugs or who are already experimenting or using drugs occasionally.

This guideline does not cover broader activities, both population-level (universal) and targeted, that aim to build people's skills, resilience and ability to make positive decisions about their health and which address the wider determinants of health. For more information, see the NICE guidance on [lifestyle and wellbeing](#).

Additionally, this guideline does not cover treatment of drugs misuse (see the NICE guidelines on [drug misuse: opioid detoxification](#) and [drug misuse: psychosocial interventions](#)).

Who is it for?

- Health and social care professionals
- Commissioners and providers
- Practitioners working in drug misuse prevention and specialist drug treatment services
- 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
- People who use drugs, their carers and families, and the public

Recommendations

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

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

1.1 Delivering drug misuse prevention activities as part of existing services

1.1.1 Deliver [drug misuse prevention](#) activities for people in [groups at risk](#) through a range of existing statutory, voluntary or private services, including:

- 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
- specialist services for people in groups at risk
- community-based criminal justice services, including adult, youth and family justice services
- accident and emergency services.

1.1.2 Ensure activities targeting groups at risk are consistent with any population-level (universal) activities aimed at preventing drug misuse.

1.2 Assessment

1.2.1 At routine appointments and opportunistic contacts with statutory and other services, such as those listed in [recommendation 1.1.1](#), assess whether someone is [vulnerable to drug misuse](#). Examples of routine appointments and opportunistic contacts include:

- health assessments for [children and young people who are looked after or care leavers](#), including initial assessments, any reviews and contacts
- appointments with GPs, nurses, school nurses or health visitors
- attendances at emergency departments as a result of alcohol or [drug use](#)
- contacts with the community-based criminal justice system.

1.2.2 Use a consistent, locally agreed approach to assessment that is respectful, non-judgemental and proportionate to the person's presenting vulnerabilities. For an example for young people, see the [practice standards for young people with substance misuse problems](#).

1.2.3 Discuss the person's circumstances, taking account of their age and developmental stage. The initial discussion could include:

- their physical and mental health and their personal, social, educational or employment circumstances (which may trigger a more in-depth assessment)
- any drug use (including the type used and how often).

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](#).

1.2.4 Think about the immediate safety of the person being assessed and any people under their care, and whether any action is needed.

1.2.5 Discuss with the person what their priorities are and take into account how these might affect next steps or referral to other services.

1.3 Children and young people assessed as vulnerable to drug misuse

1.3.1 Consider skills training for children and [young people](#) who are assessed as [vulnerable to drug misuse](#). If skills training is delivered to children and young people, ensure that their carers or families also receive skills training. For older children and young people, think about whether providing information (see

recommendations in [section 1.4](#)) may be a more appropriate approach.

1.3.2 Ensure any skills training is:

- commissioned as part of existing services (see [recommendation 1.1.1](#))
- delivered as part of activities designed to increase resilience and reduce risk
- delivered by people competent to provide skills training.

1.3.3 If skills training is offered to children and young people and their carers or families, ensure it helps children and young people develop a range of personal and social skills, such as:

- listening
- conflict resolution
- refusal
- identifying and managing stress
- making decisions
- coping with criticism
- dealing with feelings of exclusion
- making healthy behaviour choices.

Ensure that personal and social skills training for [children and young people who are looked after](#) and [care leavers](#) puts particular emphasis on how to deal with feelings of exclusion.

1.3.4 If skills training is offered to children and young people and their carers and families, ensure that it helps carers and families develop a range of skills, such as:

- communication
- developing and maintaining healthy relationships
- conflict resolution

- problem solving.

Ensure that skills training for foster carers includes using behaviour reinforcement strategies alongside the other skills listed.

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

- whether to offer training sessions to children and young people and their carers or families together, or whether to offer separate sessions
- the content of the skills training
- whether to provide individual or group-based sessions
- the number of sessions needed (a minimum of 2 sessions should be offered)
- where to hold the sessions
- how long each session should last.

For more information, see the Department of Health's [quality criteria for young people friendly services](#).

1.3.6 Discuss and agree a plan for follow-up at the skills training sessions, to assess whether additional skills training or referral to specialist services is needed.

1.4 Adults assessed as vulnerable to drug misuse

1.4.1 Offer adults who are assessed as [vulnerable to drug misuse](#) (see [section 1.2](#)) the following:

- clear information on [drugs](#) and their effects
- advice and feedback on any existing drug use
- information on local services and where to find further advice and support (see [recommendation 1.5.3](#)).

This information should be provided at the same time as the assessment.

- 1.4.2 Offer information and advice both verbally and in writing. Provide advice in a non-judgemental way and tailor it to the person's preferences, needs and level of understanding about their health. Ensure that information and advice is delivered in line with NICE's guidelines on [general](#) and [individual](#) approaches to behaviour change and [patient experience in adult NHS services](#).
- 1.4.3 Discuss and agree a plan for follow-up at the assessment, to determine whether additional information or referral to specialist services is needed.

1.5 People at risk of using drugs

- 1.5.1 Consider providing information about [drug](#) use in settings that groups who use drugs or are at risk of using drugs may attend. These settings could include:
- nightclubs or festivals
 - wider health services, such as sexual and reproductive health services or primary care
 - supported accommodation or hostels for people without permanent accommodation
 - gyms (to target people who are taking, or considering taking, image- and performance-enhancing drugs).
- 1.5.2 Consider providing information in different formats, including web-based information (such as digital and social media) and printed information (such as leaflets).
- 1.5.3 Consider providing information on:
- drugs and their effects (for example, on [NHS Choices](#))
 - local services and where to find further advice and support
 - online self-assessment and feedback to help people assess their own drug use.
- 1.5.4 Ensure that information provided is in line with NICE's guidelines on [general](#) and [individual](#) approaches to behaviour change and [patient experience in adult NHS services](#).

Terms used in this guideline

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

Care leavers

People aged 25 or under who have been looked after by a local authority for at least 13 weeks since age 14, and who were looked after by the local authority at school leaving age or after that date.

Children and young people who are looked after

Children and young people looked after by the state for whom the Children Act 1989 applies. The term includes children and young people who are subject to a care order or temporarily classed as looked after on a planned basis for short breaks or respite care. The term also includes those in residential care, foster care or boarding school, or with birth parents, other family or carers. It includes children and young people in placements out of the child or young person's home area. Children and young people who are in young offender or other secure institutions are not included in this definition, because this group is outside the scope of the guideline.

Drugs

Drugs described in the Misuse of Drugs Act 1971 and the Psychoactive Substances Act 2016, as well as new psychoactive substances (often described as 'legal highs'), solvents, volatile substances, image- and performance-enhancing drugs, prescription-only medicines and over-the-counter medicines.

Drug misuse

Dependence on, or regular excessive consumption of, psychoactive substances, leading to physical, mental or social problems. This term does not include occasional or experimental drug use in adults.

Groups at risk

Groups at risk of drug misuse, including:

- people who have mental health problems
- people who are being sexually exploited or sexually assaulted

- people involved in commercial sex work
- people who are lesbian, gay, bisexual or transgender
- people not in employment, education or training (including children and young people who are excluded from school or who truant regularly)
- children and young people whose carers or families use drugs
- children and young people who are looked after or care leavers
- 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
- people who are known to use drugs occasionally or recreationally.

Prevention

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

Treatment

The clinical management of drug misuse or dependence. This could comprise, for example, pharmacotherapy, psychosocial therapy or a combination of these.

Vulnerable to drug misuse

People in groups at risk who may be particularly vulnerable to drug misuse. This may include people:

- in multiple groups at risk
- whose personal circumstances put them at increased risk
- who may already be using drugs on an occasional basis
- who may already be regularly excessively consuming another substance, such as alcohol.

Young people

People aged 10 to 18. This term also includes people aged up to 25 who have special educational needs or a disability (consistent with the Children and Families Act 2014).

Putting this guideline into practice

NICE has produced [tools and resources](#) to help you put this guideline into practice.

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

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

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

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

- 1. Raise awareness** through a range of different communication channels. These could include digital and social media, alongside regular channels such as email, newsletters, meetings, internal staff briefings and communications with all relevant partner organisations. Identify things staff can include in their own practice straight away.
- 2. Identify a lead** with an interest in the topic to champion the guideline and motivate others to support its use and make service changes, and to find out any significant issues locally.
- 3. Carry out a baseline assessment** against the recommendations to find out whether there are gaps in current service provision.
- 4. Think about what data you need to measure improvement** and plan how you will collect it. You may want to work with other health and social care organisations and specialist groups to compare current practice with the recommendations. This may also help identify local issues that will slow or prevent implementation.
- 5. Develop an action plan**, with the steps needed to put the guideline into practice, and make sure it is ready as soon as possible. Big, complex changes may take longer to implement, but some may be quick and easy to do. An action plan will help in both cases.

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

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

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

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

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

Context

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

- Around 8% of people aged 16 to 59 had taken an illegal drug or used a substance unlawfully in the past year, and around 4% had taken one in the past month. Among young adults aged 16 to 24, this was 18% in the past year and 9% in the past month.
- More than one third of adults aged 16 to 59 (35%) have taken an illegal drug or used a substance unlawfully at some point in their lives. Cannabis was the most common, with 7% using it in the past year, followed by powder cocaine (2%) and ecstasy (2%).
- In the same age group, 3% were defined as frequent drug users (having taken an illegal drug or used a substance unlawfully more than once a month, on average, in the past year).
- Among young adults aged 16 to 24, this figure was 5%.
- Use of any class A drug was around 10 times higher among people who had visited a nightclub at least 4 times in the past month (18%) compared with those who had not visited a nightclub in the past month (2%). A similar pattern was found for those visiting pubs and bars more frequently.

The government's What About YOUth survey ([Health and Wellbeing of 15-year-olds in England – Main findings from the What About YOUth? Survey 2014](#)) found that:

- 5% of 15 year-olds had used cannabis in the past month
- 9% had used cannabis in the past year, and 2% had used it more than a year ago
- 13% said that they had been offered drugs other than cannabis, and 2% had tried other drugs.

The Health and Social Care Information Centre's survey on [Smoking, Drinking and Drug Use Among Young People in England – 2014](#) found that:

- around 3% of 11 to 15 year-olds reported inhaling glue, gas or other solvents
- of the 11 to 13 year-olds who reported some drug use in the past year, 53% reported using volatile substances.

The Home Office's [National drug strategy for England 2010](#) sets out plans for helping people to live a drug-free life. The third annual review of this strategy was published in 2015 ([Drug strategy annual review: 2014 to 2015](#)).

As part of the [Health and Social Care Act 2012](#), local authorities became responsible for commissioning [drug misuse treatment](#) services. The Home Office's drug strategy annual review highlights the key role local authorities play in helping to reduce both the supply of, and demand for, illegal drugs. This includes preventing problematic drug use and helping people to recover from drug addiction by developing their personal and social capital, through providing education, housing, public health and social care services.

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

More information

You can also see this guideline in the NICE pathway on [drug misuse prevention](#).

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

See also the [evidence reviews](#) and information about [how the guideline was developed](#), including details of the committee.

The committee's discussion

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

Approach of this guideline

The committee discussed that this guideline only covers [prevention](#) of [drug misuse](#) for [groups at risk](#). The evidence base for population-level (universal) approaches and for wider determinants of [drug use](#) in the general population or at risk groups was not considered. The committee discussed that wider determinants of health, such as housing, education and employment opportunities, social support, and personal resilience, are likely to have a fundamental effect on both the risk of drug misuse and the effectiveness of interventions to prevent drug misuse.

The committee discussed the groups at risk presented in the [scope](#) for this guideline. Based on the evidence considered, it agreed that the recommendations should be targeted at these groups. The committee also noted there may be additional groups who have not been considered, such as [young people](#) with behavioural or social problems, and that some people would be included in more than 1 group at risk. For example, a person could be considered homeless and lesbian, gay, bisexual or transgender.

The committee understood that the nature of drug use and the risk to health varies within the specified groups at risk. The groups covered by the guideline include people who are not currently using drugs but are at increased risk of doing so, through to people who are known to use drugs occasionally or recreationally. Recommendations for treating people who are dependent on drugs are outside the scope of this guideline.

The committee acknowledged that there is wide variation in vulnerability to drug misuse within each of the groups at risk. The committee noted that the variation in vulnerability within the groups at risk means that different people in each group at risk have different needs, despite being in the same group. The committee agreed that not all people in a group at risk will use drugs. It commented that drug use is more likely in some people within each group at risk than in others, such as those in multiple groups at risk, whose personal circumstances put them at increased risk, who may already be using drugs on an occasional basis, or who may already be misusing another substance, such as alcohol.

The committee developed the recommendations in the current guideline on the assumption that

they would be considered alongside other relevant NICE guidance, such as social and emotional wellbeing in [primary](#) and [secondary](#) education, [diagnosis and management of alcohol-use disorders](#), [looked-after children and young people](#), [community engagement](#), and [coexisting severe mental illness and substance misuse](#). The committee also noted the importance of considering the recommendations in this guideline alongside others on preventing and managing drug use (for more information, see NICE's guidelines on [psychosocial interventions](#) and [opioid detoxification](#) for drug misuse in people aged 16 years and older).

Overview of the effectiveness and acceptability evidence

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

No direct effectiveness evidence was identified for 3 of the groups at risk in the scope: people involved in commercial sex work [ES1.5] or who are being sexually exploited; people not in employment, education or training [ES1.9]; and people who attend nightclubs and festivals [ES1.25].

Either no, or limited, evidence was identified on the effectiveness and acceptability of interventions delivered as part of planned outreach activities [ES1.45, ES1.47, ES2.35, ES2.36] or peer education initiatives [ES1.46, ES2.37, ES2.38].

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

The committee acknowledged that most studies compared an intervention with current practice, assessment only or another intervention rather than with no intervention. The committee agreed that data showing no significant difference between the intervention and comparator tended to show a similar improvement in outcome in both the intervention and comparator groups, rather than the intervention not having an effect at all [ES1.1]. Therefore, it agreed that the interventions in the included studies were likely to be at least as effective as the comparator.

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

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

Overview of the cost-effectiveness evidence

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

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

However, the results of the modelling did suggest that some interventions, such as those that are web-based or family-based, could be cost effective if they could be provided at a lower cost and their effects sustained over a longer duration than was considered in the base case economic analysis [ES4.2, ES4.3, ES4.6]. For example, an intervention costing £100 per person that reduced drug use by 5 percentage points maintained over 2 years would be cost effective. If the intervention cost more than £100, the reduction in drug use or duration of effect would need to be higher for the intervention to be cost effective.

The committee acknowledged that there are several reasons why the interventions included in the health economic modelling do not appear to be cost effective. Most of the interventions did not change drug use by more than 5 percentage points. In addition, none of the studies showed a reduction in drug use that was maintained for more than 1 year. This means it is difficult for the interventions to make a large reduction in societal costs. In addition, most of the studies looked at cannabis and ecstasy use, and it is not clear how the social costs of using cannabis and ecstasy compare to those of other drugs.

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

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

The discussion below explains how we made the recommendations in [section 1.1](#).

Recommendations 1.1.1 and 1.1.2

The committee heard expert testimony that the focus of commissioning new [drug misuse prevention](#) interventions is changing [EP1]. Many areas are increasingly integrating drug misuse prevention activities with [drug treatment](#) or wider health and social care activities, such as activities to increase general resilience and decrease risky behaviours within sexual health services or educational support services to address truancy [EP1].

The committee acknowledged that the misuse of substances such as illegal drugs and alcohol rarely happens in isolation. Many people at increased risk of drug misuse may already be in contact with statutory, voluntary or private services such as mental health, community-based criminal justice, alcohol and drug services, and services for [children and young people who are looked after](#) and [care leavers](#). The committee heard expert testimony that local authorities are well placed to address the wider needs of some [groups at risk](#), such as their housing needs [EP1]. However, local authorities also need to collaborate with wider services, such as healthcare services, schools, or police and crime commissioners, to provide effective drug misuse prevention activities [EP1].

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

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

Section 1.2 Assessment

The discussion below explains how we made recommendations in [section 1.2](#).

Recommendation 1.2.1

The committee discussed assessing whether people are vulnerable to drug misuse. The committee agreed that it was essential to have an assessment before intervention to ensure that the intervention offered is appropriate and no harm is done. It noted that an assessment of drug use was a consistent part of effective interventions included in evidence review 1. No studies were identified that included an assessment only arm compared with assessment plus intervention and no intervention. However, the committee discussed that if comparator groups were offered assessment, improved drug or other outcomes were consistently reported. The committee also noted that there was weak evidence from review 2 that assessments of substance use and other risky behaviours may prompt reductions in drug use [ES2.22].

The committee noted that none of the 7 interventions modelled by the health economic team were cost effective in the base case as a stand-alone intervention (see overview of the cost-effectiveness evidence) [ES4.1, ES4.2, ES4.3, ES4.4, ES4.5, ES4.6, ES4.7]. The committee noted from the health economic modelling that to be cost effective an intervention would need to cost less than £100 per person and would need to reduce the number of people misusing drugs by at least 5 percentage points over 2 years [ES4.8]. The committee agreed that a reduction of at least 5 percentage points in the number of people at risk of misusing drugs was most likely to occur in people who are assessed as vulnerable to drug misuse. As such, interventions are likely to be cost effective only in people who are vulnerable to drug misuse.

The committee discussed that interventions that target people assessed as most vulnerable to drug misuse are more likely to be cost effective. The committee agreed that drug misuse prevention activities cannot be targeted to people most vulnerable to drug misuse if those people have not been assessed. It noted that undertaking assessment before an intervention is consistent with the related NICE guideline on psychosocial interventions for drug misuse in people aged 16 years and older.

The assessment could be part of either a routine appointment (such as health needs assessments for children and young people who are looked after) or an opportunistic appointment (such as when someone attends an emergency department as a result of alcohol use, or when young people come into contact with the community-based criminal justice system). Many different practitioners may be working with people at risk of drug misuse. These practitioners have an important role in identifying people who may benefit from drug misuse prevention activities, even if the practitioners do not provide drug misuse prevention activities themselves. The committee therefore recommended that routine and opportunistic appointments provided by statutory and other services should be used to assess vulnerability to drug misuse.

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

Recommendation 1.2.2

The committee was not able to recommend a particular assessment tool for a number of reasons. The committee noted that most tools that are available focus on people who already use drugs rather than those at risk of misusing drugs. Comments from stakeholders during consultation on the draft guideline highlighted several assessment tools that stakeholders believed could be useful. However, the committee noted that these tools may not fit easily into routine and opportunistic appointments provided by statutory and other services. Some of the tools focused on alcohol use rather than drug use. The committee was aware that there is no single tool that is suitable for use in all groups at risk and for assessing all vulnerabilities. It was concerned that recommending a tool for a particular group at risk may result in the tool being used with other groups at risk, which may not be appropriate. The committee noted evidence that whatever approach is chosen, it should be non-judgemental, which is likely to be more acceptable to participants [ES2.17, ES2.20, ES2.32]. So the committee was unable to recommend a specific assessment tool, but recommended that a consistent, locally agreed, respectful and non-judgemental approach is used.

The committee recommended that the approach for assessment should be proportionate to the person's presenting vulnerabilities. The committee noted that the assessor may become more aware of potential vulnerabilities through their discussion with the person and may therefore need to do a more intensive assessment to explore these vulnerabilities.

The committee noted that there are existing practice standards for young people with substance misuse problems from the Royal College of General Practitioners, Alcohol Concern, DrugScope and Royal College of Psychiatrists. The overall quality of the practice standards document was rated as 5 out of 7 using the AGREE II tool, where 1 indicates 'lowest possible quality' and 7 indicates 'highest possible quality'. The practice standards document scored well on several domains in the tool, including being clear on the aim of the guideline and its target population, involving stakeholders throughout development, presenting recommendations clearly, and providing information on implementation. It did not score as well on describing how the evidence was selected, the strengths and limitations of the evidence, or the methods for formulating the recommendations. However, this information can be found in the guidance (including NICE guidance) that the recommendations in the practice standards document are based on. The committee noted that there is no corresponding practice standards document for adults. However,

it believed that many of the practice standards were relevant for adults as well as young people. The committee agreed that the practice standards are a useful example of an approach for assessing a person's vulnerability to drug misuse.

Recommendation 1.2.3

The committee discussed the importance of an assessment considering how the wider health and personal context, such as a person's age and developmental stage, as well as their personal, social, health, mental health and educational or employment circumstances, may affect their vulnerability to drug misuse. It also discussed the importance of assessment addressing the possible harm associated with any existing drug use by that person.

The committee recommended that assessors should be aware that the person's circumstances may be complex. The committee acknowledged that people working with groups at risk need to have an understanding of the potential vulnerabilities to drug misuse. They should also be aware that people may present with more than 1 vulnerability, and that people who do present with more than 1 vulnerability may be at increased risk of drug misuse.

The committee agreed that an assessment might identify people who are already misusing drugs. As previously noted, it can be difficult to make a distinction between occasional or recreational use and regular or excessive use. The committee highlighted that the definition of 'excessive use' is subjective and may vary depending on the individual (for example, their age and developmental stage) and their circumstances. For example, drug use that is not considered excessive in an adult may be considered excessive in a younger person.

Treatment of people who use drugs or alcohol regularly or excessively is outside the scope of this guideline. NICE has guidelines on psychosocial interventions and opioid detoxification for drug misuse in people aged 16 years and older, diagnosis and management of alcohol-use disorders in people aged 10 years and older, and needle and syringe programmes for adults and young people, including those under 16.

Recommendation 1.2.4

The committee discussed the role of safeguarding. It acknowledged that safeguarding includes protecting vulnerable people of any age from physical and emotional maltreatment, sexual abuse, neglect and exploitation. It agreed that safeguarding is everyone's responsibility. It added that all practitioners who are in contact with vulnerable people have a duty to protect them from maltreatment and share information with other services.

The committee agreed that practitioners undertaking assessment of whether someone is vulnerable to drug misuse should be aware that the assessment may raise safeguarding concerns. It acknowledged that safeguarding concerns may become more apparent to the practitioner once the assessment has ended and they are reflecting on the discussion. Although the committee emphasised the importance of safeguarding, it acknowledged that recommending referral to specialist services, such as child protection services, as a result of safeguarding concerns is outside the scope of the current guideline.

The committee also acknowledged that not all concerns need immediate intervention from social care services, and that other factors (such as problems at school) may have a larger effect on the person's vulnerability to drug misuse. The committee therefore recommended that the assessor should think about whether there are concerns for the safety of the person being assessed and any people under their care.

Recommendation 1.2.5

The committee recommended that people undertaking assessments should discuss the person's priorities and consider what effect their priorities have on prevention activities or referral to specialist services. The committee highlighted that there are existing practice standards for young people with substance misuse problems from the Royal College of General Practitioners, Alcohol Concern, DrugScope and the Royal College of Psychiatrists.

Section 1.3 Children and young people assessed as vulnerable to drug misuse

The discussion below explains how we made recommendations in [section 1.3](#).

Recommendation 1.3.1

The committee noted that the health economic team modelled 7 [drug misuse prevention](#) interventions. None of these were cost effective in the base case as a stand-alone intervention (see [overview of the cost-effectiveness evidence](#)) [ES4.1, ES4.2, ES4.3, ES4.4, ES4.5, ES4.6, ES4.7].

The committee noted from the health economic modelling that to be cost effective, an intervention would need to cost less than £100 per person and would need to reduce the number of people misusing [drugs](#) by at least 5 percentage points over 2 years [ES4.8]. The committee agreed that a reduction of at least 5 percentage points in the number of people at risk of misusing drugs was most likely to occur in people who are assessed as vulnerable to drug misuse. As such, interventions

are likely to be cost effective only in people who are vulnerable to drug misuse. The committee recommended that interventions are prioritised for those with increased vulnerability.

Evidence for the effectiveness of offering personal and social skills training to children and young people at risk of drugs misuse and to their parents and carers came from 4 studies reported in 4 papers [Esc]. Two trials reported a significant reduction in drug use, including a trial undertaken with children and young people who are looked after and their foster carers. There was also evidence from 3 studies of a significant improvement in personal and social skills after skills training for children and young people and their parents or carers, which supports the studies that found a significant reduction in drug use.

One of the trials of personal and social skills training for children and young people and their parents and carers reported an increase in cannabis use in children and young people who underwent skills training. However, the committee believed this finding could be a result of participants changing their drug use from other drugs to cannabis during the study, because the study also reported a decrease in the use of drugs other than cannabis. An additional study did not report a significant reduction in drug use after the intervention; however, in this study drug use was measured immediately after the intervention only and no longer-term data were collected.

The committee noted that there was evidence from evidence review 2 that group-based skills training [ES2.33, ES2.46] and opportunistic skills training, advice and information provision are acceptable to participants [ES2.39]. However, it also acknowledged that it may not be appropriate to include carers or families in all cases, such as if children have been sexually abused.

Personal and social skills training for only children and young people who are vulnerable to drug misuse was not recommended because the evidence was limited and inconsistent [Esa]. Two studies of the effectiveness of skills training for children and young people showed an inconsistent effect on drug use, with the use of some drugs being significantly reduced but the use of other drugs not changing significantly. A third study reported no difference in drug use after skills training for children and young people. One study reported a significant improvement in drug refusal skills, problem-solving skills, and coping skills after the intervention. Another study concluded that skills training for children had no significant effect on feelings of self-worth, but it did not report data, p values or an effect size. One study reported that the intervention may have affected intention to use drugs, but the data were not reported. Another study reported a statistically significant improvement in knowledge of drugs and their risks after the intervention with peer educators but not with adult educators.

Personal and social skills training for only carers and families of children and young people at risk of

drug misuse was not recommended. This was because it was not clear that skills training for parents and carers alone had a significant effect on drug use in the children and young people they cared for. Evidence for the effectiveness of skills training for parents or carers came from 4 trials reported in 7 papers [Esb]. One trial and 2 follow-up studies reported no statistically significant difference in drug use. Three trials and a secondary analysis of one of the trials reported significantly reduced drug use after the intervention. However, 2 of the trials that reported significantly reduced drug use included other interventions for the families in addition to skills training, such as case management, weekly family therapy, individual therapy, and motivational interviewing. It is not clear whether the skills training or the other interventions had a significant effect on drug use.

Family-based interventions as a whole were not recommended because they were unlikely to be cost effective for the populations included in the current guideline. The committee acknowledged the evidence on family-based interventions showed a mixed effect on drug use, with 5 studies in 6 papers showing a significant reduction in drug use, 4 studies in 6 papers showing no significant effect on drug use, and 1 study showing a significant increase in drug use [ES1.50]. However, the committee noted that the evidence base included studies of Multidimensional Treatment Foster Care and motivational interviewing, which are more intensive than skills training alone. The committee was aware that family-based interventions were recommended in NICE's guideline on substance misuse interventions for vulnerable under 25s. It noted that this recommendation included motivational interviewing and family therapy, which were very unlikely to be cost effective for the populations included in the current guideline.

The health economic modelling looked at 3 family-based interventions that included skills training [ES4.1, ES4.3, ES4.7]. None of the interventions were found to be cost effective in the base case scenario. However, the committee noted that these interventions involved other activities as well as skills training, such as motivational interviewing, which would have made them more costly. The committee noted that the results of the modelling showed that 2 of the interventions could be cost effective if the cost of delivering them was lower and the effects of the interventions could be sustained over 2 years or more [ES4.3, ES4.7]. It also noted that interventions could be made cost effective if they were added to existing programmes of care at an additional cost of less than £100 per person [ES4.9].

Manualised and licensed programmes, of which 4 out of 5 were family-based, were not recommended because they were costly and may not be effective for the populations included in the current guideline. The committee noted that evidence review 1 included studies of manualised and licensed programmes, namely Focus on Families [ES1.10], Family Competence Program [ES1.11], Multidimensional Treatment Foster Care [ES1.14, ES1.18], Familias Unidas [ES1.17] and

Free Talk [ES1.19]. The studies either showed no significant effect on drug use [ES1.10, 1.19], an inconsistent effect on drug use [ES1.14, ES1.18] or did not report drug use outcomes [ES1.11]. The committee noted that such programmes are costly and that adapting programmes to make them cost less than £100 per person could have an impact on effectiveness. The committee also noted that none of the studies of manualised and licensed programmes were from the UK, and it is not clear whether the programmes would have the same effectiveness in a different country from where the study was performed. The committee concluded that it could not recommend adapting existing manualised or licensed drug misuse prevention programmes for use in the UK.

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

The committee noted that there were 15 unique trials of motivational interventions, of which 9 were in children and young people [Ese, Esf, Esg]. Two of the 9 trials reported significant reductions in drug use. However, 1 of these trials showed a significant difference in the use of some drugs at some time points but not others, and the other trial showed reduced drug use in some contexts but not others. The committee agreed that, overall, motivational interventions were unlikely to be significantly more effective than skills training.

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

Taking into account the uncertainty in the terminology and the effectiveness and cost-effectiveness evidence, the committee concluded that it was unable to recommend motivational interventions for [groups at risk](#) of drug misuse. The committee recommended that research is undertaken in this area (see [research recommendation 3](#)).

The committee agreed that skills training for children and young people as well as for their carers or families was likely to be a more cost effective way to reduce the risk of drug misuse than family-based interventions or manualised or licensed programs, and motivational interventions for children and young people. This is because it is more likely that skills training could be delivered as part of existing services for less than £100 per person. The committee noted that skills training is likely to improve a range of outcomes, including those that are not related to drug misuse. It did not believe there was enough evidence to recommend skills training just for children and young people, or just for their carers and families. The committee reiterated that any skills training should be delivered as part of existing services, as in [recommendation 1.1.1](#).

The committee discussed the different groups of people that this guideline is relevant to. It acknowledged that services aimed at groups at risk use different ages to distinguish between child and adult services. For example, specialist services for drug [treatment](#) aimed at adults may include people aged 16 and over, whereas services for children and young people that are looked after may include those aged up to 25. The committee was aware that 'young people' can include people with a range of ages and developmental stages. It acknowledged that for some young people it may be more appropriate to offer skills training, and for other young people it may be more appropriate to offer information on drugs and their effects. The committee recommended that following an assessment of whether a young person in a group at risk is vulnerable to drug misuse, the most appropriate prevention options for that young person should be considered.

Recommendation 1.3.2

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

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

The committee noted that skills training is likely to be delivered by people who do not work in drug and alcohol services. It agreed that any skills training should be delivered by people who are already competent to provide it, instead of investing resources in training people to deliver it. It noted that the NICE guidance on [antisocial behaviour and conduct disorders in children and young people](#) includes recommendations on the training and competencies of staff working with children

and young people.

Recommendations 1.3.3 and 1.3.4

The committee discussed the content of skills training sessions, noting that different approaches were used in different studies and that most studies included training on more than 1 type of skill. The skills training interventions for children and young people that successfully reduced the risk of drug use and improved personal and social skills included skills such as listening, conflict resolution and refusal. Other components of effective skills training interventions were identifying and managing stress, making decisions, coping with criticism, dealing with feelings of exclusion, and making healthy behaviour choices [ES1.7, ES1.8, ES1.11, ES1.13, ES1.15, ES1.21, ES1.23].

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

The committee agreed that skills training for children and young people who are looked after and care leavers, and their carers, needed particular consideration, because there was clearer evidence of the success of skills training for this group compared with other groups. Successful skills training interventions for children and young people who are looked after and care leavers included social skills and how to deal with feelings of exclusion [ES1.13]. For foster carers, the important component was how to use behaviour reinforcement systems [ES1.13, ES1.14]. The committee recommended that skills training for children and young people who are looked after, care leavers and foster carers emphasised these skills.

Recommendations 1.3.5 and 1.3.6

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

The committee considered other aspects that might influence the effectiveness of skills training offered to children and young people. It agreed that presenting vulnerabilities, cultural context, religion and ethnicity may be important. It recommended that these factors be taken into account,

along with any other specific needs or preferences of the child or young person vulnerable to drug misuse, when deciding the details of what training sessions to provide. It also noted the evidence that interventions should be made engaging, relevant and creative [ES2.12, ES2.18].

The committee considered whether interventions should be provided one-to-one or in a group-based setting. It acknowledged there was mixed evidence for the effectiveness of group-based behaviour therapy (including skills training) for children and young people [ES1.54], but that it is generally well received [ES2.13]. The committee agreed that group-based skills training is likely to cost less per person than one-to-one skills training. None of the studies looked at the effectiveness of one-to-one skills training, but the committee acknowledged that group environments may not be appropriate for everyone in groups at risk. The committee recommended taking into account the child or young person's needs and preferences when deciding whether sessions should be provided one-to-one or in groups.

The committee considered the number and duration of skills training sessions that should be delivered. It acknowledged that the overall effectiveness of family-based interventions did not appear to vary by the intensity or duration of the intervention [ES1.68]. However, it was not clear whether this was also true for the subset of family-based interventions that included skills training sessions for children or young people and their parents or carers. Studies used different numbers (3 to 14 sessions) and durations of training sessions (from not reported to 1.5 to 2 hours), and the committee noted no consistent pattern of effectiveness.

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

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

The committee was unable to recommend details of the skills training, such as where to hold the sessions, as this information was not available from the evidence. However, the committee was

aware that the Department of Health has published [quality criteria for young people friendly services](#). It recommended that these criteria are used for information when considering skills training for children and young people.

Section 1.4 Adults assessed as vulnerable to drug misuse

The discussion below explains how we made recommendations in [section 1.4](#).

Recommendation 1.4.1

The committee noted that the health economic team modelled 7 [drug misuse prevention](#) interventions. None of these were cost effective in the base case as a stand-alone intervention (see [overview of the cost-effectiveness evidence](#)) [ES4.1, ES4.2, ES4.3, ES4.4, ES4.5, ES4.6, ES4.7].

The committee noted from the health economic modelling that to be cost effective, an intervention would need to cost less than £100 per person and would need to reduce the number of people misusing [drugs](#) by at least 5 percentage points over 2 years [ES4.8]. The committee agreed that a reduction of at least 5 percentage points in the number of people at risk of misusing drugs was most likely to occur in people who are assessed as vulnerable to drug misuse. As such, interventions are likely to be cost effective only in people who are [vulnerable to drug misuse](#), and the committee recommended that interventions are prioritised for those with increased vulnerability.

The committee was unable to recommend skills training for adults at risk of drug misuse because the evidence was limited [Esd]. The committee noted that only 1 study of skills training for adults at risk of drug misuse reported significantly reduced drug use compared with before the intervention. The committee acknowledged there was mixed evidence for the effectiveness of group-based skills training as a whole; however, it noted that this evidence included studies in children and [young people](#) at risk of drug misuse, as well as adults [ES1.42].

Motivational interventions were not recommended because of the uncertainty in the terminology and the effectiveness and cost-effectiveness evidence. The evidence review identified 3 main types of motivational intervention: 'motivational interviewing', 'brief interventions' and 'motivational enhancement therapy' (see [evidence tables](#) for details of the interventions). The committee noted that most studies did not clearly describe the intervention and used terminology that may not match the committee's understanding. It acknowledged that the programme development group for NICE's guideline on [individual approaches to behaviour change](#) noted similar issues. The programme development group concluded that it was impossible to recommend motivational interviewing because the studies did not specify which principles and components were used. The

committee therefore considered the evidence for motivational interventions as a whole.

The committee noted that there were 15 unique trials of motivational interventions, of which 6 were in adults [Ese, Esf, Esg]. Of these 6 trials, 3 trials reported significant reductions in drug use. One trial showed a significant reduction in drug use compared with no assessment or intervention, but no significant reduction in drug use compared with education or information.

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

Taking into account the uncertainty in the terminology and the effectiveness and cost-effectiveness evidence, the committee concluded that it was unable to recommend motivational interventions for groups at risk of drug misuse. The committee recommended that research is undertaken in this area (see research recommendation 3).

The committee was unable to recommend skills training or motivational interventions for adults who are assessed as vulnerable to drug misuse; however, it wanted to recommend some action should be taken. The committee agreed it should provide recommendations on what current practice involves. The committee considered what current practice involved in studies that found current practice to be as effective as motivational interventions [ES1.2, ES1.22, ES1.36, ES1.37]. Current practice was found to include brief information and education on drugs and their effects (such as health and social effects), and feedback. The committee recommended that adults who are assessed as vulnerable to drug misuse should receive these components of current practice. It also recommended research in this area (see research recommendation 2).

The committee considered whether additional components should be added to the care of adults who are vulnerable to drug misuse. It agreed that information on sources of advice or support would be helpful for adults at increased risk. The committee agreed that information and advice should be offered at the time of their assessment.

Recommendation 1.4.2

The committee considered whether the information and advice offered to adults assessed as

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

The committee considered factors that may affect the provision of information to adults who are vulnerable to drug misuse. It discussed the different levels of understanding about health across groups of people. It noted that the level of understanding about health is likely to vary widely among adults who are vulnerable to drug misuse. The committee also noted that NICE's guideline on [patient experience in adult NHS services](#) recommends taking people's general literacy levels into account to meet their needs. The committee agreed that the person's level of understanding about health needs to be considered when providing information to adults who are vulnerable to drug misuse.

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

The committee noted that NICE has existing guidance on [general](#) and [individual](#) approaches to behaviour change. It recommended that information and advice is provided in line with these guidelines.

Recommendation 1.4.3

The committee considered the number of information sessions needed for adults who are vulnerable to drug misuse. It agreed that the approach used to provide information will need to vary to account for the wide range of adults who are vulnerable to drug misuse. The committee recommended that a plan for follow-up is discussed and agreed at the time of the person's assessment (see [recommendation 1.2.1](#)).

Section 1.5 People at risk of using drugs

The discussion below explains how we made recommendations in [section 1.5](#).

Recommendation 1.5.1

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

Recommendations 1.5.2 and 1.5.3

The committee considered what drug misuse prevention services could be offered to people in groups at risk who do not present to health or social care services. Digital technologies can allow interventions to be offered to people who are either unable or choose not to access services, and can offer anonymity. The committee noted the evidence showed that web-based interventions did not significantly reduce drug use [ES1.48] compared with assessment only [ES1.32, ES1.33] or a waiting list control [ES1.34]. However, 1 study did show promising effects of web-based information and advice in a subgroup analysis of people with a family history of drug problems [ES4.2]. Web-based interventions were generally well received [ES2.29, ES2.30, ES2.41].

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

The committee considered that web-based interventions could feasibly be produced at a low cost and was aware of existing online sources of information, including NHS Choices. It noted that the NHS Choices website provides reliable information and also provides links to other helpful sources of information. The committee therefore recommended that targeted new media (including web-based information as well as digital and social media), that give reliable information, and online self-assessment and feedback to help people assess their own drug use, could be provided to people at increased risk. These approaches may be particularly useful in those less likely to be in contact with health and social care services. The committee also recommended that further research should be undertaken on the effectiveness of digital technologies (see research recommendation 5).

The committee noted that some people in groups at risk may not be able to access online services. It recommended that written information should be made available for people not in contact with health or social care services.

The committee also recommended that information given to people not in contact with health or social care services should include information on local services and sources of advice and support.

Recommendation 1.5.4

The committee noted that NICE has existing guidance on [general](#) and [individual](#) approaches to behaviour change. It recommended that information is provided to people at risk of using drugs in line with these guidelines.

Evidence not used to make a recommendation

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

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

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

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

delivered effectively.

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

The committee was aware that the evidence review did not find any evidence on drug misuse prevention strategies for image- and performance-enhancing drugs or new psychoactive substances. Committee members heard expert testimony that it is difficult to identify and intervene when people are using these drugs, because they tend not to label themselves as drug users. In addition, image- and performance-enhancing drugs are available online and so can be accessed by a wide range of people. The committee recommended research is undertaken in this area (see research recommendation 6).

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

The committee recommended that further research is needed into digital technologies (see research recommendation 5).

Limitations of the evidence

Limitations of the effectiveness and acceptability evidence

The committee noted that most of the included studies used small sample sizes, short follow-up times, self-reported drug use and intermediate outcomes (such as knowledge about drugs, rather than change in drug-using behaviour). It was not possible to determine whether some studies were poorly conducted or poorly reported. Some studies may not have been adequately powered to identify significant differences between groups. In addition, some participants in some studies did not attend any of the intervention sessions, and many studies did not include a true control group. As a result, the efficacy of the intervention could have been underestimated in these studies.

The committee noted that single small studies were presented for more than 1 group at risk, resulting in multiple evidence statements from the same studies. This makes the evidence base look larger and stronger than it actually is. Overarching evidence statements have been used to summarise the body of evidence across population groups [ESa, ESb, ESc, ESd, ESe, ESf].

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

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

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

The committee noted that no good quality evidence is available for some groups at risk, despite the research recommendations made in NICE's previous guideline on substance misuse interventions for vulnerable under 25s. Committee members agreed that more evidence from well designed and adequately powered studies is needed. The committee recommended that research is undertaken on the effectiveness and acceptability of drug misuse prevention interventions in groups at risk (see research recommendations [3](#) and [4](#)).

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

Limitations of the cost-effectiveness evidence

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

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

The committee also recognised that the long-term harms and associated costs of drug use are mostly unknown. The size of the groups at risk is unknown, and it is not known what percentage of people in these groups will go on to misuse drugs. These factors will affect the accuracy of the health economic modelling. The committee therefore recommended research is done on the long-term consequences of drug use (see [research recommendation 1](#)).

Terminology

The committee discussed that many terms used in the literature to describe drug use are subjective and often used inconsistently or interchangeably (for example, terms such as 'use', 'misuse', 'occasional' or 'recreational', 'dependency' and 'abuse'). It discussed that the definition of 'recreational' use in particular was subjective. For example, fortnightly use of cannabis by an adult might be considered recreational, but fortnightly use by a child or young person may be considered problematic.

The committee discussed the term 'primary care'. It acknowledged that the use of the term by the public focuses on general practitioners. However, the committee agreed that the use of the term in this guideline includes all primary care services, including healthcare professionals such as pharmacists, dentists and optometrists.

Although treatment for drug misuse fell outside the remit of this guideline, there is an overlap between treatment, harm reduction (aiming to prevent or reduce negative effects of drugs) and prevention in this field. Despite careful consideration by 3 reviewers, some studies of harm reduction interventions may have been misinterpreted as treatment studies and so would not have been considered in this guideline. The committee noted that NICE has a range of products that cover drug misuse, and in particular that treatment has been considered by related NICE guidelines

([psychosocial interventions](#) and [opioid detoxification](#) for drug misuse in people aged 16 years and older).

Existing NICE guidance

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

The committee considered the NICE guideline on [individual approaches to behaviour change](#) in the context of the current guideline. This guideline recommends delivering very brief, brief, extended brief and high intensity behaviour change interventions and programmes to people who are at risk of damaging their health through their behaviour.

When considering the evidence for the guideline on individual approaches to behaviour change, the committee for that guideline noted that, across all interventions, those targeting the general population were more likely to be cost effective than those aimed at vulnerable populations (targeted approaches). However, it is important to note that evidence directly relating to [drug misuse](#) was not included. The committee for that guideline also noted similar difficulties to the committee for this guideline in determining the interventions used in the studies.

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

The committee considered the NICE guideline on [prevention of alcohol-use disorders](#) to be particularly relevant to this guideline because many people who misuse [drugs](#) also misuse alcohol ([Psychosocial interventions to reduce alcohol consumption in concurrent problem alcohol and illicit drug users](#) Klimas et al. 2014). This can result in people having multiple issues when they present to healthcare services. However, the committee noted that alcohol misuse is not illegal, allowing for interventions and data collection to be done more easily. The committee agreed that the recommendations for alcohol misuse [prevention](#) cannot be directly translated into recommendations for drug misuse prevention because of the lack of data for drug misuse prevention. The committee agreed that, because of the large overlap in the target populations of the current guideline and the guideline on prevention of alcohol-use disorders, the recommendations in the guideline on prevention of alcohol-use disorders should be kept in mind when providing drug misuse prevention activities.

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

The committee also noted that NICE's guidelines on [child maltreatment](#), [needle and syringe programmes](#), [attention deficit hyperactivity disorder](#), [looked-after children and young people](#), [domestic violence and abuse](#), [coexisting severe mental illness and substance misuse](#), and [physical health of people in prison](#) are relevant to drug misuse prevention. NICE also has a quality standard on [looked-after children and young people](#). The current guideline on drugs misuse prevention should be considered in the context of this other guidance.

Recommendations from NICE's guideline on substance misuse interventions for vulnerable under 25s

This guideline will update and replace the NICE guideline on substance misuse interventions for vulnerable under 25s (PH4, published 2007).

The committee discussed the recommendations and considerations in the guideline being updated and considered the view of the experts in the review decision. It acknowledged that the populations included in the scope for the above guideline differ to some extent to those included in the current guideline. The current guideline also includes adults aged over 25. The current guideline does not include black, Asian and minority ethnic groups as a specific group at risk because they are no longer considered a group at risk. The current guideline also did not include people who were considered 'at risk' or 'vulnerable' without further explanation.

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

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

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

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

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

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

Evidence reviews

Details of the evidence discussed are in [evidence reviews, reports and papers from experts in the area](#).

The evidence statements are short summaries of evidence. Each statement has a short code indicating which document the evidence has come from. All of the evidence statements are presented in the paper [Evidence statements from all reviews](#). The paper also includes overarching

statements that summarise the evidence across the groups at risk.

Evidence statement (ES) letter 'a' indicates that the linked statement is lettered 'a' in 'Evidence statements from all reviews'. **Evidence statement (ES) number 1.1** indicates that the linked statement is numbered 1 in evidence review 1. **ES2.1** indicates that the linked statement is numbered 1 in evidence review 2. **ES3.1** indicates that the linked statement is numbered 1 in the health economic evidence review. **ES4.1** indicates that the linked statement is numbered 1 in the health economic modelling report. **EP1** indicates that expert paper 1 'Current provision and future issues (opportunities and difficulties) for commissioning' is linked to a recommendation. **EP2** indicates that expert paper 2 'The use of image and performance enhancing drugs in the United Kingdom' is linked. **EP3** indicates that expert paper 3 'Night time environment and local partners role in managing harm' is linked.

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

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

Recommendation 1.1.2: EP1

Recommendation 1.2.1: ES2.22; IDE

Recommendation 1.2.2: ES2.17, ES2.20, ES2.32; IDE

Recommendation 1.2.3: IDE

Recommendation 1.2.4: IDE

Recommendation 1.2.5: IDE

Recommendation 1.3.1: ESa, ESb, ESc, ES1.50, ES2.33, ES2.39, ES2.46, ES4.1, ES4.3, ES4.7, ES4.9; EP1; IDE

Recommendation 1.3.2: EP1; IDE

Recommendation 1.3.3: ES1.7, ES1.8, ES1.11, ES1.13, ES1.14, ES1.15, ES1.17, ES1.21, ES1.23, ES1.57, ES1.58, ES1.60

Recommendation 1.3.4: ES1.11, ES1.13, ES1.15, ES1.17, ES1.21, ES1.23, ES1.57, ES1.58, ES1.60

Recommendation 1.3.5: ES1.54, ES1.68, ES2.12, ES2.13, ES2.18, ES2.19; IDE

Recommendation 1.3.6: IDE

Recommendation 1.4.1: ESd, ES1.2, ES1.22, ES1.36, ES1.37, ES1.42; IDE

Recommendation 1.4.2: ES2.17, ES2.20, ES2.27, ES2.31, ES2.32; IDE

Recommendation 1.4.3: IDE

Recommendation 1.5.1: ES2.29, ES2.30, ES1.32, ES1.33, ES1.34, ES1.48, ES2.41, ES4.2; EP2; IDE

Recommendation 1.5.2: IDE

Recommendation 1.5.3: IDE

Recommendation 1.5.4: IDE

Recommendations for research

The advisory committee has made the following recommendations for research.

1. Long-term consequences of drug use

What are the long-term consequences of drug use?

Why this is important

We identified little evidence on the long-term health and social consequences of using [drugs](#). This made it difficult to determine the full consequences and effect of drug use on people in [groups at risk](#). In particular, there was limited evidence on the long-term effects of using drugs other than cannabis. More evidence on the long-term consequences of drug use would enable more accurate modelling of the costs of drug use. This would in turn allow more accurate modelling of the cost effectiveness of [drug misuse prevention](#) interventions.

2. Identifying current practice and provision

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

Why this is important

It is unclear what current practice is, and what provision is currently in place, for drug misuse prevention in groups at risk in the UK. Studies in the current review showed that active interventions were no more effective than current practice (as received by a control group). In addition, there is a lack of UK-based studies, and it is not clear whether the current practice that was used as a control group in studies conducted elsewhere is applicable to the UK population.

It is not clear how many of the people that are referred to drug misuse prevention services attend (or are brought to) the services. Identifying existing practice and provision will allow new drug misuse prevention activities to be compared with current practice, identify gaps in current provision, and determine what proportion of people referred to drug misuse prevention services do not attend (or are not brought) to services.

3. Effectiveness and cost effectiveness of drug misuse

prevention interventions for groups vulnerable to drug misuse

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

Why this is important

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

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

The differential effect of interventions on groups at risk needs to be established, particularly for people with multiple vulnerabilities. The accuracy of tools for assessing vulnerability to drug misuse also needs to be determined. Interventions of interest include one-to-one skills training, information and advice as part of planned outreach activities, and wider behaviour change strategies. It is also important to know whether the effectiveness of interventions is affected by the content and framing of the message, the mode of delivery, where the intervention is delivered and the intended recipient of the intervention.

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

4. Acceptability of drug misuse prevention interventions

How acceptable are drug misuse prevention interventions among groups vulnerable to drug misuse in the UK? How acceptable are drug misuse prevention interventions among practitioners in the UK? How can acceptability be improved for groups that are vulnerable to drug misuse and practitioners?

Why this is important

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

Acceptable interventions are important to increase the uptake of interventions and reduce the number of people who do not attend (or are not brought to) services following a referral. Studies are needed on interventions that are acceptable to people with different levels of self-efficacy and understanding about health. It is also important to know which interventions are more acceptable to particular groups at risk. Interventions that are more acceptable to practitioners are more likely to be implemented with groups at risk. Research on the framing of messages, such as abstinence-based approaches, is needed because some ways of framing interventions may be more acceptable than others to people in groups at risk. Research is also needed on who delivers the interventions, as this may also affect the acceptability of an intervention.

5. Effectiveness of digital technologies

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

Why this is important

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

Research is needed on effectiveness, cost effectiveness and acceptability of interventions and self-assessment using digital technology. Studies could compare interventions delivered using digital technology with face-to-face interventions. Studies could also look at using interventions that use digital technologies as part of a stepped care model.

6. Use of image- and performance-enhancing drugs

What are the most effective and cost effective interventions to prevent and reduce the use of

image- and performance-enhancing drugs?

Why this is important

No evidence was identified for interventions to reduce the use of image- and performance-enhancing drugs. Several different types of drugs can be classed as image- and performance-enhancing, including drugs that are used by people trying to lose weight (such as laxatives), those used to gain weight or increase physical performance (such as anabolic steroids), and those used to increase cognitive ability (such as methylphenidate). People using these drugs may not identify as drug users, making it difficult to provide preventative interventions. In addition, image-and performance-enhancing drugs are available online and can be accessed by a wide range of people.

Update information

This guideline updates and replaces NICE guideline PH4 (published March 2007).

Glossary

Behaviour reinforcement strategies

Approaches that link behaviour with outcomes, to encourage positive behaviour and discourage negative behaviour. This includes rewarding positive behaviour (such as going to school or work) and rewarding the absence of negative behaviour (such as using aggressive language).

Brief interventions

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

Dependent [on drugs]

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

Digital technology

Technology that requires the use of a device containing a computer or microcomputer. This includes smartphones, laptops and desktop computers, tablets and other electronic devices. Devices do not have to have internet access to be classed as digital technology, although many do. The term 'digital technology' includes the use of websites and social media, apps on smartphones or tablets, and text-based computer programs. Some types of digital technology may be more commonly used by some age groups than others.

Foster carers

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

Motivational interviewing

A brief psychotherapeutic intervention. For people who misuse drugs, the aim is to help people reflect on their substance use in the context of their own values and goals and motivate them to change (adapted from [The efficacy of single-session motivational interviewing in reducing drug consumption and perceptions of drug-related risk and harm among young people: results from a multi-site cluster randomized trial](#) McCambridge and Strang 2004).

Psychoeducation

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

Skills training

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

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

ISBN: 978-1-4731-2339-7

Accreditation

