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Drug use prevention among young people

Evidence into practice briefing

February 2006

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This work was undertaken by the National Collaborating Centre for Drug Prevention (NCCDP) on behalf of the Health Development Agency (HDA), but published after the functions of the HDA were transferred to the National Institute for Health and Clinical Excellence (NICE) on 1 April 2005. This document does not represent NICE guidance.

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Foreword

This evidence into practice briefing represents the culmination of research and fieldwork on preventing and delaying the onset of drug misuse, reducing the harm associated with it and promoting cessation. The work was undertaken by the National Collaborating Centre for Drug Prevention (NCCDP) on behalf of the Health Development Agency (HDA). However, it was published after 1 April 2005, when the HDA's functions were transferred to the National Institute of Clinical Excellence to form the National Institute for Health and Clinical Excellence (NICE). This document does not represent NICE guidance.

The HDA was established in 2000 to build the evidence base in public health with an emphasis on getting what works into practice. As part of its Evidence into Practice (EIP) work, the HDA commissioned several collaborating centres (including the NCCDP) to review the evidence and, through fieldwork with practitioners, present it in a meaningful and useful way to other practitioners, commissioners, managers and researchers. This briefing is the outcome of that process. Additional fieldwork reports are also available from NICE or from the NCCDP on request. NICE welcomes comments on the content via its website at: www.nice.org.uk

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1 Summary

This evidence into practice briefing aims to help reduce the morbidity and mortality associated with drugs use by providing evidence-based information on interventions that prevent or help delay its onset, reduce the harms associated with it and promote cessation.

This briefing is for professional groups in the statutory, voluntary and private sectors. These are listed below, along with a summary of key information relevant to each group. Figures in brackets refer to relevant sections of the briefing.

1.1 Executives, senior managers, commissioners and budget holders:

- Public health professionals (for example, directors of public health (DPHs) and community development staff)
- Policy and decision makers (for example, those working in regional government offices, strategic health authorities (SHAs), the Drug Strategy Directorate (DSD) and cross-governmental drugs misuse specialists
- Commissioners and budget holders (for example, members of primary care trusts (PCTs), drug and alcohol action teams (DAATs) chairs and managers, and joint commissioners working in local authorities and the NHS
- Children's trusts.

1.1.1 Key evidence for this group of stakeholders supports:

- Development of evidence-based public health policy to promote the prevention of drug use among young people, particularly those in deprived communities (4, 5.6)
- Promotion, support and development of leadership skills to tackle health inequalities with regards to drug use (5.6)
- Needs and health impact assessments to determine which interventions will work best for a particular population (5.6, 6.4, 8)
- Identification of the community, structural and cultural barriers to developing integrated drug prevention programmes and how these barriers can be overcome (6.2, 6.4)
- Work with local strategic partnerships to implement pilot, community-based 'holistic' prevention programmes involving a number of components (5.5, 6.3)
- Allocation of resources to pilot new or innovative, evidence-based interventions via local strategic partnerships (6.3)
- Organisation and workforce development to support delivery of drug prevention interventions. This should include accredited and/or standardised training, and independent monitoring of multi-agency working (5.3, 6.2, 6.3)
- Longer-term funding in response to evaluation evidence showing effectiveness (4)
- Realistic outcomes and definitions of success shared by all stakeholders and professional groups (6.3)
- The use of 'alternative' evaluators, such as funded PhDs, standardised training workshops and courses for drug professionals (6.3).

1.2 Service providers:

- Drug treatment services
- Advocate groups
- Tier 1 and 2 young people's substance misuse services
- Resource developers
- Counselling services
- Youth offending teams (YOTs)
- Youth offender institutions (YOIs)
- Youth organisations
- Social workers
- Leaving care teams.

1.2.1 Key evidence for this group of stakeholders supports:

- An awareness of individual and group barriers to engaging with services and how to help young people identify, manage and resolve risky (drug-related) behaviours (6.4, 6.5)
- A view of young people's drugs use which looks at the broader context of their lives (improving their general health, social skills and education) may be more important than focusing specifically on health outcomes (3, 6.3, 6.4)
- Maintenance of non-drugs using behaviour by promoting and reinforcing protective factors (for example, positive experiences at school, in the social environment or with the family)
- Research and evaluation (process, fidelity and outcome) as a means of improving practice, with evaluation fully integrated from the intervention's conception (6.3)
- Discussion of project successes and failures, so contributing to Drug Education and Prevention Information Service (DEPIS) and Exchange on Drug Demand Reduction Action (EDDRA), two online databases that provide projects and resources for planners and providers of drugs prevention (7)
- Work with the media to present positive views of young people and rational, evidence-based information about drugs and drug use (5.5)
- The ability to influence and determine local and national discourse and priorities on drugs and drugs use (5.6)
- Active participation in training and professional development (5.3, 6.2)
- Work at national and local level to disseminate intervention and research outcomes through a variety of media and presentation techniques (6.4, 7)
- Monitoring of sources of referral, and the appropriate use – and quality of – external providers (including professional trainers and invited speakers) and resources (5.3.2, 6.4).

1.3 Community-based professionals:

- Healthcare professionals (for example, general practitioners, practice nurses, health promoters)
- Education specialists (for example, teachers in mainstream education and schools for excludees) and school drugs officers
- Community organisations
- Youth groups.

1.3.1 Key evidence for this group of stakeholders supports:

- Working with all sectors, in all settings, to ensure suitable and sensitive referrals, appropriate information sharing, network development and effective community engagement (4, 6.4, 6.5)
- Identification of training needs and delivery of training to individuals and groups (including volunteer groups) to help them develop and deliver drug prevention interventions (5.3, 6.2)
- Assessment of needs, resources and capacity to develop and deliver community-based drugs prevention programmes (4, 5.1, 5.2, 5.6, 6.5)
- Community profiling to identify structural and cultural barriers preventing development of community-based drug programmes and how to overcome those barriers (6.2)
- Community participation in the development of community-based drug prevention programmes such as health promotion, health education, awareness raising and other community development activities (6.2)
- The recognition of potential community leaders and champions (6.2)
- Integration of community-based drug prevention programmes with other initiatives (for example, in schools via the national curriculum and Healthy Schools and via initiatives supported by the Neighbourhood Renewal Fund (NRF)) (5.5).

1.4 Academics, designers, planners and evaluators of drug prevention projects

- Health professionals and drugs experts based in universities, government departments, DAATs, PCTs, LEAs and SHAs.

1.4.1 Key evidence for this group of stakeholders supports:

- The creation and evaluation of a wide range of activities based on drug prevention theories (5.4.1, 5.6, 6.3, 8).
- Identification of determinants of drug misuse as well as protective factors – in particular, associated behaviours which may be amenable to change (3, 3.1, 6.4).
- Refining and testing interventions for behavioural change and education, with reference to:
  – 'real world' implementation
  – gender differences

  - sensation seeking and risk-taking behaviours (which require definition and description)
  - perceptions of harm (including relative and absolute drugs risks), and cognitive and affective risk awareness
  - generic behavioural change
  - social norms and sociocultural beliefs
  - teaching methods and knowledge transfer (pedagogy and epistemology)
  - iatrogenic effects of intervention.

  (5.1, 5.2.1, 5.4, 6.3, 6.4, 8).
- Conducting, promoting and then disseminating the findings of high-quality interventions, describing:
  - confounding factors and sources of bias
  - population (type of user, control group, entry and exclusion criteria, attrition)
  - nature of the intervention and facilitators/providers
  - specific and clearly defined outcomes (qualitative and quantitative assessments of behaviours addressed, units of analysis at individual, school or community level)
  - duration of effect
  - causation and mechanisms of change
  - assessment of fidelity, practicality, transferability and cost effectiveness (5.4, 5.5, 6.3, 7).

2 Introduction

This briefing presents evidence-based information on how to prevent drugs misuse. It integrates published scientific literature with practitioner expertise and experience, including advice on how to overcome typical barriers and obstacles to effective practice.

2.1 How was this briefing developed?

This briefing is based on evidence from *Drug use prevention among young people: a review of reviews* (Canning et al. 2004), rapid reviews of the grey literature (Coomber et al. 2004a, 2004b; Millward et al. 2004), and National Collaborating Centre for Drug Prevention (NCCDP) reviews of the evidence base (Edmonds et al. 2005; McGrath 2006).

The most 'plausible' interventions were appraised by practitioners to determine those most likely to succeed. Typical barriers and opportunities for local implementation were also identified. The methodology is described elsewhere (Sumnall et al. 2005) and is summarised in Figure 1.

Briefly, key literature was systematically evaluated using a proforma and a 'long list' of 12 recommendations was constructed. This was discussed with an international group of experts that rated each recommendation in terms of appropriateness and likely effectiveness. The long list was then further refined to a shortlist of key prevention categories, programme delivery, design and content, research and indicated (particularly vulnerable) groups.

The detail was discussed at a series of fieldwork meetings involving practitioners, academics and local/regional commissioners and planners of drug services for young people. The discussions were transcribed and analysed to identify common themes, barriers to implementation and solutions. Consensus was reached through an expert meeting, and the final evidence is presented in this briefing.

2.2 Why focus on drugs misuse in young people?

2.2.1 What is the problem?

While there are no current data on the drugs used by children under 10 years old, in 2004 10% of 11–15 year olds reported taking drugs in the previous month (National Centre for Social Research/National Foundation for Educational Research 2005). UK schoolchildren (15–16 year olds) consistently report higher levels of lifetime use of any illegal drug than other European citizens (36% versus 16%) (Hibell et al. 2004). According to the British Crime Survey, people aged 16–24 are more likely than older people to have used drugs in the last year and in the last month (Condon and Smith 2003). Although reported use fluctuates, young people's perception of the prevalence of drug use among their peers generally does not change.

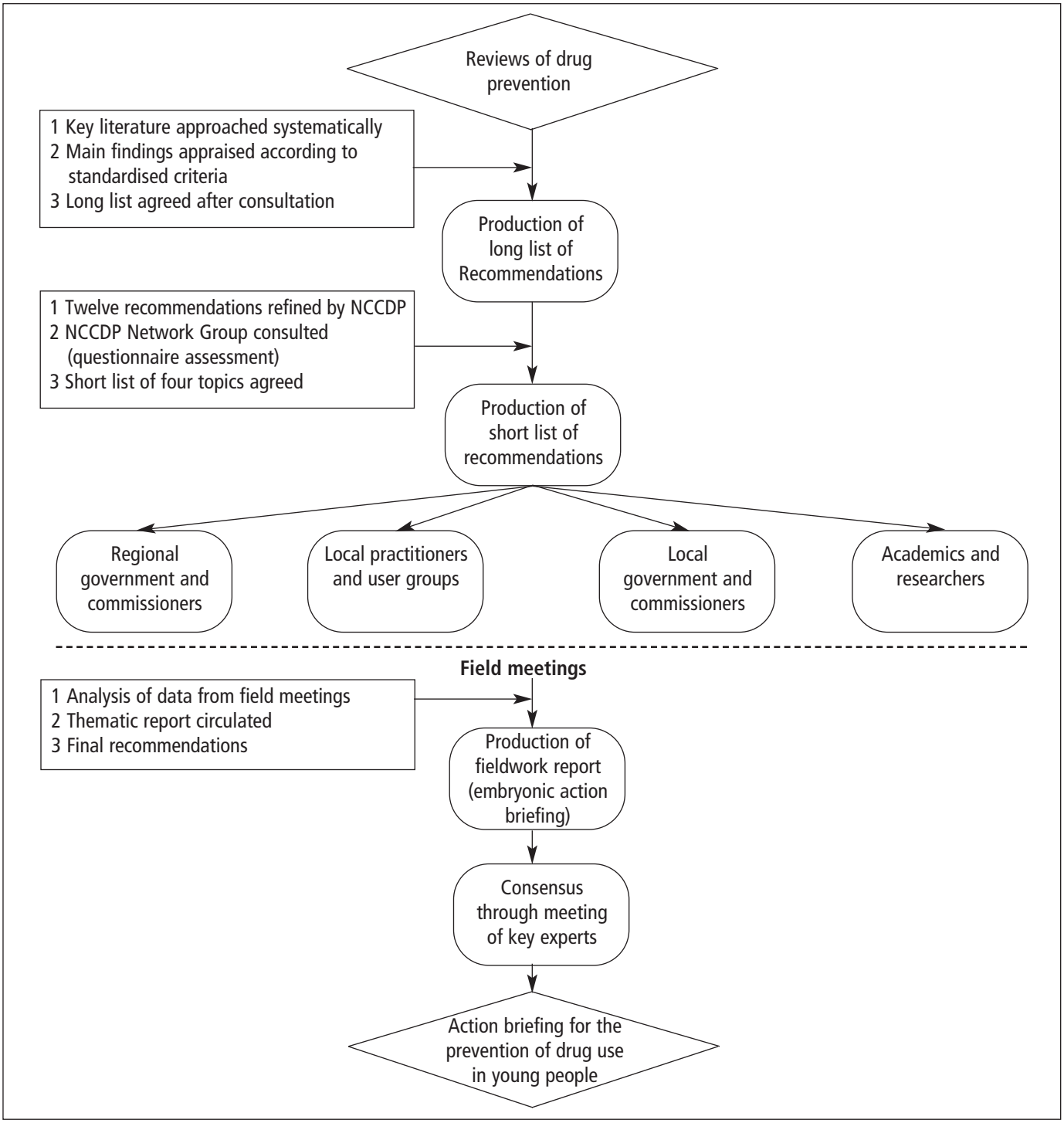
2.2.2 Why prevent drugs misuse in young people?

This age group reports the highest level of drugs use in the general population and will suffer the most years of ill health if adversely affected. Drugs use may have a negative effect on psychological development, and accumulating evidence suggests that people who start using drugs at an early age perform worse at school and have fewer employment prospects than abstainers (Hickman et al. 2004; Lynskey and Hall 2000). Twin studies suggest that they are also more likely to go on to – or become dependent on – multiple substances (Lynskey et al. 2003).

2.2.3 What is the policy context?

The *Updated Drug Strategy 2002* (see www.drugs.gov.uk) aims to reduce the use of class A drugs – and the frequent use of all illicit drugs – by all young people (< 25 years old) and, in particular, the most vulnerable, by 2008. 'Choosing not to take illegal drugs' is a key aim of *Every Child Matters: Change for Children – Young People and Drugs (*DfES 2005). A simplified and strengthened set of key performance indicators in relation to children and young people are being developed via the National Drug Strategy Performance Management Framework for 2005/2006. These reflect the contribution of mainstream services through universal interventions (including drugs education, advice and information, prevention, and via access to core services), targeted interventions with vulnerable young people, specialist treatment for young people, and the involvement of parents, carers, and families.

Figure 1: Methodology



3 The 'web of determinants'

The health of populations and individuals is influenced by a number of inter-connected determinants.

- Environment – physical, economic and social conditions (including education, employment and housing)
- Lifestyle – personal behavioural choices that increase or decrease the risk of ill health
- Services – provision and use.

Drugs use may be thought of in the context of these determinants.

3.1 Why do people take drugs?

The choice to use a particular drug involves sophisticated decisions and risk assessments. But drugs are usually taken to produce certain perceived effects and fulfil specific functions (Boys et al. 1999, 2001; Hansen et al. 2001; Williams and Parker 2001). The World Health Organization uses the following broad categories of drug use:

- **Experimental use** that might or might not continue
- **Functional use** that serves some purpose, such as recreation, but does not cause problems for the user
- **Dysfunctional use** that leads to impaired psychological or social functioning
- **Harmful use** that causes damage to the user's physical or mental health
- **Dependent use** that could involve tolerance and/or withdrawal symptoms if use is ceased, and continued use.

Evidence indicates that certain childhood problems and personality traits, such as attention deficit behaviours and sensation seeking/impulsiveness, are associated with an increased likelihood that someone will experiment with controlled drugs and develop a medical disorder associated with drugs use in later life (Giancola et al. 1996; Lynskey and Hall 2001; Tapert and Brown 2000). However, these are associated risk factors and do not imply that young people's drugs use is a pathological or 'disease state'.

The reasons for initial experimentation and continued use of drugs are different. Beliefs about the effects may have an influence independent of biological, sociocultural, and psychopharmacological factors (Brown et al. 1980). For example, youths and adults with strong expectations that alcohol intoxication will have a positive and arousing effect start drinking at an earlier age and are more likely to develop drinking problems later in life (Blume et al. 2003; Goldman and Christiansen 1985). Initial experiences of cocaine use largely determine whether it becomes habitual. In addition, there are strong links between the age when an individual first had the opportunity to use a drug and actual age of first use (Davidson et al. 1993).

Users have to make sophisticated cost-benefit analyses if they are going to continue taking a drug (Parker et al. 1998). Generally, the perceived positive effects (for example, enhanced mood, perceptual and aesthetic components) need to outweigh the negative effects (for example, criminality, anxiety, 'hangover', problems with education, work, financial state and relationships) (Van Etten et al. 1998).

In the general population, there is a random propensity to use drugs. This means that, all other factors being equal, those individuals who use more problematic drugs (such as heroin and crack cocaine) do so regardless of whether or not – or how much – they have used other drugs such as alcohol, tobacco or cannabis in the past (Morral et al. 2002). For example, a quarter of one British

clinical sample reported that they started to use cocaine and heroin before they began to use other illicit drugs (Sanju and Hamdy 2005). In addition, people often continue to take drugs despite their knowledge or experience of the negative effects or the potential risks involved (Cottler
et al. 2001), simply accepting these as part of the overall drug experience.

Several groups of young people are particularly vulnerable to developing problematic drugs use (Canning et al. 2004). These include: homeless young people, schoolchildren who have been excluded or who truant, young offenders, cared for children, young people who work in the sex industry and children of drug-using parents. These groups are reported to have high levels of drugs use compared to the general population.

The 2003 Crime and Justice Survey (Becker and Roe 2005) revealed that reported use of Class A drugs in the past 12 months was markedly low among young people in the general population (4%). Among the identified groups, truants had the highest levels of drugs use (16%) while those in care had the lowest levels (5%). There may be particularly vulnerable subsets within these groups: members of more than one group reported higher levels of Class A drugs use than members of any one group (more than one 39%; one group 18%). It must also be noted that large proportions of young people who belong to these groups do not take drugs occasionally or habitually.

A wide variety of risk factors are thought to predict a move from experimental and irregular use into drugs dependence. These include: laws and norms favourable towards drugs use, extreme economic deprivation, neighbourhoods with high levels of crime and unemployment, physiological characteristics, family history of drugs use, academic failure, early peer rejection and social influences. The variety of determining factors suggests that drugs use may be a particular manifestation of a general underlying behavioural state. In other words, there are a range of factors that can give rise to drugs use, including other potentially health compromising behaviours.

The social characteristics of the majority of young recreational drugs users are no different from the non-drugs using population (Aust and Condon 2003; Calafat et al. 1998). Most individuals stop using drugs when they reach their mid-20s. Often this coincides with their focus turning to career and family, or it could simply be because they no longer desire the effects that drugs produce (Chen and Kandel 1998).

4 The 'web of stakeholders' and the roles of different professionals

This section highlights who is responsible for – or can be engaged in – drugs prevention work with young people. The way these professionals are grouped together depends on the web of determinants previously described and the nature and organisation of services in relation to drugs prevention.

Healthcare professionals can refer patients directly or indirectly (for example, via community development workers) to appropriate services.

Education specialists provide curricular-based interventions and are key contacts for external drugs education providers. Provision for school excludees includes tailored interventions to meet their needs. Local drugs programme coordinators support the drugs prevention aspects of the National Healthy Schools Programme.

Public health specialists are often responsible for the allocation of primary care trust (PCT) drugs prevention funding, and for encouraging local agencies to work together to achieve the aims of the National Drugs Strategy. They ensure that all primary healthcare services provide evidence-based drugs information and that appropriate links are made with drugs and education services. They should also be able to make the epidemiological links between drugs use and other conditions, so that all services (health or otherwise) understand their role in drugs prevention.

Drug service providers deliver drug prevention interventions in a range of settings including schools, community and youth groups, and through media campaigns. Additional support is offered according to the young person's life circumstances. They recruit young people to help deliver key messages and to develop their self-esteem and inter-personal skills, including negotiation skills.

Local policy makers, budget holders and senior managers within the NHS and local authorities ensure resources are allocated to evidence-based, needs driven drugs prevention activities.

Community organisations can act as recruiters of young people and service providers. They are often well placed to monitor uptake and feedback on interventions; in particular, how they are meeting local needs. Community development workers can also help promote local drugs prevention initiatives.

Academics and the designers, planners, and evaluators of drugs prevention projects identify the purpose and expected outcomes of a project. All projects should be theory-driven, practical and based on appropriate methodology. Successes and failures should be assessed and shared with a wide audience to help improve subsequent interventions.

5 The evidence base for effective interventions

A review of the literature (Canning et al. 2004; Coomber et al. 2004a, 2004b; Edmonds et al. 2005) yielded a number of evidence-based interventions that were likely to prevent drugs use among young people. The review also indicated that most interventions were only effective in the short-term.

5.1 Programme design and content

The evidence suggests that an effective drug prevention programme needs to be carefully planned and developed. Special attention should be given to its structure and content. The former concerns issues such as length of the programme, implementation strategies and the management, monitoring and evaluation processes. Content needs to reflect research evidence, the characteristics of the target population (for example, gender and age) and its potential cost effectiveness. The evidence suggests that:

- school-based drugs prevention programmes have a small, short-term effect in terms of delaying the onset of drugs use or reducing the amount of drugs used (White and Pitts 1998)
- drugs prevention programmes should take 'a whole person approach', which addresses several different life issues (including drugs use and drugs-related problems) (Belcher and Shinitzky 1998; Smyth and Saulnier 1996; White and Pitts 1998; Windle and Windle 1999)
- the effectiveness of programmes varies according to gender (White and Pitts 1998). In particular, several studies found that targeted interventions were more effective for females than males. Therefore, the content needs to be gender sensitive
- young people's attitudes towards drugs can change – over time and in response to the prevailing societal climate (Coggans et al. 2003). So programmes need to be in tune with the social culture and attitudes towards drugs among the target and general populations (Coggans et al. 2003; Smyth and Saulnier 1996; White and Pitts 1998).

5.2 Indicated and targeted groups

Research has shown that particular groups of young people are more likely to try drugs and/or develop drug-related problems than the general population. Selective prevention targets these groups. Indicated prevention targets individuals who may have already started using drugs and whose habit is likely to escalate. The HDA evidence briefing, *Drug use prevention among young people: a review of reviews* (Canning et al. 2004) identified six key groups of 'at risk' young people:

- children whose parents use drugs
- young offenders
- looked-after children
- young homeless people
- schoolchildren who are excluded
- sex workers.

These groups are not exclusive: many young people will be part of more than one group or transfer between them, and there may be particularly vulnerable subsets of young people within these groups. Young people from black and minority ethnic groups (BMEG) are also considered in the HDA briefing, as the literature suggests they are particularly vulnerable and face particular barriers accessing the appropriate services.

The evidence suggests that:

- universal drugs prevention programmes (those targeting the whole population, for example, every

student in a school) can be ineffective or even harm sub-populations who have a higher risk of initiating drugs misuse and/or developing drugs-related problems (Windle and Windle 1999). These 'high risk' youths may benefit from targeted interventions which take into account their individual needs (White and Pitts 1998; Windle and Windle 1999)
- 'high risk' young people need to be identified and recruited in a sensitive manner, as 'labelling' can lead to stigmatisation and further problems (Smyth and Saulnier 1996)
- 'High risk' youths are more likely to drop out from a programme (Coggans et al. 2003). Therefore, effective strategies are needed to retain participants, with a contingency plan for those who drop out (Allott et al. 1999; Smyth and Saulnier 1996).

5.3 Programme delivery

There are two main issues with programme delivery: who should be teaching or facilitating the programme and what teaching methods should be used?

Drugs prevention programmes have been taught and/or facilitated by teachers, peers, police officers and other contributors. A programme can be interactive (offering contacts and opportunities to exchange ideas and learn drug refusal skills) or non-interactive, or both. Both the person delivering the programme and the teaching methods used need to be appropriate for the age and culture of the target audience. The evidence suggests that:

- service providers need standardised and well-monitored training (Black et al. 1998)
- programmes should be run in an environment that promotes disclosure, honest feelings and opinions (Windle and Windle 1999).

5.4 Research

The effectiveness of a prevention programme or intervention is greatly improved if it is based on evidence of effectiveness. The programme or intervention can, in turn, contribute to the research pool (providing it has been evaluated) to assess its implementation, operation and both short- and long-term outcomes. Research findings should be clearly communicated and effectively disseminated, so that drugs prevention workers can act on the evidence in concert with developers, researchers, and purchasers. The evidence highlights:

- a lack of well-conducted evaluation studies of drugs prevention programmes with clearly defined outcomes (Allott et al. 1999; Dusenbury et al. 1997; Smyth and Saulnier 1996)
- the 'fidelity of implementation' (the degree to which drug prevention providers implement programmes as intended by the programme developers) can affect outcomes (Black et al. 1998; Coggans et al. 2003; White and Pitts 1998; Windle and Windle 1999). Therefore, programme fidelity needs assessing to ensure an accurate conclusion is drawn about effectiveness
- many programmes combine different components or features; however, the effectiveness of each component was seldom examined separately. This suggests that programmes should incorporate research elements to distinguish effective and ineffective components (Allott et al. 1999; Flay 2000; White and Pitts 1998).

5.5 Attributes of effective interventions

In addition to the statements above, Canning et al. (2004) found that programmes which had a positive impact on drug-related cognitions and/or drugs use had several common characteristics.

- They tend to use a mix of focused and generic components/interventions.
- They tend to include booster sessions or additional elements that have a similar purpose (White and Pitts 1998). However, other characteristics appeared to have a stronger influence on the programme's outcomes (Coggans et al. 2003; Cuijpers 2002).
- Intensive programmes involving 10 or more sessions have been shown to be effective. However, effectiveness cannot be attributed solely to the intensity of the programme, since some less intensive programmes demonstrated positive outcomes (Black et al. 1998; White and Pitts 1998).
- Interactive programmes were more effective at preventing drugs use than non-interactive programmes (Black et al. 1998; Parkin and McKeganey 2000).
- Multi-component programmes (those which address several life issues by different means and in different settings) can help prevent drugs use and/or drugs

problems. These may involve, for example, school, parents, community organisations and the mass media (Botvin 1999a, 1999b; Flay 2000; Lloyd et al. 2000).
- Life skills training programmes demonstrated long-term, albeit small, prevention effects for tobacco, alcohol and cannabis use (Dusenbury et al. 1997; White and Pitts 1998). This was, however, limited to a sub-population of participants (Coggans et al. 2003; Gorman 2002) and then only with a high fidelity of implementation (Coggans et al. 2003).
- Police-led drugs education can have an impact on attitudes towards the police and drugs knowledge but its effect on drugs use is limited (Allott et al. 1999).

5.6 Gaps in the evidence base

No review-level evidence was found on the effectiveness of the following interventions.

- School-based interventions focused on changes in behaviour among primary schoolchildren (Belcher and Shinitzky 1998; Lloyd et al. 2000).
- Interventions targeted at particular groups, for example, vulnerable young people (Dusenbury et al. 1997; Smyth and Saulnier 1996) including those not attending school (White and Pitts 1998).

The majority of British studies do not evaluate outcomes of programmes adequately, but focus more on processes (Lloyd et al. 2000; White and Pitts 1998). In addition, methodological problems were prevalent in all drugs prevention evaluation studies, which limited the strength of the conclusions in the HDA evidence briefing (Canning et al. 2004). Methodological issues included:

- low participation rates, inappropriate choice of outcome measures, absence of appropriate controls and high rates of attrition (Allott et al. 1999). A lack of heterogeneity among evaluation studies was also highlighted, which makes meaningful comparisons difficult (Dusenbury et al. 1997)
- many studies relied too heavily on self-reported measures of drugs use – few used objective data, such as saliva or blood tests (White and Pitts 1998).

The findings only have a limited relevance to UK drugs prevention programmes as:

- cultural and societal differences can affect the effectiveness of programmes and most outcome evaluation studies were conducted in the USA
- school-based universal prevention programmes do not reach those young people who have been excluded from school.

The HDA evidence briefing was limited to a review of interventions aimed at individuals. Hence, no evidence is available on the effectiveness of interventions to change policy, practice or the environmental factors influencing the onset, experimentation and regular or 'binge' use of drugs.

The absence of evidence on what works for vulnerable populations must be considered carefully by managers, policy makers and commissioners of services. Failure to address the needs of disadvantaged groups when designing intervention programmes may increase the gradient of morbidity and mortality across the social spectrum (because an intervention programme may have a differential impact on different social groups).

A final caveat is that the absence of evidence does not necessarily imply lack of effectiveness; interventions made need to be designed and evaluated more carefully to demonstrate effectiveness among particular population groups.

6 Results of fieldwork meetings

This section presents the suggestions and observations that emerged from the fieldwork meetings. They are linked to the shortlist of evidence drawn from the original evidence statements (which, in turn, were taken from the literature reviews, see section 5). This shortlist suggests how different stakeholders can overcome implementation barriers and put evidence into practice. The fieldwork meetings were carried out in Liverpool (UK) during November and December 2004.

6.1 General observations

There is a clear need for consistent definitions of key terms (see glossary of drugs prevention related terms, below).

Periods of abstinence are often interspersed with recreational and problematic drug use during a young person's drugs-using 'career', although the distinctions between the latter two may be becoming increasingly blurred. Drugs 'careers' are shaped by the interaction of individual factors (for example, family background) with structural opportunities (for example, employment) at different times. The importance of considering young people's lives within the broader context (for example, socio-economic climate and drugs markets) should be stressed.

Glossary of drugs prevention related terms

While this glossary is not comprehensive, it introduces some of the most important terms used in drugs prevention work and, hopefully, will be developed further.

Children People under the age of 18 years, in accordance with the Children Act (1989) and the United Nations Convention on the Rights of the Child (1989).

Young people People aged under 25 (in line with Home Office definitions).

Drugs prevention Interventions that prevent, delay or reduce the harms associated with drugs use and promote cessation. There are three main prevention models:

- **universal** targets the whole population
- **selective** targets subsets of the population identified as having a higher than average risk of drug use
- **indicated** targets those who have already taken drugs and are considered to be at risk of becoming dependent.

Drugs/substance These have identical meanings. They are both agents that, when ingested in sufficient doses and by appropriate routes, can alter the way a person functions. In the literature, 'drugs' tends to refer to illicit compounds (as defined in the UK by the Misuse of Drugs Act, 1971), although it is often used interchangeably with 'substance'. In the pharmacological definition, all psychoactive compounds, from caffeine to heroin, should be defined as drugs.

Drugs/substance use The ingestion of a psychoactive agent to produce a desired behavioural, physiological or psychopharmacological state.

Problematic drugs/substance use Regular, excessive consumption and/or dependence on illegal psychoactive compounds, leading to social, psychological, physical or legal problems (that cause harm to the individual, their significant others or the wider community). It can include adverse effects on interpersonal skills; or functioning in work, school, or social settings.

Drugs/substance misuse These terms are discouraged by some professionals, who consider them judgemental.

Drugs prevention intervention An activity or set of activities used to help a group of people change their drug-using behaviour.

Drugs prevention programme The sum of all intervention modules implemented by a coordinator.

Evaluation A systematic assessment of whether (outcome evaluation) and/or how (process evaluation) the objectives of an intervention have been achieved.

6.2 Programme delivery

Suggestions

- Service providers need to work with a representative sample of the young people they aim to target to ensure the interventions are relevant, appropriate and credible.
- Competent staff are essential to get vulnerable young people interested.
- Educators and service providers should develop interactive approaches to equip young people with the skills they need to make an informed decision about drugs use.
- Sessions involving active participation should be used to build up long-term relationships with young people.
- Multi-agency working and information sharing should be commonplace. It should be coordinated at regional level and subject to independent monitoring and evaluation.
- External contributors should be assigned clear roles and expectations to ensure consistent and coordinated approaches and to avoid duplication of effort (for example, police officers in schools should talk about the legal consequences of drugs). External contributors should also share and support the ethos of the organisation's prevention strategy.
- A range of methods are recommended to target specific populations (for example, social marketing techniques) and for research (tools such as the Internet and libraries).

Barriers

- Education techniques and training skills need to be developed through accredited and/or standardised courses.
- Opportunities for training people to deliver drugs prevention programmes are limited due to a lack of resources or time.
- Negative educational experiences may reduce the effectiveness of school-based interventions, or reduce the likelihood of personal disclosure and honesty about drugs.
- Organisational and legal restrictions pose a barrier. For example, if protocol restricts the breaking of confidentiality, or promotes a 'zero tolerance' approach. Similarly, some workers do not wish to breach the personal confidences and trust established with a client.

Solutions

- Drugs prevention providers should be informed of approved agencies/organisations to consult if they have a problem or concern.
- Involving existing youth organisations with drug prevention initiatives builds on the credibility of these organisations.
- Exciting and inspiring environments should be used to deliver the intervention.
- Any 'personal contracts' with young people (for example, regarding behaviour and mutual expectations resulting from participation) should clearly state that the service deliverer would act if they believe that the welfare of the individual is of concern. Section 8 of the Misuse of Drugs Act (controlled drugs use on premises) may provide justification for taking further action in particular circumstances (for example, if a residential service is provided).

6.3 Research and evaluation

Suggestions

- Prevention programmes should include a research element.
- Prevention programmes should have clearly defined aims and expected outcomes and should measure the behaviour being addressed. The impact on attitudes and knowledge should not be measured by self-report alone.
- Evaluations should be designed in parallel with, and not after, the project.
- Evaluation should be realistic about what constitutes a success or failure and indicate over what time period any benefits will be measured.
- As well as distinguishing between effective and ineffective interventions (and offering explanations),

evaluations help to support decisions on the quality of evidence arising from an intervention. (There are wide differences in the quality of published evaluations/research and these should be explored and understood)
- Different outcome measures have their own benefits and disadvantages.
- In some circumstances, generic health and social improvements are more important than specific ones related to drugs use.
- Rigorous process evaluation is essential. It helps to explain successes and failures, some of which may not be entirely related to the intervention.

Barriers

- Sources of funding and funding criteria impact on the choice of outcome measures. Some projects do not include an evaluation component.
- Often, service providers show a lack of interest in robust evaluation.
- Service providers' understanding of what constitutes evaluation varies and there is confusion about what each type of evaluation offers (for example, monitoring services versus process evaluation versus outcome/impact evaluations). Process evaluation is often incorrectly used as an outcome assessment. In such cases, target group endorsement or enthusiasm is confused with effectiveness.
- Some traditional outcome measures (for example, temporary delay in onset of drugs use) may not be meaningful, as drugs use is a product of other risky behaviours which, if not addressed simultaneously, will reoccur.
- The fidelity of an intervention needs to be operationally defined in line with the reality of delivery (for example, delivering an intervention in a busy classroom).
- The value of evaluation findings is limited when generalising to other populations, social environments or geographic locations.
- Unsuccessful projects are less well publicised, which means practitioners cannot learn from other people's mistakes.

Solutions

- Raise awareness of the value and usefulness of good quality evaluation studies, in terms of good practice and appeal to funders.
- Allocate pilot or priming funds for services to conduct small projects. This will reduce the risk of conducting costly and ineffective interventions.
- Pool resources to increase the providers' capacity to evaluate programmes and ensure a coordinated approach locally.
- Participants are useful process evaluators. They can ensure a programme meets everybody's expectations (their own, the providers' and the funders) and is delivered with fidelity.
- Experienced practitioners or university researchers with a background in prevention research should train service providers in evaluation techniques.
- There are alternative and cost effective ways of evaluating short and long term projects. For example, by utilising the skills of Master's and PhD students.

6.4 Design and content

Suggestions

- Programmes with both generic and substance-specific units are the most appropriate for young people.
- Content should be developed in consultation with – and be relevant to – the targeted, at-risk population and should address both health and lifestyle issues.
- Creative, flexible content is essential to interest vulnerable young people and to make them feel as if they are developing several useful skills – not just drug-related ones.
- Innovative ideas and shared experiences are needed to design an effective non-curricular based intervention in schools.
- Generic strategies to reduce risk taking behaviours (for example, impulsive decision making) will have a direct and indirect effect on drug-using behaviour, and will have a positive influence on other health-related behaviours.
- In designing interventions to address or identify risky behaviour (that is, drug use or its determinants) it must be noted that an individual's response to risk can change over time, depending on their ability to cope (for example, with challenging life events), and their positive or negative experiences of drugs.
- Interventions should provide users with information about the legal and social consequences of drugs use.
- Appreciation of the potential negative effects that drugs use can have on work, relationships, community and education provides a useful approach.

- Parental components, such as homework sessions or family discussions about drugs are potentially useful.
- Subtle alterations in design and mode of delivery (leaving core messages intact) will broaden the appeal to both sexes. However, the fidelity of implementation must always be considered.
- Universal prevention interventions delivered to mixed gender groups encourages young people to shape and share their gender-based experiences, including, for example, pressure in a relationship to use drugs.
- Young people are very aware of the media, so accurate information delivered by a credible media channel can be an effective way to target them.

Barriers

- Young people already involved in risky behaviours are resistant to many health related messages.
- There is no evidence base of good practice for interventions with 18–25 year olds.
- Sensational reporting in the popular media undermines the credibility of anti-drugs related messages, and prevents some parents from talking to their children about drugs.
- Often, parents show little interest in existing drugs awareness schemes. This may be due to the stigma associated with drugs use, their busy lives, or their attitudes towards drugs use and education.
- Changes in social attitudes towards drugs and drugs use will take a long time.
- School exclusion and non-attendance are serious barriers to delivery of school-based prevention interventions.
- An over-reliance on information provision does not allow young people to develop their self-esteem and the interpersonal skills they need – such as the ability to negotiate.
- Skills development programmes should be clearly defined.

Solutions

- Engagement with young people should take place at the earliest opportunity. For example, through the delivery of personal, social, and health education and citizenship (PSHE and C) in schools. This begins at Key Stage 1 and aims to gives pupils the knowledge, skills, and understanding they need to lead healthy, confident lives.
- Continuity in care plans/paths and multi-agency working are especially important for young people at risk of developing or making their drugs problem worse. Tailoring the messages to ensure they are relevant to the individual concerned will increase effectiveness.
- Mentoring (establishing a relationship between two people where one is a role model who will offer advice and guidance) is a useful way of identifying and responding to individual needs.
- Sensationalism should be challenged through the promotion and dissemination of evidence-based, dispassionate information about drugs and drugs use.
- School attendance is a very strong protective factor against drugs use and so must be maintained as far as possible; exclusion must be a last resort.

6.5 Indicated and vulnerable groups and individuals

Suggestions

- Focusing on those identified as most at-risk could lead to labelling and stigmatisation. In addition, other vulnerable sub-populations could be missed.
- Although care plans can be useful tools, taking action according to the plan can be challenging, especially if more than one agency is involved.
- Retention of participants may be difficult due to the factors that made the young person vulnerable in the first place. Responses to disengagement may take the form of crisis management (which simply aims to keep the young person on the programme) rather than trying to continue with specific drug prevention work.

Solutions

- Recruitment processes and the content of targeted approaches need to be sensitive to the target audience and their parents or care-givers. This could be achieved by screening at key transition points such as when pupils move between schools.
- Structures for effective multi agency working should be in place.
- Retention is more likely if participants find the programmes interesting and meaningful and they are delivered in a flexible manner. Staff efforts to build trusting relationships are key.

7 Dissemination of good practice

One of the main objectives of this evidence into practice briefing is to facilitate the exchange of drugs prevention evidence so that local/regional/national practitioners and administrations can monitor the quality and the evolution of their interventions. An incremental system of dissemination is proposed so that people can access the type of evidence they need from the following sources.

- Dedicated websites featuring case studies that put across key learning points and hyperlinks to related material.
- Conferences where people can exchange information and network (although the 'silent majority' are unlikely to participate in discussions).
- Interactive workshops and sessions which respond to the needs of the audience. Topics could include, for example, how to conduct evaluations.
- Participation in evaluations (in other words, organisations and individuals that provide drug prevention should receive constructive feedback).
- Regional meetings with strategic leads to disseminate evidence among – and within – organisations.

In addition, specialised drugs education is needed for health undergraduates and graduates to reach the health professionals of the future.

8 Concluding remarks

Drugs use in the UK consistently exceeds that of other European countries. It has been estimated that 3 million people in England and Wales aged 16 to 24 have used illicit drugs (Chivite-Matthews et al. 2005). Younger age of initiation is associated with potentially greater years of ill health, poorer academic performance and a stronger likelihood of progression onto problematic patterns of use.

Drug use has direct and indirect economic and social costs, and problematic drug use can be a burden on families and communities.

Increased understanding of the reasons why young people use drugs – and the role that drugs play in their lives – means that drugs use cannot be considered in isolation. Indeed, there is a strong relationship with other risky social and personal behaviours and activities.

The most successful prevention interventions provide both generic and specific support in response to changing needs and circumstances. Drugs prevention is therefore a means of addressing a range of health-related behaviours, reducing health inequalities and promoting social inclusion.

This briefing has presented a range of evidence for key stakeholders and offered important points of consideration for those trying to put this evidence into practice. Success requires collaborative working at a number of stages: building up an evidence base, translating the evidence into practice, and subsequently evaluating it to inform the evidence base. All these stages require appropriate structures and funding.

This briefing was produced jointly by a number of stakeholders working together to improve the quality and provision of drugs prevention initiatives and support available for young people.

If implemented, these findings could help change various parts of the healthcare system and have an impact on the wider determinants of health. Different stakeholders can alter certain variables to increase the likelihood of getting evidence-based recommendations into practice.

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APPENDIX 1

Considerations when designing a drug prevention implementation strategy

National and local government strategy

This includes:

- *Updated Drug Strategy 2002* (www.drugs.gov.uk)
- Drugs Bill (www.publications.parliament.uk)
- *Every Child Matters: Change for Children* (www.everychildmatters.gov.uk)
- *Hidden Harm*: *Responding to the Needs of Children of Problem Drug Users* (www.drugs.gov.uk)
- *Choosing Health: making healthier choices easier* (www.dh.gov.uk)
- *National Service Framework for children, young people and maternity services* (www.dh.gov.uk)
- *Drugs: Guidance for Schools* (www.dfes.gov.uk/drugsguidance)
- D(A)AT young people's plans
- National Healthy Schools Programme (www.wiredforhealth.gov.uk)
- National Curriculum (www.dfes.gov.uk).

Current evidence

Available from organisations such as the National Collaborating Centre for Drug Prevention (NCCDP – www.cph.org.uk/nccdp), NICE (www.publichealth.nice.org.uk) and the Drugs Strategy Directorate (www.drugs.gov.uk), as well as from the academic literature and databases such as those run by the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA – www.emcdda.eu.int) and the National Institute on Drug Abuse (NIDA – www.nida.nih.gov)

Examples of 'best practice'

Find out if strategies are based on evidence-based interventions (via peer reviewed sources such as the Drug Education and Prevention Information Service (DEPIS – hosted at www.dh.gov.uk) and the Exchange on Drug Demand Reduction Action (EDDRA – http://eddra.emcdda.eu.int). Despite their apparent success, consider whether programmes in the USA can be transferred to a UK context.

Gaps in service provision

Needs assessment studies and consultation with target groups will identify any gaps. Inclusive, creative thinking will offer solutions to fill these gaps.

Local strategies

Joined-up local working is needed to bring together the relevant 'hooks/levers' and to link in with relevant local strategies including: Children's Fund delivery plans, parenting strategies, the young people's substance misuse strategy; the alcohol harm reduction strategy; Connexions business plans, Healthy Schools partnership plans, crime reduction strategies, Prevent and Deter strategy, Education Development Plans; Teenage Pregnancy Strategy; Children and Young People's Plan.

Local partner organisations

Existing strategic partnerships and delivery plans need to be taken into account when introducing new ways of working.

Local champions

These need to be identified and supported. They include members of community groups, youth workers and teachers.

Key influences

Include the effectiveness of the primary/secondary care interface, economics, judicial policy and practice and local education.

Resources

Implementation of evidence-based practice is likely to have funding implications and there will be areas where money can be saved (for example, by closing ineffective programmes). Start-up, staff recruitment and continued professional development, evaluation and dissemination of findings all need to be well resourced.

Barriers

Interventions may need to overcome cultural, organisational and individual barriers to change (see section 6).

Workforce issues

Who is likely to be involved and what are their skills and competencies? Do they need awareness training and education? Do people need to be recruited? Will new roles and career paths be required?

Potential implications for other services if evidence is put into practice

The overall costs and benefits will have a knock-on effect on crime, health, social inclusion, education, community development, family relationships, parental support and training services. Leaders in these fields need to be consulted.

APPENDIX 2

Common public health issues and levers

Political drivers and imperatives
What is driving the content and shape of the work plan?

Decision makers
Who holds local power to make and influence decisions for change? How can the decision making process be accessed?

Partnerships – who works together?
What is understood by 'partnership'? How important is it to local politicians, the PCT, local authority, emergency services, schools, health visitors, nurses and voluntary agencies. What is the driver encouraging the PCT and LA to sustain partnership working? What is the role of the voluntary sector in planning and delivery? For further discussion see the HDA/NICE publication *Partnership working: a consumer guide to resources* (HDA 2003).

Budget
Who manages the budget? Identify those sectors that need to be accountable.

Other resources
Can include people, professional time and facilities.

Stakeholders
Identify who they are. Do they include people living in the local community, community workers and frontline staff (in the NHS, local authorities and the voluntary sector)?

Consultation
Is it comprehensive?

Commissioning
Is the commissioning process evidence-based or historical? Does it take account of national, regional and local evidence of need, evidence of effectiveness and cost effectiveness? Is there a local evidence base of effectiveness and need?

Shared data and information services
Is there an overarching data collection and information system? What is required to achieve shared data services?

Performance management
Do performance targets relate to public health promotion and prevention practice, or mainly serve as a monitoring tool?

APPENDIX 3

A summary of key stakeholders' objectives (sections 1.1–1.4)

Executives, managers, commissioners and budget holders

- Work in partnership to address underlying determinants of health and barriers to population health gain.
- Create public policy promoting healthy lifestyle choices in young people.
- Support development of capacity to deliver interventions promoting prevention of drugs use in young people.
- Develop evidence-based public health policy to promote prevention of drugs use among young people, particularly those in deprived communities.
- Develop local implementation strategies to support pilot, community-based 'holistic' prevention programmes.
- Develop leadership skills for action on health inequalities.
- Fund needs and health impact assessments to determine local population needs.
- Fund pilots of new or innovative evidence-based schemes via local strategic partnerships.
- Fund longer-term prevention programmes where pilot/research evidence shows effectiveness.
- Fund organisational and workforce development to support delivery of drugs prevention interventions.
- Fund 'alternative' evaluators such as funded PhD students, university/practitioner-led training workshops and courses.
- Identify and address community, structural and cultural barriers to developing integrated drugs prevention programmes.

Service providers

Objectives

- Develop awareness of drugs within the broader context of young people's lives: improving their general health, social skills and education may be more important than focusing on specific drugs use related outcomes.
- Develop awareness of individual and group barriers to engagement with services.
- Develop research and evaluation to improve practice.
- Develop ways of verifying drugs use without relying on self-reporting.
- Take part in evaluation training and make use of participant evaluation.
- Strive to be active participants in training and professional development.
- Work with the media to present positive views of young people, and rational, evidence-based information about drugs and drugs use.
- Monitor sources of referral and use external providers (including professional training and other resources) where appropriate.
- Maintain non-drugs using behaviour by promoting and reinforcing protective factors (such as positive schooling).
- Share project successes and failures via the DEPIS and EDDRA online databases and a variety of media.

Community-based professionals

Objectives

- Work with all sectors and in all settings to share appropriate information, develop networks and engage communities.
- Identify training needs and deliver training to support development of drugs prevention programmes.
- Assess local needs, resources and capacity to develop and deliver community-based drugs prevention programmes.
- Identify structural and cultural barriers to the development of community-based drugs prevention programmes and how to address them.
- Identify potential community leaders and champions.

Engage

- Provide individuals and groups with training, skills development and support.
- Ensure community-based drugs prevention programmes are integrated with other initiatives (for example, in schools via the national curriculum and Healthy Schools and via initiatives supported by the NRF).

Academics, designers, planners and evaluators

Objectives

- Create and evaluate a wide range of activities based on drugs prevention theories.
- Work at all levels to disseminate intervention and research outcomes through a variety of media and presentation techniques.
- Influence and determine local and national discourse and priorities on drugs and drugs use, to share research and evaluation skills.
- Identify the determinants and promoters of drug use as well as protective factors – in particular, associated behaviours that may be amenable to change.
- Refine and test specific interventions.