National Institute for Health and Clinical Excellence

Interventions to reduce substance misuse among vulnerable young people

Issued: March 2007

NICE public health guidance 4

guidance.nice.org.uk/ph4

Contents

Introduction

The Department of Health asked the National Institute for Health and Clinical Excellence (NICE or the Institute) to produce public health guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people.

The guidance is for NHS and non-NHS practitioners and others who have a direct or indirect role in – and responsibility for – reducing substance misuse. This includes those working in local authorities and the education, voluntary, community, social care, youth and criminal justice sectors.

The Public Health Interventions Advisory Committee (PHIAC) has considered a review of the evidence, an economic appraisal, stakeholder comments and the results of fieldwork in developing these recommendations.

Details of PHIAC membership are given in appendix C. The methods used to develop the guidance are summarised in appendix D. Supporting documents used in the preparation of this document are listed in appendix E.

Full details of the evidence collated, including fieldwork data and activities and stakeholder comments, are available on the NICE website, along with a list of the stakeholders involved and the Institute's supporting process and methods manuals.

1 Recommendations

This document constitutes the Institute's formal guidance on community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people.

The recommendations in this section are presented without any reference to evidence statements. Appendix A repeats the recommendations and lists their linked evidence statements.

Community-based interventions are defined as interventions or small-scale programmes delivered in community settings, such as schools and youth services. They aim to change the risks factors for the target population.

For the purposes of this guidance, substance misuse is defined as intoxication by – or regular excessive consumption of and/or dependence on –psychoactive substances, leading to social, psychological, physical or legal problems. It includes problematic use of both legal and illegal drugs (including alcohol when used in combination with other substances).

Vulnerable and disadvantaged children and young people aged under 25 who are at risk of misusing substances include:

- those whose family members misuse substances
- those with behavioural, mental health or social problems
- those excluded from school and truants
- young offenders
- looked after children
- those who are homeless
- those involved in commercial sex work
- those from some black and minority ethnic groups.

Recommendation 1

Who is the target population?

Any child or young person under the age of 25 who is vulnerable and disadvantaged.

Who should take action?

Local strategic partnerships.

What action should they take?

- Develop and implement a strategy to reduce substance misuse among vulnerable and disadvantaged people aged under 25, as part of a local area agreement. This strategy should be:
  - based on a local profile of the target population developed in conjunction with the regional public health observatory. The profile should include their age, factors that make them vulnerable and other locally agreed characteristics
  - supported by a local service model that defines the role of local agencies and practitioners, the referral criteria and referral pathways.

Recommendation 2

Who is the target population?

Any child or young person under the age of 25 who is vulnerable and disadvantaged.

Who should take action?

Practitioners and others who work with vulnerable and disadvantaged children and young people in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. In schools this includes teachers, support staff, school nurses and governors.

What action should they take?

- Use existing screening and assessment tools to identify vulnerable and disadvantaged children and young people aged under 25 who are misusing – or who are at risk of misusing – substances. These tools include the Common Assessment Framework and those available from the National Treatment Agency.
- Work with parents or carers, education welfare services, children's trusts, child and adolescent mental health services, school drug advisers or other specialists to:
    - provide support (schools may provide direct support)
    - refer the children and young people, as appropriate, to other services (such as social care, housing or employment), based on a mutually agreed plan. The plan should take account of the child or young person's needs and include review arrangements.

Recommendation 3

Who is the target population?

- Vulnerable and disadvantaged children and young people aged 11–16 years and assessed to be at high risk of substance misuse.
- Parents or carers of these children and young people.

Who should take action?

Practitioners and others who work with vulnerable and disadvantaged children and young people in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. In schools this includes teachers, support staff, school nurses and governors.

What action should they take?

- Offer a family-based programme of structured support over 2 or more years, drawn up with the parents or carers of the child or young person and led by staff competent in this area. The programme should:

  - include at least three brief motivational interviews (see glossary) each year aimed at the parents/carers
  - assess family interaction
  - offer parental skills training
  - encourage parents to monitor their children'sbehaviour and academic performance
  - include feedback
  - continue even if the child or young person moves schools.
- Offer more intensive support (for example, family therapy) to families who need it.

Recommendation 4

Who is the target population?

- Children aged 10–12 who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse.
- Parents or carers of these children.

Who should take action?

Practitioners trained in group-based behavioural therapy.

What action should they take?

- Offer the children group-based behavioural therapy over 1 to 2 years, before and during the transition to secondary school. Sessions should take place once or twice a month and last about an hour. Each session should:
  - focus on coping mechanisms such as distraction and relaxation techniques
  - help develop the child's organisational, study and problem-solving skills
  - involve goal setting.

- Offer the parents or carers group-based training in parental skills. This should take place on a monthly basis, over the same time period (as described above for the children). The sessions should:
    - focus on stress management, communication skills and how to help develop the child's social-cognitive and problem-solving skills
    - advise on how to set targets for behaviour and establish age-related rules and expectations for their children.

Recommendation 5

Who is the target population?

Vulnerable and disadvantaged children and young people aged under 25 who are problematic substance misusers (including those attending secondary schools or further education colleges).

Who should take action?

Practitioners trained in motivational interviewing.

What action should they take?

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

2 Public health need and practice

Illicit drugs use in the UK is most prevalent among young people aged between 16 and 24 years (Roe 2005).

In 2003, 24% of vulnerable young people reported using illicit drugs frequently during the preceding 12 months, compared with 5% of their less vulnerable peers (Becker and Roe 2005). There were significantly higher levels of drug use among those who belonged to more than one vulnerable group. Becker and Roe (2005) define five groups of vulnerable young people: 'those who have ever been in care, those who have ever been homeless, truants, those excluded from school and serious or frequent offenders'.

Substance misuse is associated with significant health risks including anxiety, memory or cognitive loss, accidental injury, hepatitis, HIV infection, coma and death. It may also lead to an increased risk of sexually transmitted infections.

In England and Wales in 2003/04, class A drug use was estimated to cost around £15.4 billion in economic and social terms (Gordon et al. 2006).

Vulnerable and disadvantaged children and young people

Factors that influence substance misuse among children and young people include:

- environment (for example, availability of drugs)
- family (for example, sibling and/or parental substance misuse and lack of discipline)
- individual experience (for example, early sexual encounters and peer group pressure to misuse substances)
- mental health (for example, low self-esteem, depression)
- education (for example, parental expectations)

(adapted from Canning et al. 2004).

The guidance is aimed at reducing substance misuse among vulnerable and disadvantaged children and young people. Those at particular risk include:

- those who are – or who have been – looked after by local authorities, fostered or homeless, or who move frequently
- those whose parents or other family members misuse substances
- those from marginalised and disadvantaged communities, including some black and minority ethnic groups
- those with behavioural conduct disorders and/or mental health problems
- those excluded from school and truants
- young offenders (including those who are incarcerated)
- those involved in commercial sex work
- those with other health, education or social problems at home, school and elsewhere
- those who are already misusing substances.

Policy background

Numerous government strategies and policies aim to reduce or prevent substance misuse among vulnerable and disadvantaged children and young people (see below).

- The most recent update of the national drug strategy, 'Tackling drugs, changing lives – keeping communities safe from drugs' (Home Office 2004). This aims to: reduce the use of class A drugs and the frequent use of all illicit drugs by children and young people (under 25 years old), in particular the most vulnerable, by 2008.
- 'Every child matters' (HMG 2003) and related documents (HMG 2004; DfES 2004a) state that: all professionals working with children and young people should be trained to identify, assess and respond to those with drug use problems. They also state that primary care trusts (PCTs), local authorities and drug (and alcohol) action teams (DA(A)Ts) should work together to identify vulnerable children and young people through the common assessment framework (CAF). The DfES also points to the importance of developing youth services (DfES 2006) and responding to the needs of children and young people in care (DfES 2005a).

- A joint strategy published by the DfES and the Home Office (DfES 2005b) linked 'Every child matters' and the 'National drug strategy for young people'. This joint strategy was supported by the DH. It states that those responsible for children's services and for the drug strategy should cooperate, planning holistic responses for children and young people who use, or who are affected by, drug misuse.
- 'Essential elements' (NTA 2005) sets out guidance from the National Treatment Agency (NTA) on models of service delivery, types of intervention and issues of quality (including specification of competencies). 'Models of care' (NTA 2006) sets out national frameworks for commissioning adult substance misuse treatments, together with models of care.
- 'National service framework for children, young people and maternity services' (DH 2004) states that staff from all agencies should identify children and young people at risk of misusing drugs or alcohol. They should also provide them with access to prevention and treatment services.
- 'Drugs: guidance for schools' (DfES 2004b) proposes that schools should provide supportive relationships, encourage school attendance and identify – and respond to – the drug-related needs of vulnerable pupils.
- 'National specification for substance misuse for juveniles in custody'(Youth Justice Board 2004) requires that drug use needs are assessed and identified as part of the reception into a facility; that drug education and prevention programmes are provided; and that support programmes acknowledge the needs of children and young people.
- A framework for addressing 'volatile substance abuse' (VSA) (DH 2005) has been developed by the DH, in partnership with the Home Office and the DfES.
- The children of problem drug misusers were the subject of a UK government report (DfES 2005c). The report looked at the progress made in response to recommendations by the Advisory Council on the Misuse of Drugs (ACMD 2004).

3 Considerations

PHIAC took account of a number of factors and issues in making the recommendations.

3.1 The recommendations will contribute to implementation of 'Every child matters: change for children' programme. The programme's common assessment framework, care planning and review processes will in turn support implementation of the recommendations.

3.2 The recommendations for the education sector are in line with existing guidance from the DfES (DfES 2004b) and support standard nine of the 'National service framework for children, young people and maternity services'. In addition, they recognise the important role that children and adolescent mental health services play in preventing substance misuse (DH 2004).

3.3 Local joint commissioning groups will need to take the recommendations into account when implementing local substance misuse strategies.

3.4 There is a need for close working between statutory and other agencies to ensure substance misuse prevention forms part of an holistic, family-based approach to vulnerable and disadvantaged children and young people. Activities should take place in both formal and informal settings and aim to prevent stigmatisation of the children, young people and families being targeted.

3.5 Substance misuse interventions should be one component of a care plan that takes the child or young person's full range of needs into account. For example, the plan may include support to help them stop smoking or to reduce their intake of alcohol, as well as helping to meet their housing and training needs.

3.6 The relationship between a practitioner and the child, young person or family is critical to the success of interventions to reduce substance misuse.

3.7 Practitioners can only implement the recommendations effectively if they have achieved the necessary competencies as recommended, for example, by the

Home Office and the NTA. These cover screening, assessment and intervention. Screening, assessment and intervention tools are available from the NTA and these may be developed locally (NTA 2005).

3.8 Practitioners may face confidentiality issues relating to illegal substance misuse, especially if the individual is a minor.

3.9 The guidance covers children and young people aged under 25. This is the age range covered by the public service agreement (PSA) target for substance misuse shared by the Home Office and DfES (Home Office 2004). Some evidence focused on particular age groups and there was a lack of evidence in relation to children aged under 10. PHIAC took the view that, where appropriate, the recommended interventions should be offered to all vulnerable and disadvantaged children and young people.

3.10 There was a lack of evidence on how to prevent substance misuse among particular groups of vulnerable and disadvantaged children and young people. These include:

- children in care
- those who are homeless
- those with parents who misuse substances
- young offenders
- those excluded from school
- those involved in commercial sex work
- those with mental health problems
- those from black and minority ethnic groups.

PHIAC was keen to emphasise that these groups are a priority, despite the absence of specific recommendations for them. The Committee noted that the gap in evidence for these groups needs to be addressed as a matter of urgency.

3.11 If a community-based intervention has been omitted from the recommendations this does not necessarily mean it should be discontinued. The recommendations are based on the available evidence and a range of interventions have not been evaluated yet.

3.12 PHIAC expressed concern that some group-based prevention activities may encourage, rather than discourage, substance use (including the use of alcohol and tobacco). For example, this might happen where participants with little or no experience of substance misuse are put together with experienced users. Trained professionals should deliver these activities to ensure the desired outcomes are achieved.

3.13 The economic analysis carried out to determine whether or not an intervention is cost effective was subject to very large uncertainties. It was based on an innovative modelling process which, in almost all cases, relied on the extrapolation of short-term results (up to a year) to the longer term (generally from 5 to 20 years).

PHIAC also recognised that an intervention not considered to be cost effective from a health perspective, may well be cost effective when the associated social consequences are taken into account.

3.14 The relative effectiveness of the recommended interventions compared with other types of intervention (for example, universal interventions) was not considered because this was beyond the remit of this guidance.

3.15 Alcohol and tobacco misuse among children and young people represents a significant problem. However, interventions concerned solely with either alcohol or tobacco misuse were beyond the remit of this guidance.

3.16 Forthcoming NICE guidance on psychosocial interventions for drug misuse will make additional recommendations for adults who are dependent on drugs.

4 Implementation

The Healthcare Commission assesses the performance of NHS organisations in meeting core and developmental standards set by the DH in 'Standards for better health' issued in July 2004. The implementation of NICE public health guidance will help organisations meet the standards in the public health (seventh) domain in 'Standards for better health'. These include the core standards numbered C22 and C23 and developmental standard D13. In addition, implementation of NICE public health guidance will help meet the health inequalities target as set out in 'The NHS in England: the operating framework for 2006/7' (DH 2006).

Integrated support for NICE guidance on substance misuse

NICE will provide integrated support to help implement the recommendations made in this guidance and two related clinical guidelines on drug misuse (on psychosocial interventions and detoxification). The latter are due to be published in July 2007. (Clinical guidelines are recommendations by NICE on the appropriate treatment and care of people with specific diseases and conditions within the NHS.)

The following are available on the NICE website.

- A costing statement outlining the approach being taken to create a joint costing report and template for both the clinical guidelines and the public health intervention. It will also describe costing work completed on two technology appraisals on drug misuse published by the Institute in January 2007.
- An implementation briefing statement which describes the future support being planned for practitioners who use this guidance.

At the launch of the two clinical guidelines (due to be published in July 2007) the following will be available on the NICE website.

- Costing tools
    - a national costing report which estimates the resource impact of implementing all three pieces of guidance

  - a local costing template: a simple spreadsheet that can be used to estimate the local cost of implementation.

Approximately 10 weeks after the launch of the two clinical guidelines the following will be available on the NICE website.

- A slide set to support awareness raising activities and outlining key messages for local discussion.
- Implementation advice offering practical ways to overcome potential barriers to implementation.
- Audit criteria to help organisations review and monitor practice against NICE guidance.

5 Recommendations for research

PHIAC recommends that the following research questions should be addressed in order to improve the evidence relating to community-based interventions to reduce substance misuse among vulnerable and disadvantaged children and young people in the UK.

1. What characteristics of groups of vulnerable and disadvantaged children and young people increase their risk of substance misuse? Are some groups more at risk than others?
2. Which community-based interventions are most effective and cost effective at preventing or reducing substance misuse among the following high risk groups?
    - vulnerable and disadvantaged children aged under 10
    - looked after children and young people
    - children whose parents/carers or other family members misuse substances (interventions could be aimed at family members and/or children)
    - vulnerable or disadvantaged children and young people from black and minority ethnic groups
    - young offenders
    - those involved in commercial sex work.
3. How can substance misuse interventions be designed and delivered to ensure they do not increase misuse among vulnerable and disadvantaged children and young people?
4. What is the most effective and cost effective way of providing family-based interventions (for example, family therapy) for vulnerable and disadvantaged children and young people who are misusing substances? How do group-based interventions compare with individual or no intervention?
5. What parts of a multi-component intervention for vulnerable or disadvantaged children and young people are most effective at reducing substance misuse? How does the effectiveness of these individual components vary according to the target population or the intervention itself (including design and delivery)?

More detail on the evidence gaps identified during the development of this guidance is provided in appendix B.

6 Updating the recommendations

In March 2010, these recommendations will be reviewed and the state of the evidence base at that time will be reassessed. A decision will then be made about whether it is appropriate to update the guidance. If it is not updated at that time, the situation will be reviewed again in March 2012.

7 Related NICE guidance

Methadone and buprenorphine for the management of opioid dependence. NICE technology appraisal guidance 114 (2007).

Naltrexone for the management of opioid dependence. NICE technology appraisal guidance 115 (2007).

Brief interventions and referral for smoking cessation in primary care and other settings. NICE public health intervention guidance 1 (2006).

Drug misuse: opioid detoxification. NICE clinical guideline 52 (2007).

Drug misuse: psychosocial interventions. NICE clinical guideline 51 (2007).

The most appropriate generic and specific interventions to support attitude and behaviour change at population and community levels. NICE public health programme guidance 6 (2007).

Smoking cessation services. NICE public health programme guidance 10 (2008).

Community engagement. NICE public health programme guidance 9 (2008).

8 Glossary

Drugs generally refer to illicit compounds although the term is often used interchangeably with 'substances'

Indicated interventions target people who already misuse substances and are considered to be at increased risk of dependency.

Motivational interviewing (MI) is a brief psychotherapeutic intervention. For substance misusers, the aim is to help individuals reflect on their substance use in the context of their own values and goals and motivate them to change (adapted from McCambridge and Strang 2004).

Selective interventions target subsets of the population at an increased risk of substance misuse.

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

Substances are agents that, when ingested in sufficient doses, alter functioning.

(Adapted from Edmonds et al. 2005.)

9 References

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Canning U, Millward L, Raj T et al. (2004) Drug use prevention among young people: a review of reviews. London: Health Development Agency.

Department for Education and Skills (2004a) Every child matters: next steps. Nottingham: Department for Education and Skills.

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HM Government (2003) Every child matters green paper. Norwich: The Stationery Office.

HM Government (2004) Every child matters: change for children. Norwich: The Stationery Office.

Home Office (2004) Tackling drugs, changing lives – keeping communities safe from drugs. London: Home Office.

McCambridge J, Strang J (2004) 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. Addiction 99 (1): 39–52.

National Treatment Agency (2005) Young people's substance misuse treatment services – essential elements. London: National Treatment Agency.

National Treatment Agency (2006) Models of care for the treatment of adult substance misusers. London: National Treatment Agency.

Roe S (2005) Drug misuse declared: findings from the 2004/05 British crime survey. London: Home Office.

Youth Justice Board (2004) National specification for substance misuse for juveniles in custody. London: Youth Justice Board for England and Wales.

Appendix A: recommendations for policy and practice and supporting evidence statements

This appendix sets out the recommendations and the associated evidence statements taken from the review of effectiveness and economic appraisal (see appendix D for the key to study types and quality assessments).

Recommendations are followed by the evidence statement(s) that underpin them. For example: [**evidence statement 52.1**] indicates that the linked statement is numbered 52.1 in the review of effectiveness. Where a recommendation is not taken directly from the evidence statements, but is inferred from the evidence, this is indicated by **IDE** (inference derived from the evidence).

The review and economic appraisal are available on the NICE website.

Recommendation 1

Who is the target population?

Any child or young person under the age of 25 who is vulnerable and disadvantaged.

Who should take action?

Local strategic partnerships.

What action should they take?

- Develop and implement a strategy to reduce substance misuse among vulnerable and disadvantaged people aged under 25, as part of a local area agreement. This strategy should be:
    - based on a local profile of the target population developed in conjunction with the regional public health observatory. The profile should include their age, factors that make them vulnerable and other locally agreed characteristics
    - supported by a local service model that defines the role of local agencies and practitioners, the referral criteria and referral pathways.

(IDE)

Recommendation 2

Who is the target population?

Any child or young person under the age of 25 who is vulnerable and disadvantaged.

Who should take action?

Practitioners and others who work with vulnerable and disadvantaged children and young people in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. In schools this includes teachers, support staff, school nurses and governors.

What action should they take?

- Use existing screening and assessment tools to identify vulnerable and disadvantaged children and young people aged under 25 who are misusing – or who are at risk of misusing – substances. These tools include the Common Assessment Framework and those available from the National Treatment Agency.
- Work with parents or carers, education welfare services, children's trusts, child and adolescent mental health services, school drug advisers or other specialists to:
    - provide support (schools may provide direct support)
    - refer the children and young people, as appropriate, to other services (such as social care, housing or employment), based on a mutually agreed plan. The plan should take account of the child or young person's needs and include review arrangements.

(IDE)

Recommendation 3

Who is the target population?

- Vulnerable and disadvantaged children and young people aged 11–16 years and assessed to be at high risk of substance misuse.
- Parents or carers of these children and young people.

Who should take action?

Practitioners and others who work with vulnerable and disadvantaged children and young people in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. In schools this includes teachers, support staff, school nurses and governors.

What action should they take?

- Offer a family-based programme of structured support over 2 or more years, drawn up with the parents or carers of the child or young person and led by staff competent in this area. The programme should:
    - include at least three brief motivational interviews each year aimed at the parents/ carers
    - assess family interaction
    - offer parental skills training
    - encourage parents to monitor their children'sbehaviour and academic performance
    - include feedback
    - continue even if the child or young person moves schools.
- Offer more intensive support (for example, family therapy) to families who need it.

(Evidence statements 15.1, 15.2, 15.3, 16.4)

Recommendation 4

Who is the target population?

- Children aged 10–12 who are persistently aggressive or disruptive and assessed to be at high risk of substance misuse.
- Parents or carers of these children.

Who should take action?

Practitioners trained in group-based behavioural therapy.

What action should they take?

- Offer the children group-based behavioural therapy over 1 to 2 years, before and during the transition to secondary school. Sessions should take place once or twice a month and last about an hour. Each session should:
  - focus on coping mechanisms such as distraction and relaxation techniques
  - help develop the child's organisational, study and problem-solving skills
  - involve goal setting.
- Offer the parents or carers group-based training in parental skills. This should take place on a monthly basis, over the same time period (as described above for the children). The sessions should:
  - focus on stress management, communication skills and how to help develop the child's social-cognitive and problem-solving skills
  - advise on how to set targets for behaviour and establish age-related rules and expectations for their children.

(Evidence statements 63, 64.1)

Recommendation 5

Who is the target population?

Vulnerable and disadvantaged children and young people aged under 25 who are problematic substance misusers (including those attending secondary schools or further education colleges).

Who should take action?

Practitioners trained in motivational interviewing.

What action should they take?

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

(Evidence statements 52.1, 52.2, 53.1, 53.2)

Evidence statements

Evidence statement 15.1

There is evidence from one RCT (+) to suggest that a tiered, multilevel prevention strategy focusing primarily on parenting practices (the most recent version of the 'Adolescent transitions program') that is delivered according to the needs and motivation of the family can produce long-term decreases in overall substance use in young people (Dishion et al. 2002). Applicability rating B.

Evidence statement 15.2

There is evidence from one RCT (+) to suggest that a brief, family-focused intervention (the 'Family check up' programme; the selective prevention component of the most recent 'Adolescent transitions program') designed to target family management and parental monitoring through motivational interviewing, individual consultation and feedback, can produce significant long-term reductions in overall tobacco, alcohol and cannabis use in young people (Dishion et al. 2003). Applicability rating B.

Evidence statement 15.3

There is evidence from one RCT (+) and one CNRT (+) to suggest that interventions that aggregate high-risk peers (such as the teen-focused peer support element of the older version of the 'Adolescent transitions program', or the parent and teen-focused elements combined) may have negative effects on smoking behaviours (Dishion and Andrews 1995; Poulin et al. 2001). Applicability rating B.

Evidence statement 16.4

There is evidence from one RCT (+) to suggest that a brief, school-based family-focused intervention (the 'Family check up' programme; the selective prevention component of the most recent 'Adolescent transitions program'), comprising individual and group-based family behavioural therapy, motivational interviewing, individual consultations and feedback on their child's behaviour, and parent/student activities designed to enhance family management, can produce long-term increases in parental monitoring of their child's activities (Dishion et al. 2003). Applicability rating B.

Evidence statement 52.1

There is evidence from one SR (+), two RCTs (one [+] and one [-]) and one CNRT (-) to suggest that motivational interviewing and brief intervention can have short-term effects on the use of cigarettes, alcohol and cannabis (Tait and Hulse 2003; McCambridge and Strang 2004; Oliansky et al. 1997; Aubrey 1998). Applicability rating A.

Evidence statement 52.2

There is evidence from one RCT (+) however, to suggest that motivational interviewing does not have a significant medium-term impact on the use of cigarettes, alcohol or cannabis, although

there is a non-significant trend favouring intervention compared with control (McCambridge and Strang 2005). Applicability rating A.

Evidence statement 53.1

There is evidence from one RCT (+) to suggest that a single session of motivational interviewing can have a positive impact on attitudes, intentions and behavioural outcomes related to substance use in the short term (McCambridge and Strang 2004). However, there is evidence from one RCT (+) to suggest that these positive effects do not last in the medium term (McCambridge and Strang 2005). Applicability rating A.

Evidence statement 53.2

There is evidence from one RCT (+) to suggest that brief intervention, enhanced with additional support, can have a positive impact on attendance at community treatment agencies and psychological wellbeing compared to usual hospital treatment (Tait et al. 2004). Applicability rating B.

Evidence statement 63

There is evidence from two RCTs (+) to suggest that a multi-component parent and child programme, the 'Coping power' programme, can have an immediate and medium-term impact on reducing use of alcohol, tobacco and cannabis, compared to no intervention, in children with aggressive and behavioural problems (Lochman and Wells 2003; 2004). Applicability rating C.

Evidence statement 64.1

There is evidence from six RCTs (one [++], four [+] and one [-]) to suggest that multi-component programmes (including child and parent components) targeting children with behavioural and aggressive problem behaviours can have a positive impact in reducing some problem behaviours compared to no intervention (August et al. 2002; Barrera et al. 2002; CPPRG 2002; Lochman and Wells 2002; 2003; 2004). Applicability rating C.

Cost-effectiveness evidence

It was judged that the recommended interventions are likely to be cost effective. See 'Modelling the cost effectiveness of community-based substance misuse interventions for vulnerable young people' (main and supplementary reports) for further details.

Fieldwork Findings

Fieldwork aimed to test the relevance, usefulness and the feasibility of implementing the recommendations and the findings were considered by PHIAC in developing the final recommendations. The fieldwork was conducted with commissioners and practitioners involved in delivering services to vulnerable and disadvantaged children and young people. They included those working in the NHS, local authorities and the education, voluntary, community, social care, youth and criminal justice sectors. (For details, go to the NICE website).

Fieldwork participants were generally positive about the recommendations and their potential to help prevent and reduce substance misuse, although they had concerns about resources and training. Many participants stated that the recommendations were already part of current practice.

The recommendations were seen to have the potential to reinforce various aspects of national policy on preventing and reducing substance misuse in vulnerable and disadvantaged children and young people. Participants believed that wider participation and more systematic implementation could be achieved by:

- ensuring that interventions are delivered as part of existing care packages and not as standalone interventions
- ensuring the recommendations support guidance from other government bodies, for example, the DfEE's 'Every child matters'
- making sure the recommendations tie in with current practice (for example, by advocating the use of existing screening tools)
- clarifying some of the specific terms used in the guidance

- ensuring that the recommendations help practitioners to avoid stigmatising young people and their families
- standardising training for practitioners.

Appendix B: gaps in the evidence

PHIAC identified a number of gaps in the evidence relating to the interventions under examination, based on an assessment of the evidence, stakeholder comments and fieldwork. These gaps are set out below.

- Almost all studies of interventions to reduce problematic substance misuse have looked at the effects achieved over the short term, reporting within weeks, months, 1 or 2 years. However, almost all the desired outcomes relate to issues that persist over many years. Assumptions which extrapolate short-term effects to the long term are subject to considerable uncertainty.
- Few rigorous evaluations have been carried out in the UK on the effectiveness and cost effectiveness of community-based interventions to reduce and prevent substance misuse among vulnerable and disadvantaged children and young people. Future studies should be sufficiently powered to detect any reduction in use or delay in the onset of substance misuse. In addition, the outcome measures used should be consistent across studies.
- Few studies compare the relative effectiveness of different practitioners working in different settings to deliver interventions. (For example, few studies compare the effectiveness of specialists with generic practitioners, or compare delivery in schools with delivery in youth and outreach or custodial settings.)
- There is a lack of evidence on the specific components of a substance misuse intervention that make it effective.
- Generally, evaluations do not report on factors which make particular at-risk groups vulnerable (for example, black and minority ethnic groups, looked after young people or young people in custodial settings).
- There is little evidence on the characteristics which make certain vulnerable and disadvantaged children and young people particularly susceptible to substance misuse.
- Few evaluations have examined the possible iatrogenic effects of interventions to prevent/reduce substance misuse among vulnerable and disadvantaged children and young people. (As an example, increasing young people's awareness of substances or 'normalising' misuse may encourage, rather than discourage, use.)

- A dearth of evidence means it is difficult to derive utility scores that can then be used to generate accurate QALYs. These are needed to carry out cost-effectiveness analyses in relation to children and young people who misuse substances.
- There is little evidence on whether interventions aimed at parents or carers who misuse substances help to reduce, prevent or delay the onset of substance misuse among their children.
- There is limited evidence on the impact of substance misuse interventions on wider outcomes, for example greater personal and social independence. Also, there is limited evidence on whether improving educational self-efficacy can help to reduce substance misuse, or whether there is a link between educational attainment and substance use among school excludees and truants.

The Committee made five recommendations for research. These are listed in section 5.

Appendix C: membership of the Public Health Interventions Advisory Committee (PHIAC), the NICE Project Team and external contractors

Public Health Interventions Advisory Committee (PHIAC)

NICE has set up a standing committee, the Public Health Interventions Advisory Committee (PHIAC), which reviews the evidence and develops recommendations on public health interventions. Membership of PHIAC is multidisciplinary, comprising public health practitioners, clinicians (both specialists and generalists), local authority employees, representatives of the public, patients and/or carers, academics and technical experts as follows.

Mrs Cheryll Adams Professional Officer for Research and Practice Development with the Community Practitioners' and Health Visitors' Association (CPHVA)

Professor Sue Atkinson CBE Independent Consultant and Visiting Professor in the Department of Epidemiology and Public Health, University College London

Professor Michael Bury Emeritus Professor of Sociology at the University of London and Honorary Professor of Sociology at the University of Kent

Professor Simon Capewell Chair of Clinical Epidemiology, University of Liverpool

Professor K K Cheng Professor of Epidemiology, University of Birmingham

Mr Philip Cutler Forums Support Manager, Bradford Alliance on Community Care

Professor Brian Ferguson Director of the Yorkshire and Humber Public Health Observatory

Professor Ruth Hall Regional Director, Health Protection Agency, South West

Ms Amanda Hoey Director, Consumer Health Consulting Limited

Mr Andrew Hopkin Senior Assistant Director for Derby City Council

Dr Ann Hoskins Deputy Regional Director of Public Health for NHS North West

Ms Muriel James Secretary for the Northampton Healthy Communities Collaborative and the King Edward Road Surgery Patient Participation Group

Professor David R Jones Professor of Medical Statistics in the Department of Health Sciences, University of Leicester

Dr Matt Kearney General Practitioner, Castlefields, Runcorn and GP Public Health Practitioner, Knowsley

Ms Valerie King Designated Nurse for Looked After Children for Northampton PCT, Daventry and South Northants PCT and Northampton General. Public Health Skills Development Nurse for Northampton PCT

CHAIR Dr Catherine Law Reader in Children's Health, Institute of Child Health, University College London

Ms Sharon McAteer Health Promotion Manager, Halton PCT

Professor Klim McPherson Visiting Professor of Public Health Epidemiology, Department of Obstetrics and Gynaecology, University of Oxford

Professor Susan Michie Professor of Health Psychology, BPS Centre for Outcomes Research & Effectiveness, University College London

Dr Mike Owen General Practitioner**,** William Budd Health Centre, Bristol

Ms Jane Putsey Lay Representative. Chair of Trustees of the Breastfeeding Network

Dr Mike Rayner Director of British Heart Foundation Health Promotion Research Group, Department of Public Health, University of Oxford

Mr Dale Robinson Chief Environmental Health Officer, South Cambridgeshire District Council

Professor Mark Sculpher Professor of Health Economics at the Centre for Economics (CHE), University of York

Dr David Sloan Retired Director of Public Health

Dr Dagmar Zeuner Consultant in Public Health, Islington PCT

Expert cooptees to PHIAC:

Dr Clare Gerada GP, member of the Advisory Council for the Misuse of Drugs (ACMD) and Chair of NICE Guideline Development Group (GDG) on drug misuse detoxification

Mark Gilman North West Regional Manager of the National Treatment Agency (NTA)

Dr Jenny McWhirter Head of Education and Prevention at DrugScope and Chair of the Drug Education Forum

Expert testimony to PHIAC:

Eric Carlin Chief Executive of Mentor UK and Deputy Chair of the Drug Education Forum

Keith Hughes Deputy North West Regional Manager of the National Treatment Agency (NTA)

Alex Hall Professional Trainer and Senior Worker for the Spark Team, Drug and Alcohol Services for London

Dr Jim McCambridge Lecturer (Epidemiology/Quantitative Social Science) Centre for Research on Drugs and Health Behaviour, Department of Public Health and Policy, London School of Hygiene and Tropical Medicine, London

NICE Project Team

Professor Mike Kelly
CPHE Director

Simon Ellis
Associate Director

Dr Nichole Taske
Analyst

Dr Amanda Killoran
Analyst

Dr Louise Millward
Analyst

Chris Carmona
Analyst

Dr Alastair Fischer
Health Economics Adviser.

External contractors

External reviewers

The National Collaborating Centre for Drug Prevention (NCCDP) at Liverpool John Moores University (LJMU) carried out the review of the evidence of effectiveness. The authors were: Lisa Jones, Harry Sumnall, Karl Witty, Michelle Wareing, Jim McVeigh and Mark A Bellis.

Matrix Research and Consulting Ltd carried out the economic appraisal. The authors were: Kevin Marsh, David Chandiwana, Silja Korpelainan and Emma Hamilton.

Fieldwork

The fieldwork was carried out by the NCCDP at LJMU, in conjunction with HIT, a Merseyside based training and health promotion organisation.

Appendix D: summary of the methods used to develop this guidance

Introduction

The reports of the evidence review and economic appraisal include full details of the methods used to select the evidence (including search strategies), assess its quality and summarise it.

The minutes of the PHIAC meetings provide further detail about the Committee's interpretation of the evidence and development of the recommendations.

All supporting documents are listed in appendix E and are available from the NICE website.

The guidance development process

The stages of the guidance development process are outlined in the box below:

1. Draft scope
2. Stakeholder meeting
3. Stakeholder comments
4. Final scope and responses published on website
5. Reviews and cost-effectiveness modelling
6. Synopsis report of the evidence (executive summaries and evidence tables) circulated to stakeholders for comment
7. Comments and additional material submitted by stakeholders
8. Review of additional material submitted by stakeholders (screened against inclusion criteria used in reviews)
9. Synopsis, full reviews, supplementary reviews and economic modelling submitted to PHIAC
10. PHIAC produces draft recommendations
11. Draft recommendations published on website for comment by stakeholders and for field testing
12. PHIAC amends recommendations
13. Responses to comments published on website
14. Final guidance published on website

Key questions

The key question was established as part of the scope. It formed the starting point for the review of evidence and facilitated the development of recommendations by PHIAC. The overarching question was:

What community-based interventions are effective and cost effective in reducing substance misuse among the most vulnerable and disadvantaged children and young people, compared with one another, no intervention or usual practice?

Each intervention was considered further by asking a number of subsidiary questions to determine the factors related to its effectiveness and cost effectiveness. These questions included:

- What did the intervention itself comprise (for example, what was the content and duration)?
- Who delivered it (for example, generic health professional or specialist)?
- What were the characteristics of the target population (for example, what was the nature of their vulnerability/disadvantage)?
- What factors may inhibit or facilitate implementation (for example, the views of young people)?
- Were there any differential effects across population subgroups (for example, by gender, social class or ethnicity)?
- Were there any adverse or unintended effects (for example, increased drug use, stigmatisation or disruption of community cohesion)?

Reviewing the evidence of effectiveness

A review of effectiveness was conducted.

Identifying the evidence

The following databases were searched for primary studies and reviews

published between 1990 and April 2006:

- ASSIA
- CINAHL
- Cochrane CENTRAL
- Cochrane Database of Systematic Reviews (CDSR)
- Database of Abstracts of Reviews of Effects (DARE)
- Embase
- ERIC
- Medline

- PsycINFO
- Sociological Abstracts.

Further details of the search terms and strategies are included in the review report.

Selection criteria

Studies were included if they:

- described *selective* or *indicated* small scale, community-based interventions that aimed to prevent, delay the initiation of, reduce or stop substance use
- targeted vulnerable or disadvantaged children and young people up to the age of 25.

Studies were excluded if they described an intervention that:

- was delivered to all children and young people, regardless of their likelihood of misusing substances
- focused on preventing or reducing the adverse physiological and psychological affects of substance use
- aimed to prevent or reduce alcohol or tobacco use alone, unless it was delivered as part of a broader strategy to reduce concurrent use of multiple substances (including illicit drugs).

Quality appraisal

Included papers were assessed for methodological rigour and quality using the NICE methodology checklist, as set out in the NICE technical manual 'Methods for development of NICE public health guidance' (see appendix E). Each study was described by study type and graded (++, +, -) to reflect the risk of potential bias arising from its design and execution.

Study type

- Meta-analyses, systematic reviews of RCTs or RCTs (including cluster RCTs).
- Systematic reviews of, or individual, non-randomised controlled trials, case-control studies, cohort studies, controlled before-and-after (CBA) studies, interrupted time series (ITS) studies, correlation studies.

- Non-analytical studies (for example, case reports, case series).
- Expert opinion, formal consensus.

Study quality

++ All or most criteria fulfilled. Where they have not been fulfilled the conclusions are thought very unlikely to alter.

+ Some criteria fulfilled. Those criteria that have not been fulfilled or not adequately described are thought unlikely to alter the conclusions.

- Few or no criteria fulfilled. The conclusions of the study are thought likely or very likely to alter.

The interventions were also assessed for their applicability to the UK and the evidence statements were graded as follows:

1. likely to be applicable across a broad range of settings and populations
2. likely to be applicable across a broad range of settings and populations, assuming they are appropriately adapted
3. applicable only to settings or populations included in the studies – broader applicability is uncertain
4. applicable only to settings or populations included in the studies.

Summarising the evidence and making evidence statements

The review data was summarised in evidence tables (see full review).

Effectiveness was assessed at five intervals:

- immediate term (up to and including 7 days)
- very short term (8–31 days)
- short term (1–6 months)
- medium term (6 months to 1 year)

- long term (1 year or more).

The findings from the studies were synthesised and used as the basis for a number of evidence statements relating to each population, type of intervention, primary and secondary outcomes. The evidence statements reflect the strength (quantity, type and quality) of evidence and its applicability to the populations and settings in the scope.

Economic appraisal

The economic appraisal consisted of a review of economic evaluations and a cost-effectiveness analysis.

Review of economic evaluations

A systematic search was carried out on the NHS EED and HEED databases. This was supplemented by material found in the accompanying effectiveness review, as well as studies identified via the ESRC Evidence Network and consultation with experts. Five studies met the inclusion criteria applied to the accompanying effectiveness review. These were assessed for quality using a checklist based on the criteria developed by Drummond and colleagues (1997). Studies were then given a score (++, +, -) to reflect the risk of potential bias arising from their design and execution (see appendix E).

Cost-effectiveness analysis

An economic model was constructed to incorporate data from the reviews of effectiveness and cost effectiveness. The aim was to estimate the cost effectiveness of all interventions which met the inclusion criteria.

A number of assumptions were made which could underestimate or overestimate the cost effectiveness of the interventions. The results are reported in 'PHIAC 5.4a: Modelling the cost effectiveness of community-based substance misuse interventions for vulnerable young people' (Matrix RCL) and 'PHIAC 7.5b: Modelling the cost effectiveness of community-based substance misuse interventions for vulnerable young people – Supplementary analysis' (Matrix RCL). They are available on the NICE website.

Fieldwork

Fieldwork was carried out to evaluate the relevance and usefulness of NICE guidance for practitioners and the feasibility of its implementation. It was conducted with commissioners and practitioners who provide services for vulnerable and disadvantaged children and young people. They included those working in the NHS and local authorities and the education, voluntary, community, social care, youth and criminal justice sectors.

The fieldwork was overseen by the National Collaborating Centre for Drug Prevention (NCCDP) at Liverpool and delivered by HIT, a Merseyside-based training and health promotion organisation.

The fieldwork comprised:

- a series of three 1-day meetings, each attended by 30 participants, in Liverpool, Bristol and Manchester. The locations were chosen to ensure widespread geographical coverage and included participants from urban and rural services. All three areas have been designated 'high crack areas' by the Home Office.
- an online questionnaire to a large mailing list of people involved in preventing and reducing substance misuse.

The main issues arising from the fieldwork are set out in appendix A under 'Fieldwork findings'. The full fieldwork report is available on the NICE website.

How PHIAC formulated the recommendations

At its meetings in September and October 2006, PHIAC considered the evidence of effectiveness and cost effectiveness. In addition, at its meeting in January 2007, it considered comments from stakeholders and the results of fieldwork to determine:

- whether there was sufficient evidence (in terms of quantity, quality and applicability) to form a judgement
- whether, on balance, the evidence demonstrates that the intervention is effective or ineffective, or whether it is equivocal

- where there is an effect, the typical size of effect.

PHIAC developed draft recommendations through informal consensus, based on the following criteria.

- Strength (quality and quantity) of evidence of effectiveness and its applicability to the populations/settings referred to in the scope.
- Effect size and potential impact on population health and/or reducing inequalities in health.
- Cost effectiveness (for the NHS and other public sector organisations).
- Balance of risks and benefits.
- Ease of implementation and the anticipated extent of change in practice that would be required.

Where possible, recommendations were linked to an evidence statement(s) – see appendix A for details. Where a recommendation was inferred from the evidence, this was indicated by the reference 'IDE' (inference derived from the evidence).

The draft guidance, including the recommendations, was released for consultation in November 2006. The guidance was signed off by the NICE Guidance Executive in March 2007.

Appendix E: supporting documents

Supporting documents are available from the NICE website. These include the following:

- Review of effectiveness
- Economic analysis: review and modelling reports
- Fieldwork report
- A quick reference guide for professionals whose remit includes public health and for interested members of the public.

Other supporting documents include:

- 'Methods for development of NICE public health guidance (second edition, 2009)'
- 'The NICE public health guidance development process: An overview for stakeholders including public health practitioners, policy makers and the public (second edition, 2009)'.

Changes after publication

February 2012: minor maintenance.

February 2013: minor maintenance.

About this guidance

NICE public health guidance makes recommendations on the promotion of good health and the prevention of ill health.

This guidance was developed using the NICE public health intervention guidance process.

The recommendations from this guidance have been incorporated into a NICE Pathway. Tools to help you put the guidance into practice and information about the evidence it is based on are also available.

Your responsibility

This guidance represents the views of the Institute and was arrived at after careful consideration of the evidence available. Those working in the NHS, local authorities, the wider public, voluntary and community sectors and the private sector should take it into account when carrying out their professional, managerial or voluntary duties.

Implementation of this guidance is the responsibility of local commissioners and/or providers. Commissioners and providers are reminded that it is their responsibility to implement the guidance, in their local context, in light of their duties to avoid unlawful discrimination and to have regard to promoting equality of opportunity. Nothing in this guidance should be interpreted in a way which would be inconsistent with compliance with those duties.

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