Summary

- Drug prevention, harm reduction, and treatment are complimentary activities that sit along a conceptually unified continuum of response to substance use. Selection of activities is determined by the age, development stage, nature of drug use, and the broader profile of risks and harms of the target group.

- Drug use (and resulting harm) is a result of the interactions between individuals, the choices they make, and the social, cultural, and political contexts in which those choices are made and in which people live their lives. Individual choices are influenced by the resources that people can draw upon, and the opportunities and constraints placed upon them. Drug prevention activity should therefore not just be thought of in relation to ‘drug education’ or school curricula, but those ‘hidden’ and ‘unlabelled’ activities that foster positive social relationships between recipients and protective family, community, and social structures (including consideration of the effects of public and economic policy).

- A historic focus on drug prevention activity within schools means that there has been a lack of focus on prevention provision for other groups, and in relation to these broader ‘hidden’ determinants of drug use.

- We know increasingly more about ‘what works’ in drug prevention (and importantly, what doesn’t), and how best to deliver it. However, UK provision of evidence based prevention programmes is currently poor, rarely reaches the right target groups, and has been severely affected by public sector spending cuts.

- There are very few prevention specialists in the UK, including within drug treatment services.

- Schools and educators continue to struggle with the development and delivery of evidence based drugs prevention and will require specialised support to deliver drugs (and alcohol) components of compulsory Sex, Relationships, and Health Education.

- Drug use is still a minority activity, and so although appealing, harm reduction approaches have limited relevance for most school pupils/students.

- Experience with alcohol and tobacco shows that the fundamental objectives of prevention, mechanisms of behaviour change, and possibly outcomes, are unlikely to be affected by the legal status of the target substance. Changes in drug law would not necessarily make prevention more difficult, and may in fact open up more opportunities to improve health. However, despite popular discussion, drug law change in itself is not a preventative activity.

About me

1. I am submitting evidence to the Committee because of my commitment to, and belief in the importance of evidence-based approaches to drug prevention, and the importance of understanding preventive responses in the context of adversity, vulnerability, and other challenges that (young) people who use drugs or are at increased risk of use, may face.
2. I am submitting evidence in a personal capacity as an academic. My areas of research and expertise include drug prevention, and drug-related risk in young people. I am a former member of the ACMD (2011-2019); former President and current Board member of the European Society for Prevention Research (EUSPR); a Trustee of the prevention charity Mentor UK; and an expert consultant to the UNODC and the EMCDDA on prevention. As a member of ACMD I led the Council’s report on prevention of drug and alcohol dependence (2015); and its recent report on vulnerabilities and substance use (2018). Other relevant activities include leading research into the effectiveness of prevention programmes; leading the economic evidence review work underpinning NICE guidance on drug prevention (2017); guideline development committee membership (co-opted) for the same guidance; leading evidence reviews underpinning NICE guidance on alcohol education (2007); leading evidence reviews underpinning the 2017 Irish National Drug Strategy; and leading the development of European Quality Standards in Drug Prevention, which are components of the prevention/demand reduction strand of the 2017 UK Drug Strategy, and the European Union’s Drug Action Plan 2017-2020.

3. If invited, I would welcome opportunities to provide oral testimony or other evidence to the Committee on the content of my submission, or other topics related to prevention more generally.

Committee Questions

4. In this submission I am specifically responding to the prevention/early intervention topics, and best practice responses to prevention. My responses should be read alongside that of Mentor UK, who are also submitting evidence. I would highly recommend that the Committee refer to ACMD reports on prevention and vulnerability as these directly address the prevention/early intervention questions raised in the consultation. I wrote these reports, but in my submission, I have tried not to duplicate their content, and offer some additional perspectives.

What are the reasons for both the initial and the continued, sustained use of drugs? This refers to the wide spectrum of use, from high-risk use to the normalisation of recreational use.

5. I refer the Committee to the ACMD (2018) report on What are the risk factors that make people susceptible to substance misuse problems and harms? In particular I would draw attention to the summaries of key points on pages 7; 12; 16; 19; 21; 25; and Table 1 (pg 17).

- How effective and evidence-based are strategies for prevention and early intervention in managing and countering the drivers of use? This includes whether a whole-system approach is taken.
- What would a high-quality, evidence-based response to drugs look like?
- What responses to drugs internationally stand out as particularly innovative and / or relevant, and what evidence is there of impact in these cases?

1 https://www.gov.uk/government/organisations/advisory-council-on-the-misuse-of-drugs
2 http://euspr.org/
3 https://mentor.org.uk/
6. Drug prevention relates to policies, programmes and practices designed to reduce the incidence and prevalence of drug use and related health, behavioural and social problems. Prevention activities are justified on the basis that they serve to protect and promote health- and social development, and not because they target illegal behaviours. Effective prevention is based on, and contributes significantly to, the positive engagement of children, youth and adults with families, schools, workplaces, and communities. The UNODC international quality standards in prevention promote a developmental approach to prevention that supports healthy and safe development of populations. However, most prevention activity in the UK targets school-aged children, and there are notable gaps in activity for older young people, students, ‘at risk’ groups, and adults, who may face different risks and require different types of support.

7. The USA Institute of Medicine (1994) presents a taxonomy of prevention that describes the continuum of services/interventions between prevention (universal, selective, and indicated), treatment, recovery, and harm reduction. This is a useful tool for describing a conceptually unified and evidence-based continuum of services and responses to drug use. The taxonomy is important because it describes how preventive actions sit alongside, and are complemented by harm reduction approaches. This does not present an incongruity. In a similar manner to Rose’s proportionate universalism, whole populations benefit from universal prevention, groups at risk of use or already using drugs benefit from selective approaches, and individuals screened at high risk of drug related harms benefit from indicated prevention actions. For those people who have chosen to use drugs, prevention aims to persuade them to stop use or reduce frequency, whilst harm reduction approaches are delivered alongside these to reduce risk of harm from drug practices.

8. The most effective prevention approaches include interactive skills training, classroom management activities and school retention programmes, and family activities such as skills development, monitoring and supervision (ACMD, 2015). Interventions that help people cope with individual-level risk factors for substance use, such as anxiety, hopelessness, impulsivity, or sensation seeking are also effective. NICE Guideline 64, UNODC quality standards in prevention (2nd edition), and the evidence review undertaken by the author to support the Irish National Drugs Strategy 2017 identify specific effective approaches in prevention, and the Committee is referred to those reports rather than restate the findings here.

9. Most prevention approaches are, in fact, ‘unlabelled’, meaning that they do not directly target drug use (cf a school drugs education curriculum). These target those factors that make substance use more likely or factors that protect against use (ACMD, 2018). These approaches aim to improve health and social decision-making more generally, and foster positive social relationships between recipients and protective family, community, and social structures (including consideration of the effects of public and economic policy). For example, policy and practice with potential drug prevention impact might target school dropout, divert people away from the criminal justice system, address mental ill health and behavioural disorders, tackle deprivation and poor life-opportunities, or ensure that people have access to good housing. This can sometimes make identifying prevention activity difficult, and ‘selling’ prevention to decision-makers and funders even more so, as it requires a different way of thinking about drug use. With respect to the Committee’s key questions, this also poses challenges to understanding the overall effectiveness of drug-prevention activity. Therefore, it

---

7 https://www.nice.org.uk/guidance/ng64
9 https://www.drugsandalcohol.ie/27253/
makes sense to undertake ‘systems dynamic mapping’ exercises, which would help to understand components of likely prevention activity within a broader (complex) system. This work has, as far as I am aware, not yet been undertaken in the UK, although has with respect to other topics (e.g. obesity, mental health), and at a community level in the USA.

10. Some of the most successful preventive approaches to tobacco and alcohol have modified environments of use (e.g. marketing, pricing, availability, regulation, good coverage and easy access to services). These approaches lead to changes in social norms and culture, and create positive ‘policy boundary conditions’ which support more traditional prevention activities. Although I do not wish to focus on drug laws in this brief submission, the Misuse of Drugs Act 1971 does not allow for a similar approach with respect to illicit drugs, reduces the menu of potential preventive response, and may even discourage help-seeking (Benfer et al., 2018). Although there have been few analyses undertaken in those countries that have introduced radical changes to drug law (prohibition ↔ legalisation/regulation), available evidence suggests that drug law change in itself is not a preventative action (or a risk factor for increased drug use). Internationally, in those countries and territories that have liberalised drug laws, prevention work is not fundamentally different to that delivered in the UK, and still focuses on the key determinants of behaviour. Some content does reflect differences in legal status, but parallels may be drawn between alcohol and tobacco prevention in the UK. Even though use of these drugs is permitted (albeit restricted with age limits), effective prevention draws attention to negative health and social impact of use, makes reference to protective social norms (e.g. delaying use as long as possible, CMO alcohol guidance), and activities support target groups to better understand those external social and industry factors which determine, and manipulate, automatic behaviour and choice.

11. Bearing in mind par. 10&11 above, most academic research has investigated school-based prevention targeting substance use alone (see par. 8). This means that there is a lack of research and evidence of ‘what works’ in other settings, or multi-sector approaches that seek to address the complex determinants of drug use. For example, there is very little international evidence, and virtually no UK evidence of what is effective in recreational settings such as nightclubs and festivals. Whilst it is common to hear that ‘prevention doesn’t work’, that is because preventive interventions are some of the most scrutinised and researched health and social programmes. This has allowed us to identify what is effective, and what is not. In contrast, many other responses to drug use, including many popular harm reduction and treatment approaches, are under-researched. If subject to the same scrutiny, a similar conclusion would emerge.

12. International evidence suggests that a number of popular approaches to prevention are either ineffective or can produce harmful effects such as increased interest in drugs, or increased use of drugs. These should not be used. They include (but are not limited to):

- Standalone information-only based approaches (regardless of whether focusing on ‘scare tactics’ or presented as being ‘accurate’ by credible organisations);
- The use of former drug users or people in recovery, where the individual’s life story is the intervention;
- ‘Fear arousal’ (e.g. ‘these are the harms that will occur to you if you use drugs’) or ‘scared straight’ (e.g. experiences and accounts of going to prison or role playing being treated as a prisoner) approaches. Fear arousal may work if followed up by efficacious and supportive actions. A good example here is the fear of lung cancer to
drive smoking cessation/prevention. The difference with drugs is that buying and using tobacco is not an illegal behaviour, and cessation responses taken place openly across community settings without fear of criminalisation and with little stigmatisation of use and users;

- Recreational and diversionary approaches such as sports and theatre/drama (although such approaches are useful in developing positive pro-social relationships between participants, and with facilitators);
- Mentoring programmes that mix groups with different levels of ‘vulnerability’.

These approaches are not only a waste of scarce resource (and often school curriculum time) but are also unethical. In prevention, good intentions are not enough. Young people deserve to receive evidence-based support that is likely to be effective, and not to be exposed to prevention approaches that i) do not equip them with the skills to address risk; ii) may lead to behaviours (i.e. increase drug use) which may potentially expose them to direct and indirect harm such as contact with the criminal justice system. Ethical drug prevention is important because drug use remains a stigmatised and targeted behaviour, particularly for those members of our communities already experiencing health and social inequality (e.g. members of BMAE communities; people living in socioeconomically deprived communities; young offenders). Stigmatisation affects equality of access to support and intervention, quality of intervention, and outcomes of intervention.

13. It is very important to note that most evidence on effective drug prevention is derived from highly structured ‘manualised’ programmes, delivered by trained staff, often as part of well-funded research trials. In contrast, few of these programmes are delivered in the UK, and where they are, they usually contain many informal adaptations, which may undermine their effectiveness. It is probably fair to conclude that in the UK, as with the rest of Europe, prevention practice primarily comprises of delivery of un evaluated, and highly probably, ineffective actions (Faggiano et al., 2014).

14. Despite priority in the 2017 Drugs Strategy, the best efforts and welcomed work of organisations such as PHE and local prevention specialists, and the availability of NICE guidelines and high quality support systems such as Mentor-ADEPIS, UK prevention infrastructure and practice is poor. Prevention at local and national levels has been historically underfunded, but young people’s substance use services have been particularly affected by reductions in spending since 2010. The Health Foundation (2018) have estimated that spending on substance use services for young people has fallen by 41% since 2014/15. In this financial climate, and faced with acute need it is unsurprising (but short-sighted) that local authorities are diverting resources away from prevention towards treatment services for young people. However, bearing in mind the broader determinants of drug use mentioned in par. 9 & 10, reductions in provision of other support services not only undermines prevention activity, but makes drug use more likely.

15. Department for Education guidance published in 2018 as part of a consultation on compulsory sex, relationships, and health education includes a focus on the risks from substance use¹⁰. Schools

have been encouraged to apply the final guidance from September 2019, and will be mandated to do so from September 2020. Proposed substance content for secondary school pupils includes topics such as the relationship between substance use and risky sexual behaviour; drug-crime links; drug ‘facts and figures’; and information about effective interventions and where to get support. This specific information is delivered against a background of broader health skills development, and drug use behaviours are contextualised within broader societal and cultural factors. The draft guidance encourages a ‘whole-school’ approach whereby curriculum content is supported by the school’s wider policies on issues such as behaviour and safeguarding, the development of pupil wellbeing, and engagement with community structures such as parents and specialist providers of support.

16. This proposed guidance is encouraging and adheres with principles of effective drug education and prevention (Brotherhood & Sumnall, 2011; UNODC, 2018). Evidence on whole school approaches is emerging for a number of health-related outcomes, but little work has been undertaken on whether it is also effective in addressing drug use (Langford et al., 2014). Learning from other health domains suggest that critical to the success of these types of approach is sufficient planning and curriculum time, and coordination of curricula with the ethos and environment of the school (including school policies), and external engagement. Although there is emphasis throughout the guidance on facts and knowledge, it encourages teachers to provide ‘opportunities and contexts for pupils to practise applying and embedding new knowledge so that it can be used skilfully and confidently in real life situations’. This is an important element. Developing pupils’ knowledge on drugs without these other supportive and complementary actions is simply repeating ineffective historical practice.

However, it is uncertain whether educators have the sufficient skills and competencies to deliver this in relation to drug use\(^1\). Whilst the draft does include useful links to resources, including suggested programmes of study from the PSHE Association, and Mentor-ADEPIS guidance on planning drug education\(^2\), there is relatively little advice and guidance on models of integration within the proposed whole-school approach.

17. Prevention is not a specialist skill across the wider drug treatment workforce, and levels of professional skills and competence are unknown, despite drug treatment providers frequently being used to deliver prevention activity with young people.

18. Some police forces in the UK have included prevention and drug education components as part of (pilot) diversionary and behavioural contract responses to drug offences (e.g. Thames Valley, Avon and Somerset, Durham). However, the function, purpose, and effectiveness of these components is uncertain. If these activities are considered to have preventative functions, then these should be evaluated with respect to relevant outcomes. There is a lack of international research on the impact of these types of activity, including in popularly countries such as Portugal. However, whilst a study of a similar approach delivered in France found no impact on drug behaviour, 20% of attendees reported they would change their behaviour to avoid being caught by police again (EMCDDA, 2015).

March 2019

\(^1\) [http://mentor-adepis.org/quality-standards-for-drug-education-consultation-and-survey-findings/?dm_i=HSS,1UYCW,37J5KO,6ODO7.1](http://mentor-adepis.org/quality-standards-for-drug-education-consultation-and-survey-findings/?dm_i=HSS,1UYCW,37J5KO,6ODO7.1)

Key References

UNODC. (2018). *International Standards on Drug Use Prevention (2nd ed.)*. Retrieved from Vienna, AT: