Written evidence from Mentor UK

I. Executive Summary

- Recent increases in self-reported drug use among young people in the UK highlight the ongoing need for high-quality drug prevention and education among this group.

- There are several current approaches to drug prevention that draw on the evidence-base for ‘what works’ and clear messages are emerging regarding this for young people in school, family and community settings.

- It is also clear, however, that more in-depth work needs to be done to understand the attitudes towards, drivers and patterns of drug use among different groups of young people throughout the UK.

- Research with young people and those who have a stake in their future should inform approaches to prevention in school, family and community settings.

- Approaches to preventing drug use among young people need to be properly implemented and evaluated over the long-term if we are to understand what is most effective for countering the drivers of use among different groups of young people in the UK.

II. Introduction

1. Mentor is the UK’s leading alcohol and drug prevention charity. We work with young people to help them make the best, healthiest choices as they grow up and support all those who have a stake in their future to do the same. We do this in three main ways:

   a. By supporting teacher and staff training in schools, Pupil Referral Units (PRUs) and Alternative Education arrangements and developing up-to-date information and resources for them to deliver high quality drug education.
   b. By providing vital support to families, parents and carers of vulnerable and at-risk children, working with them to understand trauma and have open and informed conversations about the risks of drug misuse.
   c. By working with community based youth service providers to identify local needs around drug prevention and to deliver peer-education training for young people to become sources of support for others in their communities.

This evidence-base informs the present submission, which focuses on ‘what works’ in drug prevention and education with children and young people.

3. NHS England data shows that drug use among 11 to 15 year-olds declined between 2006 and 2014 (NHS Digital 2017). A similar trend has been reported among 13 to 15 year-olds in Scotland (Scottish Government 2015). Findings from 2016’s Smoking, Drinking and Drug Use among Young People in England survey, however, indicate that drug use may be on the rise again among these groups (NHS Digital 2017). These statistics urge us not to be complacent about the gains of recent decades.

4. The World Health Organization (WHO) estimates that use of illicit substances and alcohol accounts for 14% of the global health burden in people under 25 (ACMD 2018; Degenhardt et al. 2016; Gore et al. 2011; Mokdad et al. 2016). The cost of drug-related harm in England is £10.7 billion; £3.5 billion in Scotland and £780 million for class A drugs in Wales (ACMD 2018). These statistics highlight the ongoing need for high-quality drug prevention work among young people in the UK.

III. Prevention and Early Intervention

1. There are several current approaches to prevention and early intervention that seek to delay or prevent the use of drugs (including alcohol and tobacco) among children and young people and that draw from the current evidence-base.

2. One of the challenges in determining whether they are effective arises from the fact that few of them have generated enough comparable or in-depth data to evaluate their long-term impact. As the United Nations Office on Drugs and Crime (UNODC) makes clear, in order to be effective prevention approaches need to be backed by sufficient funding, regulatory infrastructure and enough sustained and high-quality training to have long-term results (UNODC 2015). They also need to be properly implemented and evaluated over at least a three-year period (Babor et al. 2018).

3. More in-depth research into attitudes around illegal substances, patterns of use and the different drivers of drug use among young people is needed to inform effective strategies for prevention and early intervention. This is especially true given that drivers of use will be different among different groups of young people and some are more vulnerable and at-risk than others (cf. ACMD 2018). Experiences of childhood trauma, exposure to parental substance misuse and the effects of poverty all produce risk factors for potential substance misuse (Rudzinski et al. 2017). That said, there is clear evidence emerging from both research and practice about approaches to prevention likely to have the most success.

School-based approaches to prevention

1. School-based approaches to prevention often target an entire class or year, most often at secondary school level and deliver a consistent message to deter drug use
regardless of student background. They are often referred to as ‘universal’ approaches (Babor et al. 2018; James 2013). Though the term most often used by the international community, at Mentor we recognize that the term ‘universal’ can sometimes be misleading. Effective approaches to drug education, even when delivered across a whole school or year, should always respond to the environment of the school and the ages, backgrounds, concerns and experiences of its students.

2. Drug education in schools has been shown to have an impact on young people’s attitudes towards the three most commonly used substances – alcohol, tobacco and cannabis (Foxcroft and Tsertsvadze 2011a; Thomas and Perera 2013). There is less evidence, however, to show that it has an impact on hard drug use. Systematic reviews of school-based prevention approaches determined that they currently have no effect on hard drug use over the short or long term (cf. Faggiano et al. 2014).

3. The success of school-based drug prevention models depends on how well and consistently they are delivered (whether they are implemented with integrity, at frequent intervals and across all school years) and whether other population level prevention measures exist to compliment them (Babor et al. 2018; Faggiano et al. 2014; James 2013).

4. Systematic reviews make clear what does not work in school-based approaches to prevention and intervention. Scare tactics and fear-based approaches have been shown to be ineffective, as have many approaches that draw on the experience of former users or those in recovery (cf. James 2013; Warren 2016).

5. It has also been convincingly shown that approaches to prevention emphasizing knowledge or information only and that do not explore the social context of drug use or incorporate life-skills content in their models, have little effect for young people. This conclusion also holds true for marketing and awareness campaigns aimed at population level when not accompanied by other approaches (Ferri et al. 2013).

6. ‘Confidence building’ approaches to prevention that do not also include information about different drugs and the effects they have on physical and mental health also have little effect on the drivers of use among young people (James 2013). This may not be the case for developmental approaches implemented at primary school. The Good Behaviour Game (GBG), for instance – a classroom-management tool that takes a developmental approach to encouraging pro-social behaviour among primary school children has had positive evaluations in the USA (Babor et al. 2018). The assumption behind programmes like this is that increasing pro-social behaviour among young children will deter drug use in the long run.

7. The GBG has been trialed by Mentor in the UK and did not have the same impact as in the USA. UK evaluations found no evidence it improved pupils’ pro-social behaviour, though there was some ‘tentative evidence’ that boys deemed at risk may have had a small reduction in concentration problems (Humphrey et al. 2018). Generally, developmental models aimed at primary school children that do not include drug education content have been shown to be no more effective than programmes that do incorporate this content (Babor et al. 2018).
8. There is a clear need for further development and evaluation of effective drug education and prevention work among primary school children in the UK. It is clear from recent statistics on alcohol and drug use among young people, as well as research into the experiences of children at-risk of recruitment into ‘county lines’ crime (Children’s Commissioner 2019a, 2019b), that effective drug prevention and education needs to begin with children before they reach high school.

9. The results of the GBG trial in the UK highlight one of the challenges of establishing ‘what works’ in drug prevention and education. Much of the evidence for this comes from programmes developed in the USA, Canada or Australia. It cannot be assumed that prevention programmes trialed elsewhere will have the same effects in the UK. Programmes need to be culturally adapted to be effective and even when this takes place there is no guarantee that they will have the same level of impact as elsewhere. There therefore needs to be more investment in UK-specific drug prevention programme research, development and evaluation.

10. Teachers are best placed to deliver effective drug education to their pupils and to do so consistently throughout a young persons’ time at school (James 2013). Many teachers, however, currently feel ill prepared to do this and lack the training, information and confidence they need. The government guidelines accompanying new statutory health education in schools are welcome in this respect. However, without appropriate levels of funding or infrastructural support they will not go far enough in helping teachers embed effective drug education across their schools.

11. This is a missed opportunity given that we know that partial implementation of drug prevention programmes in schools reduces their impact (Babor et al. 2018; Foxcroft & Tsertsvadze 2011a; James 2013). Mentor therefore recommends ongoing investment in services such as the Alcohol and Drug Education and Prevention Information Service (ADEPIS), as well as in teacher training, professional development and support.

12. Mentor’s experience, based on 20 years of working with young people in the UK, is that approaches to school-based prevention that use interactive and peer-to-peer learning are more likely to be successful (cf. James 2013). Approaches that help young people develop problem-solving skills for difficult or emotionally charged situations can also be particularly effective, especially when they also provide young people with accurate information about drugs and their effects on physical and mental health. Indeed, this is something that young people have told Mentor they want more of (cf. Boughelaf and Thurman 2015).

13. Mentor is currently running a pilot of a programme that combines these two approaches in schools and PRUs in Blackpool, England. *Real Life Skills (RLS)* has been developed by Mentor UK and draws on successful evaluations from previous Mentor projects (cf. Reid-Howie Associates Ltd. 2018), as well as positive evaluations of models for prevention trialed elsewhere in Europe, such as *Unplugged* (Dewulf et al. 2017; Fagianno et al. 2008, 2010).
14. The evidence emerging from RLS highlights the need for consistent, long-term implementation of drug education based on a ‘whole-school approach’ in schools and PRUs across the UK. It can, however, be difficult to implement programmes with integrity in schools facing significant organisational challenges and with large numbers of disengaged students. The evidence from RLS thus also underscores the importance of drug prevention work with young people that goes beyond the school gates and engages with pupils’ families and communities.

**Family and community-based approaches to prevention**

1. Family-based approaches to prevention, and those that combine school-based universal drug education alongside interventions with students’ families have been shown to have consistent positive effects for young people that can continue over the long-term (Babor et al. 2018; Foxcroft and Tsertsvadze 2011b; McKay et al. 2018; Newton et al. 2012).

2. Most of the evidence for the effectiveness of family-based approaches in the UK comes from models that focus on young people’s attitudes and behaviours towards alcohol, rather than illicit drugs (Segrott et al. 2015). More work is needed to trial and evaluate family-based approaches to prevention focused on illicit drugs, including cannabis (Gates et al. 2006). Mentor UK recommends that participatory research and needs assessments with families and young people form the basis for the development of appropriate prevention and intervention approaches with families. This is crucial if they are to be effective in the long run and appropriately combat the drivers of use among families from different socio-economic backgrounds. This is especially important given that the risk and protective factors for young people will be different depending on their family’s situation.

3. Mentor has worked for over ten years to support Kinship Care families in the UK. Kinship Care arrangements can be varied and range from the informal to the formal (cf. Mentor and The Scottish Government 2016; Thurman 2013). However, all have in common the fact that close relatives – a grandparent, aunt, uncle or older sibling – or family friends will take over the care of a child when parents are unable to look after them. Often, the parents of children in Kinship Care are unable to care for their children because of issues arising from drug misuse. This means that without the right support, children in Kinship Care can be especially vulnerable to risk factors around drug misuse and many have already experienced trauma or been exposed to parental substance misuse at a young age.

4. Because the recognition of Kinship Care arrangements by social services and their financial support by local authorities can be varied, both carers and children living in this situation do not always receive the support that they need. This extends to training and advice around bereavement, childhood attachment, childhood trauma and how to talk to children about drug related issues and provide them with appropriate support. Mentor has worked for over a decade to ensure that this support is available to kinship carers and their families, providing them with the skills and opportunities to strengthen the family bonds that can protect children in vulnerable situations from the dangers of substance misuse in the future. So far, the
evidence emerging from this work is positive and in the future Mentor UK will expand work with kinship care families to include children in other forms of care or who may potentially be more vulnerable to problematic drug use as a result of separation from or loss of their parents.

5. It is difficult to establish how effective community based approaches to drug prevention are, because there have been few methodologically robust or long-term evaluations of these approaches (cf. Gates et al. 2006; Shiner et al. 2004). Community level, grassroots coalitions focused on preventing drug use and supporting young people across services may be effective (Babor et al. 2018). There is, however, little evidence on which to base firm conclusions about their impact. Given the positive effects witnessed for models that combine work with young people and their families, it may be that approaches to prevention work with young people that build on already existing community assets and create links between youth services may have positive results (Casswell 2001; Shiner et al. 2004). There have been positive results, for instance, from public health approaches in the USA that included community stakeholders in the research, design and delivery of public health and prevention-focused programmes (cf. Israel et al. 1998, 2001; Johnson-Shelton et al. 2015).

6. Evidence from Mentor’s own work indicates that working with young people in their communities, especially when done in collaboration with other organizations and services can have positive effects on the drivers of drug use (cf. Evans et al. 2017 for a USA based example). Training young people to be peer-educators in their own communities can be effective, both for those young people and for others they work with through becoming involved in outreach work in local schools and youth centres.

7. Prevention work of this kind is not easy, especially when undertaken with young people made vulnerable by the effects of poverty, inter-generational drug use, or lack of support for services and infrastructure in their communities. Approaches that aim to build capacity among young people must be responsive to local needs and based on participatory models that take into account the local culture and context. If they are to be effective, these sorts of approaches to prevention also need to be long-term. They need to be able to focus on building the drug prevention and education skills of young people and adults already embedded in and with experience of their local communities.

IV. Recommendations

1. More qualitative and in-depth research should be conducted into young people’s attitudes towards illicit substance use and different patterns of use throughout the UK. This should inform approaches to drug prevention and education with young people in schools, families and communities.

2. More emphasis should be placed on researching and developing effective approaches to drug education in primary schools, given that vulnerabilities can exist for children as young as 8 years-old when it comes to potential drug use.

3. Alcohol and drug education training should be included as a standard part of teacher training programmes in the UK.
4. There should be more focus on and investment in developing and evaluating UK-specific drug prevention programmes for schools, families and communities.

5. More work is needed to trial and evaluate family and community-based approaches to prevention focused on illicit drugs, including cannabis.

6. More recognition, support and holistic prevention work is needed with young people in care (including kinship care) and their families.

References

Advisory Council on the Misuse of Drugs. 2018. *What are the risk factors that make people susceptible to substance use problems and harms?* ACMD


Evans et al. 2017. ‘The Living the Example Social Media Substance Use Prevention Program: A Pilot Evaluation’, *JMIR Mental Health*, 4:2


2010. ‘The effectiveness of a school-based substance abuse prevention program: 18-month follow-up of the EU-Dap cluster randomized control trial’, *Drug and Alcohol Dependence*

2014. ‘Universal school-based prevention for illicit drug use’, *Cochrane Database of Systematic Reviews*

Ferri et al. 2013. ‘Media campaigns for the prevention of illicit drug use in young people’, *Cochrane Database of Systematic Reviews*

Foxcroft & Tsertsvadze. 2011a. ‘Universal school-based prevention programs for alcohol misuse in young people’, *Cochrane Database of Systematic Reviews*

2011b. ‘Universal family-based prevention programs for alcohol misuse in young people’, *Cochrane Database of Systematic Reviews*

Gates et al. 2006. ‘Interventions for prevention of drug use by young people delivered in non-school settings’, *Cochrane Database of Systematic Reviews*


Israel et al.


James, Claire.

Johnson-Shelton et al.
2015. ‘A Community-Based Participatory Research Approach for Preventing Childhood Obesity: The Communities and Schools Together Project’, Prog Community Health Partnersh., 9:3, pp. 351-361

McKay et al.

Mentor.
2013. The London Youth Involvement Project. Mentor

Mentor & The Scottish Government.

Milliken-Tull & McDonnell.
2017. Alcohol and Drug Education in Schools. Mentor-ADEPIS

Mokdad et al.

Newton et al.

NHS Digital.


Reid-Howie Associates Ltd.

Rudzinski, Katherine.

Segrott et al.
2015. ‘Preventing alcohol misuse in young people: an exploratory cluster randomized controlled trial of the Kids, Adults Together (KAT) programme’, Public Health Research, 3:15

Scottish Government.

Shiner et al.

Thomas & Perera.
2013 (2006). 'School-based programmes for preventing smoking', *Cochrane Database of Systematic Reviews*.

Thurman, Ben.

Warren, Fran.

UNODC.

UNODC/WHO.