ACMD

Advisory Council on the Misuse of Drugs

A Whole-System Response to Drug Prevention in the UK

May 2025

Contents

1. Introduction

Background to Ministerial Commission

1.1. The Advisory Council on the Misuse of Drugs (ACMD) was commissioned in July 2023 to provide advice on drug prevention for young people, supporting the 10-Year National Drugs Strategy (From Harm to Hope). Specifically, this report provides key foundational principles for long-term drug prevention action for all young people (11-24 year olds) and includes recommendations on:

- a whole-system response to prevention of drug use and related harms, including actions for younger age groups, which have positive effects later in life.
- effective labelled (universal, selective and indicated) interventions on prevention.
- the necessary structural components of a robust drug prevention system.

Prevalence of drug use in the UK

1.2. Approximately 971,000 people aged 16-24 years (16.5% of the age group) in England and Wales reported using a controlled drug in the previous year in 2023/24 (ONS, 2024). In Scotland, 22% of 16-24 year olds used a controlled drug in 2021 (Scottish Government, 2022). Contemporaneous comparable data are not available for Northern Ireland, and the most recently available data suggested 10.8% of 15-34 year olds used a controlled drug in 2014/15 (DHSSPS, 2015).

1.3. As with other related behaviours such as alcohol and tobacco use, there has been a long-term decline in drug use since the late 1990s. In England and Wales, for example, use of any drug in the past year is now lower in 16-24 year olds than it was 30 years ago (29.7% in 1995/1996 vs 16.5% in 2023/24) (ONS, 2024). The reasons for this are complex and may relate to factors such as changes in socialisation practices and leisure preferences, greater risk adversity, and close associations of drug use with (tobacco) smoking and alcohol use. Economic uncertainties and an increasingly competitive environment in education and employment may have also contributed. However, the rate of long term decline in drug use has slowed over the last decade, and use of some drugs among people aged 16-24 fluctuates (e.g.,

ketamine, cannabis, MDMA, powder cocaine). Similar long term changes have been recorded in 11-15 year old school pupils in England, with a decline in the prevalence of lifetime and past-year drug use, but less fluctuation in the use of individual drugs (NHS Digital, 2024).

1.4. In both age groups, despite these long term declines in drug use, there have been increases in some indicators of overall drug-related harm such as the proportion of school exclusions and suspensions, that were drug-related, hospital presentations, and drug-related deaths (Department for Education, 2025; ONS, 2024; NHS Digital, 2021) .

1.5. Around 44% of 15 year olds report having been offered drugs, and 55% of 16-19 year olds and 45% of 20-24 year olds report that they think it would be ‘very’ or ‘fairly’ easy to obtain drugs if they wanted to (NHS Digital, 2024; ONS, 2024).

1.6. Population prevalence of drug use begins to increase around 14/15 years of age (e.g., 32% of 15-year-olds in England reported having ever used a controlled drug), and peaks between the ages of 20-24 years (NHS Digital, 2024; ONS, 2024). Most people stop drug use before they reach their 30s as prevalence decreases sharply from the mid-20s onwards, although data from England and Wales suggest use of some drugs such as cannabis and powder cocaine continues into the 30s as prevalence rates do not fall as much as other drugs.

1.7. For those who use drugs, modal frequency of use across younger age groups (11-15 year old school pupils in England) is at least monthly. However, this is due to an increase in frequency between the ages of 14 and 15 years old, as younger pupils typically only use drugs once a year (NHS Digital, 2023). This is important information when planning the targeting of delivery of prevention interventions.

What is Drug Prevention?

1.8. Drug prevention aims to prevent or delay the onset of psychoactive substance use in individuals and populations. Where use has already started, drug prevention aims to support cessation of use, and prevent the development of more harmful patterns of use, including escalation of use, polysubstance use, substance use disorders and risky use episodes. Prevention activities may target drug use directly, or those factors (including biopsychosocial and environmental) that make drug use, and escalations in use, more likely.

1.9. Evidence-based drug prevention refers to those activities that have been tested in, or grounded in, research, and have been shown to be efficacious, and achieve practically meaningful improvements in health and wellbeing (Gottfredson et al., 2015).

1.10. **A well-functioning drug prevention system** requires coordination and collaboration across sectors at national and local levels. This requires consistency and coherence in the scope and quality of delivered interventions and adequate resources and infrastructure to sustain the system in the long-term.

1.11. An effective prevention system can be characterised by (ACMD, 2022; Burkhart and Helmer, 2019):

- the availability of a range of evidence-based interventions and policies
- supportive policy and regulatory frameworks
- a well defined and effective implementation framework
- an appropriately trained workforce
- collaborative cross-sector involvement
- a culture of prevention research and evaluation, meeting the needs of local contexts
- knowledge dissemination that informs system activity; and
- sufficient funding to achieve long-term system objectives.

Why Prioritise Drug Prevention?

1.12. There are numerous economic, social and governmental benefits for policy makers to prioritise resources towards drug prevention measures. Four key reasons for prioritisation include;

Reason 1: Cost-effective nature of prevention: there is a high cost of illicit drug use to society

The annual costs to society of illicit drug use was over £20bn in 2021 (H.M. Government, 2021). This includes the costs of:

- policing,
- criminal justice,
- private financial and quality adjusted life years (QALY) losses from crime and drug-related deaths,
- costs of drug treatment,
- treating infectious diseases related to drug use, and

- child and adult social care.

1.13. In its 2023 Value for Money report on the Drug Strategy, the National Audit Office (NAO) reported that almost all the recent uplift in sector funding was used to continue or expand existing treatment, harm reduction, and recovery interventions, or reverse some of the declines in funding seen over the last decade (NAO, 2023). The NAO concluded that, in its view, government did not yet have the evidence to "know how to reduce the demand for drugs". The NAO recommended that government "must urgently" develop a plan to reduce the demand for illegal drugs and cautioned that a "current lack of emphasis on preventing illegal drug use means that departments risk only addressing the consequences, rather than the causes, of harm".

1.14. Prevention activities can be very cost-effective. There is evidence that public health prevention interventions in general have a median return on investment of £14 to £1 spent (including non-financial returns) (Masters et al., 2016). A review of cost effectiveness models of public health interventions conducted by the National Institute of Health and Care Excellence (NICE) found a median cost per QALY of £1,986, which is lower than many clinical interventions.

1.15. There is a high potential for effective drug prevention programmes to deliver a return on investment, although most of the evidence is from outside the UK (Pennington et al., 2018). A recent systematic review included 11 drug prevention studies that included an economic evaluation (Faller et al., 2023). These were all delivered in high-income countries, mainly the United States (US). The review found that school and family-based programmes, or combinations of these, demonstrated positive impacts in terms of cost benefit or cost-effectiveness.

1.16. Analysis from Washington State Institute for Public Policy in the US has estimated benefit-cost ratios (BCR) for different drug prevention programmes (Lemon et al., 2014). The majority had a positive BCR and these were higher than estimates for treatment programmes.

1.17. However, there is very limited evidence, including economic evidence, of impacts of prevention programmes on the most harmful types of drug use (e.g., crack cocaine and opioid use) in young people and young adults. This is because it is methodologically challenging to assess prevention intervention impact when drug use prevalence is very low (e.g. general population prevalence of last year use of heroin in England and Wales was estimated to be <0.1% in 16-24 year olds in 2023/24) (ONS, 2024).

Reason 2: Wider societal benefits of drug prevention activities

1.18. Drug prevention activities not only include structured programmes specifically focusing on preventing drug use, but wider activities that aim to support positive health and social development (sometimes called 'unlabelled' prevention activities). Examples of these types of activities include early years support, family skills, school readiness and retention, and educational support. By investing in such measures, the Government could achieve several societal goals simultaneously.

Reason 3: Prevention of drug use supports wider government policy priorities

1.19. Much of the work of drug prevention can contribute to the Government's missions of "taking back the streets" and "reducing barriers to opportunities". Prevention activity also supports Government priorities of improving mental health, reducing health inequality, and taking action on public health under the mission to "build an NHS fit for the future".

1.20. The Government's mission of "taking back the streets" involves halving serious violent crime and raising confidence in the police and criminal justice system to its highest levels. By investing in drug prevention programmes, which address many underlying social and local factors, the Government would tackle many roots of violent crime.

1.21. The Government's mission of "breaking down barriers to opportunity" involves reforming childcare and education systems, to make sure there is no "glass ceiling" on the ambitions of young people in Britain.

1.22. Adolescent drug use, and establishment of regular drug use behaviours is associated with lower educational outcomes and poorer life opportunities in later life (e.g. Amialchuk et al., 2024; Boden et al., 2020; Linblad et al., 2024; Stiby et al., 2015; White et al., 2020).

1.23. By implementing effective drug prevention approaches, the Government will increase the skills, capabilities and confidence of young people.

Reason 4: Prevention is an important way of reducing drug demand and drug harms

1.24. Prevention is an important component of the overall response to reduce drug demand, and is likely to play a part in reducing overall drug harms, and demand-led drug supply (ACMD, 2016; 2022). A well funded and sustained national programme of evidence-based drug prevention activity will contribute to reducing drug use, and its associated harms.

1.25. Changes in drug markets, such as the emergence of novel synthetic opioids sold as illicit pharmaceuticals, and contamination of so-called recreational drugs pose new threats to people who use drugs. Drug prevention leading to reduced demand is an important response to drug market harms.

State of the current drug prevention system in the UK

1.26. At present, there is no coordinated UK-wide drug prevention strategy. Even if there were, there is no clear delivery mechanism for such a programme of work. Funding for drug prevention is poorly defined, with the majority of recent investment being in drug treatment and recovery interventions and programmes. At present, there is a lack of clarity on which prevention interventions and programmes should be prioritised in the UK and a lack of a trained workforce to deliver prevention activities. Furthermore, the systems are not in place to monitor prevention activities, nor the outcomes of these activities. The rest of this report will focus on defining what a UK-wide prevention system should look like, what interventions should be considered, and what outcome could be used to determine if it is achieving its aims and providing value for money.

2. Whole-System Response

Creating a Framework for Prevention in the UK

2.1 Most international research on drug prevention has focused on establishing the effectiveness of single interventions, but fewer studies, and almost none from the UK, have considered the wider contexts, settings and framework of delivery, including how to upscale interventions to reach more people. In the absence of a broader implementation framework, many prevention approaches identified as effective in research trials are not delivered as intended in real-world practice, and where this does happen, implementation is often poor and rarely sustained. This is not just related to availability of funding (although that is an important factor), but also due to lack of consideration of broader systems into which interventions are delivered, including fit within policy and commissioning processes, and available infrastructure, services, workforce capacity and competencies, and professional cultures.

2.2 The extent of provision of evidence-based drug prevention in the UK is currently unknown, as demonstrated by the findings of the ACMD's call for evidence, and the expert view of Prevention Committee members (see Annex A). An important step to develop a prevention system will be to take stock of current UK prevention activity to understand the strengths and weaknesses, including:

- What kind of prevention activities are delivered?
- Have activities been developed in accordance with evidence on effective approaches, guidelines, and/or quality standards?
- How are activities monitored and evaluated?

Applying a systems approach to prevention

2.3 UK drug prevention activity currently consists of separate and often poorly defined strands, often working in isolation without the benefit of an overarching framework that specifies how these activities may bring about desired outcomes. There is therefore a need for work to clarify what an effective 'prevention system' could look like in the UK, and what actions are needed to achieve this.

2.4 The ACMD previously recommended taking a ‘whole-system’ approach to prevention (ACMD, 2022). This was based on the principle that as drug use is influenced by a complex set of societal, cultural, environmental, and individual factors (e.g. ACMD, 2018; Nawi et al., 2021), prevention responses also required a similarly comprehensive approach. This requires thinking about how prevention activity can be ‘normalised’ across diverse areas of policy and practice, to become embedded across different settings so that it is not seen as a ‘standalone’ activity that is the sole responsibility of the substance use field (Sloboda et al., 2023). This view of prevention was presented as the foundation to improve the implementation, quality, and sustainability of UK prevention work. It is acknowledged, however, that systems change is a gradual process that requires long term commitment, based on small, incremental steps.

2.5 As well as taking a whole system approach, drug prevention activities will be delivered within a larger ‘complex system’ of wider activity at both national and local levels (Lich et al., 2013). Introducing a new policy or intervention requires input from a range of different system agents, including organisations, services, and groups of people such as decision makers and those who commission and deliver prevention, and target groups. Specialist prevention professionals contribute to, but are not the only ones with the responsibility to address drug use (ACMD, 2022). Some interventions may be discrete activities (e.g., targeted prevention interventions); but others may aim to intervene in aspects of the system more broadly (e.g., policies linking work across services/sectors). A complex system way of thinking suggests that the impact and sustainability of new prevention activity will be affected by how all these different aspects operate, and work together – and that this can sometimes be unpredictable.

2.6 Taking a systems perspective on drug prevention means thinking about how individual activities might be connected and better integrated across different areas of policy and practice. It emphasises that changes in one part of the system can have ripple effects throughout. This requires flexibility and adaptability as there is no ‘one size fits all’ universal solution, and responses must be adapted to local needs. This requires working with communities and other stakeholders to understand problems and develop solutions.

2.7 Effective system working requires strong relationships between different sectors, based on the alignment of common values and objectives, with permeability of boundaries in professional roles (Egan et al., 2019). Such an understanding of preventing and responding to drug related harm suggests the need for a diverse prevention workforce. Effective prevention requires sound partnerships across sectors such as housing, local government, policing and criminal justice, education, health and the third sector (Burkhart

and Helmer, 2019). Similarly, but more challengingly, decision-making processes (including commissioning and funding) needs to work across boundaries. This requires stable and predictable funding strategies that recognise the inherent complexity of prevention and that are not siloed or restricted to benefits accruing in any one part of the system.

Components of the System

2.8 For this report, the ACMD Prevention Committee developed a system map, which details the components required to drive improvement in the implementation, quality, and sustainability of drug prevention activity in the UK. There are eight components in this system map:

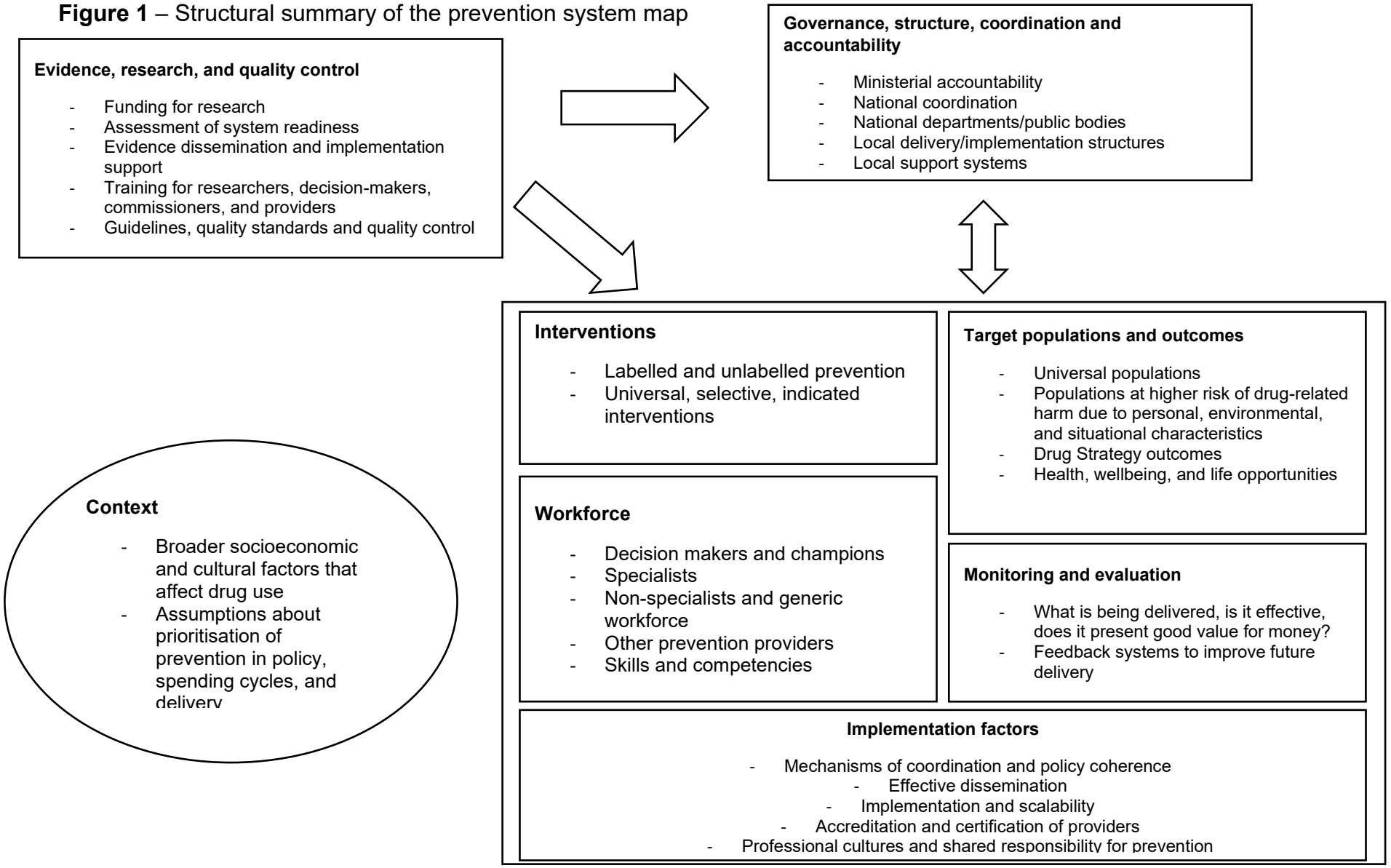
Component	Component description
A	Contextual factors
B	Prevention interventions and activities
C	Target populations in prevention and outcomes
D	Governance, structure, coordination and accountability
E	Workforce
F	Evidence, research and quality control
G	Monitoring and evaluation
H	Implementation factors

2.9 The map represents an ‘idealised’ prevention system and will now be considered in more detail (Figure 1).

A. Contextual Factors

2.10 Contextual factors are the societal conditions in which drug use, and responses to drug use, occur. These factors are complex, multifaceted, and interacting. Such factors should inform thinking about prevention responses, and those factors that can be meaningfully addressed should be included in intervention and policy approaches. Developers of drug prevention strategies at both national and local levels should consider the interplay and relevance of different contextual factors and how these may influence delivery of prevention activities and outcomes.

Figure 1 – Structural summary of the prevention system map



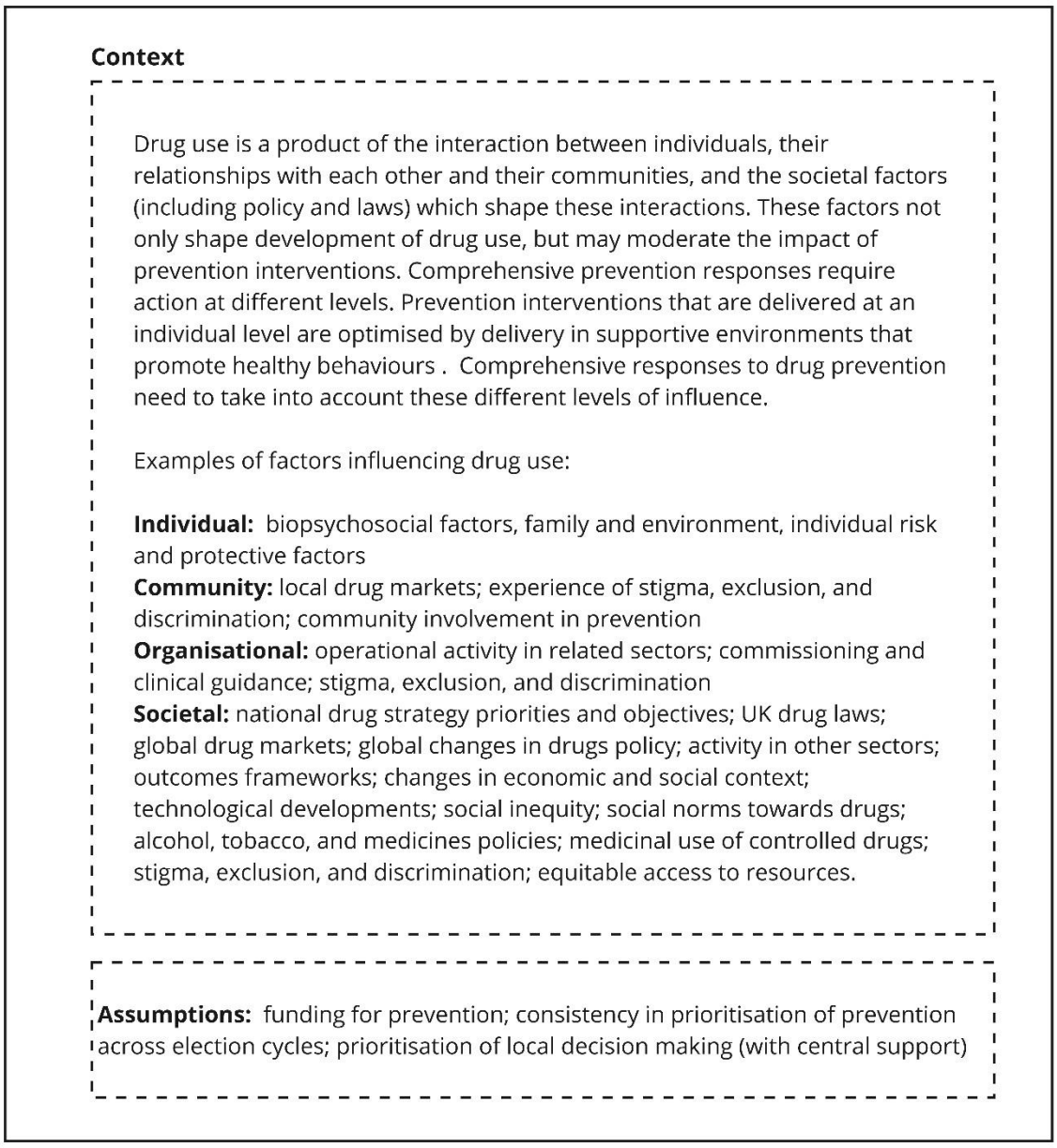


Figure 2 – Contextual factors

Expenditure on drug prevention

2.11 In England, as part of the overall £3.1 billion spend on the response to drugs, additional Drug Strategy funding for 2022/23 to 2024/25 was £903m for treatment and recovery, disrupting supply and demand reduction (NAO, 2023).

2.12 It is not possible to estimate annual expenditure on drug prevention activities in the UK. This is due to:

- the lack of clear definition and labelling of prevention interventions
- differences in budgetary mechanisms between England and devolved administrations, and expenditure on activities across multiple funding streams

(e.g., the Supplemental Substance Misuse Treatment and Recovery Grant in England; local public health grants; funding for schools and other educational settings, local discretionary spending on prevention in Police and Crime Commissioner budgets).

2.13 In England, whilst local prevention activities can be funded from the Supplemental Substance Misuse Treatment and Recovery Grant, there are no data available on how much is spent on labelled and evidence-based drug prevention activities.

2.14 An additional £30m (rounded total) was allocated to departments for demand reduction activities over 2022/23 to 2024/25, which includes prevention spending (NAO, 2023). Of this:

- £22m was allocated to policing activities (drug testing on arrest; out of court disposals)
- £1m on a project to develop behaviour change messaging in universities (this activity is currently paused)
- £350,000 on research to better understand young people's drug use; and £5m to undertake early phase research on prevention intervention development and delivery
- £50,000 on research to review international evidence on drug prevention.

Local authority funding

2.15 In England, the Health Foundation (2025) estimated that local authority public health funding fell by 26% on a per-person basis between 2015/16 and 2025/26, and councils nationally had their funding cut by 54% in real terms between 2010/11 and 2019/20, affecting the provision of activities addressing the wider determinants of health, including drug use.

2.16 The Health Foundation (2025) also estimated that public health grant spending over this period for drug and alcohol services fell by 19% in real terms for youth, and 25% for adults. The 2021 Spending Review committed to maintain the public health grant in real terms until 2024/25, but this was affected by high levels of inflation. According to the Health Foundation this meant that the grant reduced by 5% in real terms since 2021/22 (Health Foundation, 2025). These significant financial challenges pose a considerable threat to maintaining and developing local drug prevention approaches.

B. Prevention interventions and activities

2.17 Prevention interventions, approaches and activities can be categorised into:

- labelled activities (including universal, selective and indicated activities named as drug prevention activities)
- unlabelled activities (not necessarily drug prevention specific, but that may directly influence drug use and have preventative effects, e.g., early years support, youth services, educational engagement activities. Complementary drug strategy priority actions on treatment, harm reduction and supply reduction, and alcohol and tobacco policies are not specifically labelled as drug prevention activities but are important parts of the wider policy and practice landscape and may support prevention aims); and
- **broader approaches** that address the wider determinants of health, wellbeing, social development, and life chances.

2.18 A comprehensive prevention strategy combines labelled and unlabelled activities, and encompasses systems perspectives and approaches that address multiple risk behaviours. In considering approaches to drug prevention in the UK, the ACMD Prevention Committee has reviewed and supports the findings of the WHO/UNODC international standards in drug prevention, the European Drug Prevention Quality Standards (EDPQS), NICE guidance on targeted drug prevention (NG64) (NICE, 2017a), the 2024 toolkit issued by the Joint Combating Drugs Unit (JCDU) to assist Combating Drugs Partnerships in England to develop local approaches to drug prevention (*Promising practice in prevention of drug use and harm 2024*) and guidance issued on drug prevention by Public Health England in 2015 (PHE; 2015) and the Scottish Government (2016). Recommended interventions are further described in Section 3 of the report.

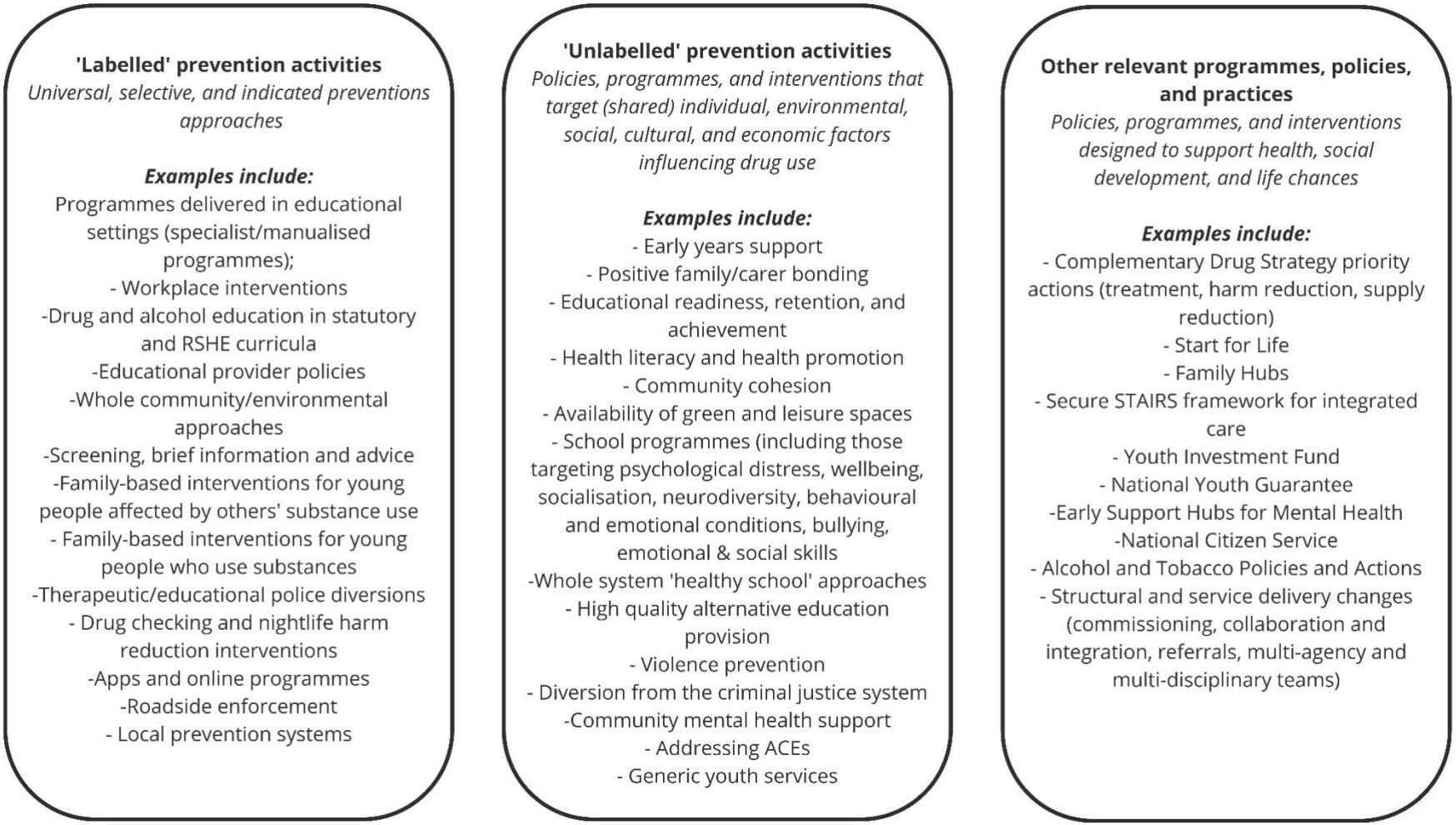


Figure 3 – Summary of prevention interventions and activities

Labelled activities

2.19 Labelled drug prevention interventions and programmes (Table 1) are important components of a prevention system, and are the most evidenced of all prevention interventions. They typically require specialist skills to deliver and require careful adapation for local systems and structures. Labelled interventions are clearly identified as ‘drug prevention’ interventions and are divided into universal, selective and indicated approaches. These interventions should be delivered by appropriately trained staff.

2.20 **Universal approaches** to drug prevention are delivered irrespective of the level of risk of drug use in the population that receives them.They are often delivered at population level, or to large groups. Examples of universal programmes include structured school-based drug programmes.

2.21 Universal prevention activities have the greatest reach and can target the highest total number of (potential) drug use cases. These types of interventions are not just potentially beneficial for ‘lower risk’ populations, as they have also been shown to have positive effects in higher risk groups who may be more vulnerable to drug harms on the basis of individual or shared characteristics (ACMD, 2022).

2.22 **Selective prevention** (sometimes referred to as **targeted prevention**) focuses on specific contexts, settings, risk behaviours, groups or communities associated with a higher probability of drug use and related harms. These actions may be delivered to individuals, but they are not targeted on the basis of an individual assessment of risk of drug use. These types of actions may directly target drug use, but may also aim to improve resilience to a wide range of risky behaviours and outcomes through targeting common underlying or interacting determinants.

2.23 **Indicated prevention** includes interventions that are targeted specifically at individuals with increased likelihood of experiencing drug harms. Indicated approaches target those individuals who have already initiated drug use or those with specific risk factors such as specific behaviour conditions and personality traits.

Table 1: Labelled interventions recommended by the ACMD

	Labelled approach	Intervention recommended
1	Universal	Educational setting programmes (specialist/manualised programmes)
		Whole-community approaches
		Whole-school approaches
		Parents and carers: drug conversations and prevention in the home
2	Selective	Programmes targeting multiple health risk behaviours and comorbidities
3	Indicated	Family-based interventions targeting young people's drug use
		Family-based interventions to support young people affected by others' drug use.

Example of Universal Prevention Activities: Focus on substance use education

The primary source of drug-prevention related activity received by young people in the UK is from substance use education (alcohol, tobacco, and other drugs). This is currently a compulsory component of statutory relationships, sex and health education (RSHE) curriculum in State Schools in England. In Scotland, it is a compulsory part of the Curriculum for Excellence Health and Wellbeing area. In Wales, it is part of the mandatory Health and Well-being curriculum, although the focus and extent of provision is a decision for schools.

However, the aim of drug prevention is to change behaviour and is broader than substance use education on its own. Historically, the focus of responses to children and young people's drug use (including prevention) has been on school-based drug education.

Drug education may be delivered by teachers or through external providers (DfE, 2020), or in other community and leisure settings by drug services, charities, young and community groups and families. Drug education can be a component of wider prevention interventions, but there is a lack of evidence that education alone leads to positive behaviour change. Some research suggests that the provision of information alone can sometimes lead to an increase in drug use and other unintended outcomes.

School inspectorates currently undertake assessment of student health and wellbeing as part of routine inspections, and this includes monitoring of the quality and provision of whole-school support, RSHE provision and other strategies and activities that contribute to these outcomes and help to improve standards of delivery in schools. There are no up-to-date assessments published by Ofsted or other school inspectorate bodies of the quality of delivery and outcomes of substance use education in schools. The Department for Education is currently reviewing

implementation of the RSHE curriculum in schools in England as well as the age-appropriateness of curriculum content, including substance use education. DfE are expected to publish revised RSHE guidance for schools in England.

Unlabelled activities and broader approaches

2.24 There are a range of other policies, interventions, and practices that can contribute to drug prevention, but which do not directly focus on drugs, such as (but are not limited to):

- policies designed to reduce socioeconomic inequalities
- community-based health promotion
- school readiness and retention activities
- generic youth work
- provision of recreational facilities for young people
- mental wellbeing initiatives
- health skills-development programmes; and
- community pathways that provide timely and easy access to more specialist services.

Integrating labelled and unlabelled approaches

2.25 Combining labelled and unlabelled interventions provides an opportunity to develop programmes and policies that target different levels of influence on drug use (e.g. individual, family, community) and at different life stages to reduce drug use (ACMD, 2018). Drug prevention activities can also have positive effects in related domains (e.g., mental health, education, violence), even if that is not the primary aim of the activity, as health/social behaviours and conditions often cluster together in young people due to the presence of shared determinants and risk factors (ACMD, 2022; Campbell et al., 2020; Grummitt et al., 2021). For this reason, other types of policies and interventions that aim to improve health, wellbeing, and life chances can have indirect drug prevention effects.

Example: Marmot Places and the Healthy City Model

Marmot Places are an example of a place-based initiative targeting multiple determinants of health and wellbeing. Nine Marmot Places have already been established in England, covering 40 local authorities in England, and these aim to develop and deliver policies and interventions, based on eight key principles:

- Give every child the best start in life
- Enable all children, young people, and adults to maximise their capabilities and have control over their lives
- Create fair employment and good work for all
- Ensure a healthy standard of living for all
- Create and develop healthy and sustainable places and communities
- Strengthen the role and impact of ill-health prevention
- Tackle racism, discrimination, and their outcomes
- Pursue environmental sustainability and health equity together

Similarly, the World Health Organization's Healthy Cities Model is an initiative that focuses on promoting health and wellbeing by addressing environmental factors that influence the health of populations. The model operates on the principle that the places where people live are essential platforms for improving health and wellbeing through collaboration, community engagement, and policy-making. The model focuses on:

- **Holistic health**: Emphasising physical, mental, social, and environmental wellbeing.
- **Community participation**: Involving local people in planning and decisions.
- **Equity**: Reducing health disparities and ensuring fair access to resources.
- **Collaboration**: Working across sectors like housing, education, and transportation.
- **Sustainability**: Creating healthy, long-lasting environments.

Interventions for low-prevalence drugs

2.26 Most universal drug prevention programmes target the most prevalent substances, including alcohol, tobacco and cannabis. There is currently a relative lack of evidence supporting effectiveness of prevention activities targeting lower prevalence drugs, such as heroin and other opioids, crack cocaine, and novel psychoactive substances. Importantly, some types of universal interventions targeting low-prevalence drug use may lead to unintended adverse outcomes if not carefully planned and delivered. Interventions, particularly mass media and communications-based campaigns, might create inaccurate norms about the prevalence and acceptability of this type of substance use, or increase awareness where none previously existed (Birckmayer et al., 2008; Colfax et al., 2010). Caution should therefore be exercised in generalising evidence on universal prevention approaches for

higher prevalence drug use to low prevalence drug use. Specifically targeted interventions may be required for the latter.

C. Target populations in prevention and outcomes

2.27 Some young people have a greater likelihood of using drugs, or risk of drug harm than others because of differences in risk factors including those at the individual-level; social, family, and economic environments; and access to high quality and timely support (ACMD, 2018; 2022). For these individuals and groups, selective or indicated approaches may be more appropriate than universal ones. However, as noted previously, universal approaches may still have positive effects in higher risk groups.

2.28 Regardless of which groups are targeted with prevention activities, the people the service is aimed for should also have an active role in their design, as co-production and collaboration increases the likelihood that they will be appropriate, attractive and successful (Burkhart & Helmer, 2019).

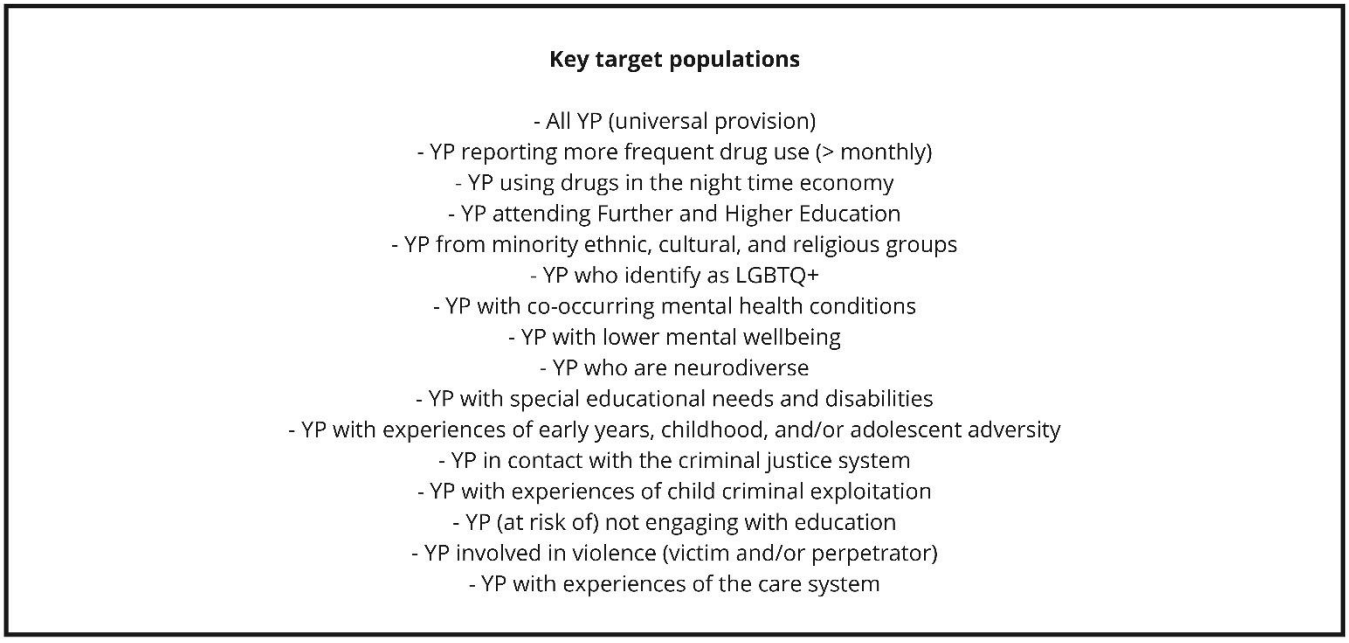


Figure 4 – Target populations/groups in prevention

2.29 We note that for many of these key target groups (Figure 4), whilst there is evidence for elevated drug use or risk of harm, there is a lack of prevention provision, and a lack of UK research into effective interventions. Young people attending higher education, for example, report higher rates of drug use than the general population of equivalent age, but provision of prevention and other activities to reduce drug harms is inconsistently applied across campuses, and

is not uniformly embedded across wider community drug and other service support (Boden & Day, 2023; Waples et al., 2024).

2.30 Young people involved in crime and the criminal justice system (including drug offences) are at increased risk of early onset substance use, and increased levels of risky or harmful substance use. Youth justice (including police activity) therefore provides an important, although under-developed, setting for prevention (Duke, Gleeson, et al., 2020; Duke, Thom, et al., 2020). The EPPIC project (Exchanging Prevention Practices on Polydrug Use among Youth in Criminal Justice Systems), provides a set of quality standards to help improve the quality of (prevention) interventions for drug-experienced young people in contact with the criminal justice system.

2.31 Several police force areas now offer pre-court diversionary activities as an alternative to criminalisation, including educative and therapeutic interventions, for drug possession offences. There have been few evaluations of these interventions or their outcomes, despite an increased use of diversionary approaches. There is work currently underway trialling diversionary programmes in some police force areas such as the Youth Endowment Fund Re-Frame diversionary programme for 10-17 year olds found in possession of Class B or C drugs in England.

2.32 Other populations and groups may be targeted by prevention interventions not because of their personal characteristics and shared risk factors, but because of features of their social environment (e.g. nightlife and festival settings) (Brotherhood, 2023; Burkhart et al., 2022). Taking a proportionate approach, universal provision delivered in such environments should be complemented by selective work for groups at greater risk of harm.

2.33 An important target group for prevention, with potentially the highest risk of harm (and highest societal costs), are those individuals and groups with experiences of childhood adversity, or who have been identified as being affected by risk factors for drug use and drug-related harm (ACMD, 2022). Here there is an overlap between (indicated) prevention interventions, early intervention, and treatment/targeted support. Support for this group is usually individualised and needs-led, but is relevant to work on addressing early years adversity, and embedding prevention across communities and diverse professional responses.

Adverse Childhood Experiences

2.34 Adverse Childhood Experiences (ACEs) can be sources of serious and/or uncontrollable stress and adversity, and include being a victim of abuse or

neglect, and growing up in households affected by parental substance use, violence between parents, parental mental health problems or suicide, family breakdown, and parental imprisonment (Hughes et al., 2017). Exposure to chronic stress can cause maladaptive developmental changes, resulting in impaired cognitive, social, and emotional functioning, leading to compromised development of healthy coping/protective strategies (Grummitt et al., 2022).

2.35 A large body of work in this area has indicated that at population level there is a cumulative relationship between exposure to ACEs and social and health harming behaviours in adolescence and adulthood, including drug use (Grummitt et al., 2022). These behaviours lead to poorer physical and mental health, fewer life opportunities, and premature death. Whilst exposure to ACEs is common in the population, inequities in the cumulative distribution and impact of ACEs can be attributed to the historical, social, and economic environments in which some families live. For example, there is an established link between poverty and poor outcomes in children (Costello et al., 2003; Duncan et al., 2017; Wickham et al., 2017). This is particularly evident when poverty accumulates with ACEs, in which children exposed to persistent poverty and ACEs are almost three times as likely to use drugs (Adjel et al., 2022).

2.36 Preventing ACEs and reducing their impact is a means to address multiple public health and social challenges, including drug use. Just as with responses to drug use, addressing ACEs requires a comprehensive and coordinated cross-sectoral response, including policies and interventions to prevent their emergence and build resilience against harmful impacts (Bellis et al., 2023). Approaches include:

- Policies, legislation and strategies that address the social determinants of health, address inequalities in health, and alter norms, behaviours and environments that promote ACEs
- Providing early years activities that develop safe, stable, environments for children, families and wider communities. Approaches include family-based interventions, strengthening economic support for families, and providing opportunities for young people to develop healthy social attachments and bonding outside of family units (e.g., positive school environment, youth and community groups)
- Teaching skills to help young people develop healthy coping strategies to deal with stress, and manage their emotions and behaviours and to resolve conflict. Skills training and education should be extended to target a wide range of professionals who come into contact with young people to raise awareness of ACEs and improve support
- Services providing psychological support, work to address the health impacts of abuse, and practical support such as legal advice or safe housing.

Mental health and substance use

2.37 Some young people may use substances to cope with (the emergence of) mental health disorders (Turner et al., 2018). As this coping strategy becomes more frequently relied-on, drug use can escalate, and mental health problems can be exacerbated. In 2022 it was estimated that 18% of the population aged 7 to 16 years, and 22% of those aged 17 to 24 years had a probable mental health disorder (NHS Digital, 2022). It is estimated that 8% of the population aged under 25 years had an active referral to Children and Young People's Mental Health Services (CYPMHS) in 2022/23 (Children's Commissioner, 2024). Professionals such as GPs provide a first contact and significant level of support to help young people manage their mental health (Young Minds & The Children's Commissioner, 2021). However, some young people report negative experiences and a reluctance to engage with GPs. This can be due to concerns about stigma, their mental health concerns not being taken seriously, a perceived lack of treatment options, or the consequences of disclosing drug use. GPs also report that they have limited options for signposting young people to non-specialist support in the community (e.g., youth clubs, local charities, drop-in centres, etc).

2.38 Whilst the direction of association between substance use and mental health is complex and bidirectional, both substance use and mental health share risk factors (both genetic and environmental), which may be part of the reason they co-occur (Hines et al., 2020). Knowing the precise direction of association might not be necessary when developing prevention interventions, and it is enough to know that young people with mental health problems are a group in which there is greater prevalence of illicit drug use, and also frequent/problematic drug use.

2.39 The current structure and commissioning of mental health treatment often results in drug use being siloed from mental health treatment. As well as mental health treatment, young people with mental health difficulties may present at GP practices, school wellbeing services or community support groups in the first instance (Young Minds & The Children's Commissioner, 2021). Again, this represents an opportunity to engage this at-risk group. The Government's proposed Young Futures Hubs programme aims to establish a network of community-based hubs offering support for young people. This includes mental health support, and so these hubs may be an appropriate setting to deliver drug prevention alongside mental ill-health prevention and early intervention.

Outcomes

2.40 Relevant outcomes of prevention include those that clearly map onto UK drug strategy outcomes (Figure 5) and are directly drug related, including onset of use, escalation, and cessation. These include a reduction in the proportion of individuals reporting use of drugs; a reduction in the number of permanent educational exclusions that are substance related; a change in societal attitudes and acceptability of drug use; reducing hospital admissions for drug poisoning and drug-related mental health and behavioural disorders; and cessation or change in cannabis and/or other drug use.

2.41 As one justification for drug prevention activity is that drug use can lead to harm (to self and others), then prevention impact should also be assessed against meaningful health and social outcomes, and not just surrogate indicators of harm (e.g., reports of lifetime drug use) (ACMD, 2015). These include physical and mental health, education and employment, quality of life, and direct drug related harms. Other relevant outcomes of prevention that do not directly relate to drug use, but that may support work to improve the health and wellbeing of target groups, include changes in system dynamics, ways of working, professionalisation, knowledge exchange and utilisation, collaborations and processes.

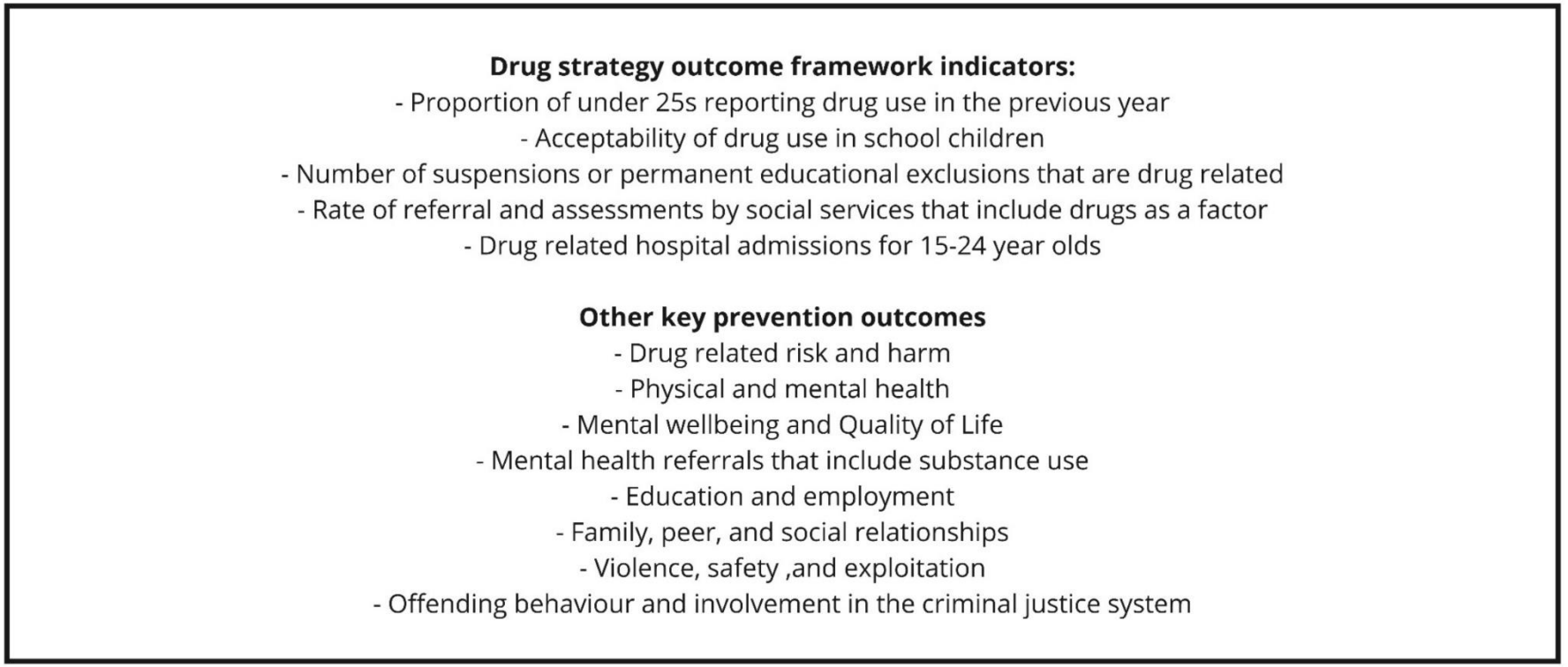
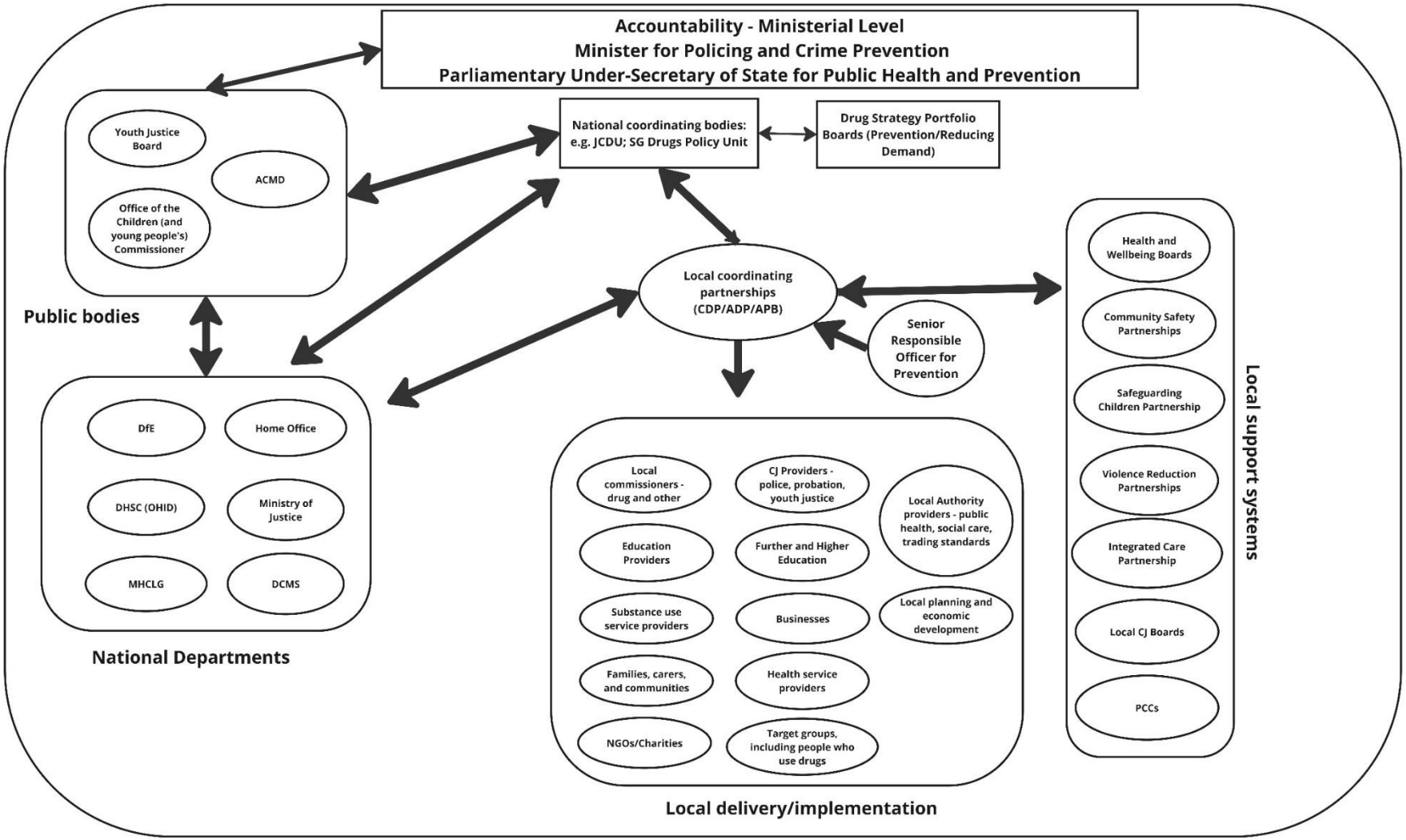


Figure 5 – Prevention outcomes

D. Governance, structure, coordination and accountability

2.42 The ACMD does not recommend the development of a new, stand-alone prevention architecture, but instead, drug prevention activities should be embedded within existing organisations and structures. The establishment of the cross governmental Joint Combating Drugs Unit (JCDU), and local Combating Drugs Partnerships (CDPs) in England provides structures and mechanisms that can coordinate collaborative prevention action at national and local levels across a range of (competing) interests and priorities. Alcohol and Drug Partnerships, and Area Planning Boards serve similar functions to the CDPs in Scotland and Wales respectively.



Key: *DfE*, Department for Education; *DHSC*, Department for Health and Social Care, including *OHID*, Office for Health Improvement and Disparities; *MHCLG*, Ministry of Housing, Communities and Local Government; *DCMS*, Department for Culture, Media and Sport; *JCDU*, Joint Combating Drugs Unit; *SG*, Scottish Government; *CDP*, Combating Drugs Partnership; *ADP*, Alcohol and Drug Partnership; APB, Area Planning Board; *NGO*, Non governmental organisation; *CJ*, Criminal Justice; *PCC*, Police and Crime Commissioner

Figure 6 – Accountability, and national/local delivery structures (non exhaustive).

2.43 Although prevention actors[1] are already represented within current structures, it is unclear, particularly at local level, whether there is the necessary expertise and despite drug strategy prominence, how well prevention is prioritised compared to other actions.

2.44 Strengthening of local prevention systems requires bold leadership that promotes a robust partnership approach that can build trust and collaborative action across professional and public communities in order to realign work towards evidence-based prevention (ACMD, 2022). At a local level, actors and stakeholders such as families, carers, communities, educational providers and young people's elements of other partnerships and bodies, such as Health and Wellbeing Boards and Violence Reduction Partnerships, have a particularly important contribution to make.

2.45 Senior local leadership should specifically:

- communicate a shared understanding of evidence-based prevention and help to create a climate whereby delivery of high-quality interventions are the norm
- emphasise the importance of prevention work in society, helping organisations and professionals to feel supported in their work
- have good knowledge and understanding of evidence-based drug prevention, but they do not have to be drug prevention specialists
- have the skills and standing to advance a collaborative approach.

E. Workforce

2.46 In our previous report on preventing drug use among vulnerable people, the ACMD (2022) concluded that "the UK lacks a functioning drug prevention system, with workforce competency a key failing in current provision". The report further highlighted the need for significant, long-term public investment to build a prevention infrastructure and coordinate support services across domains to support the healthy development of young people, including efforts to address inequalities.

[1] Any individual, group, or organisation that is directly or indirectly involved in the prioritisation, formulation, implementation, or evaluation of prevention activity.

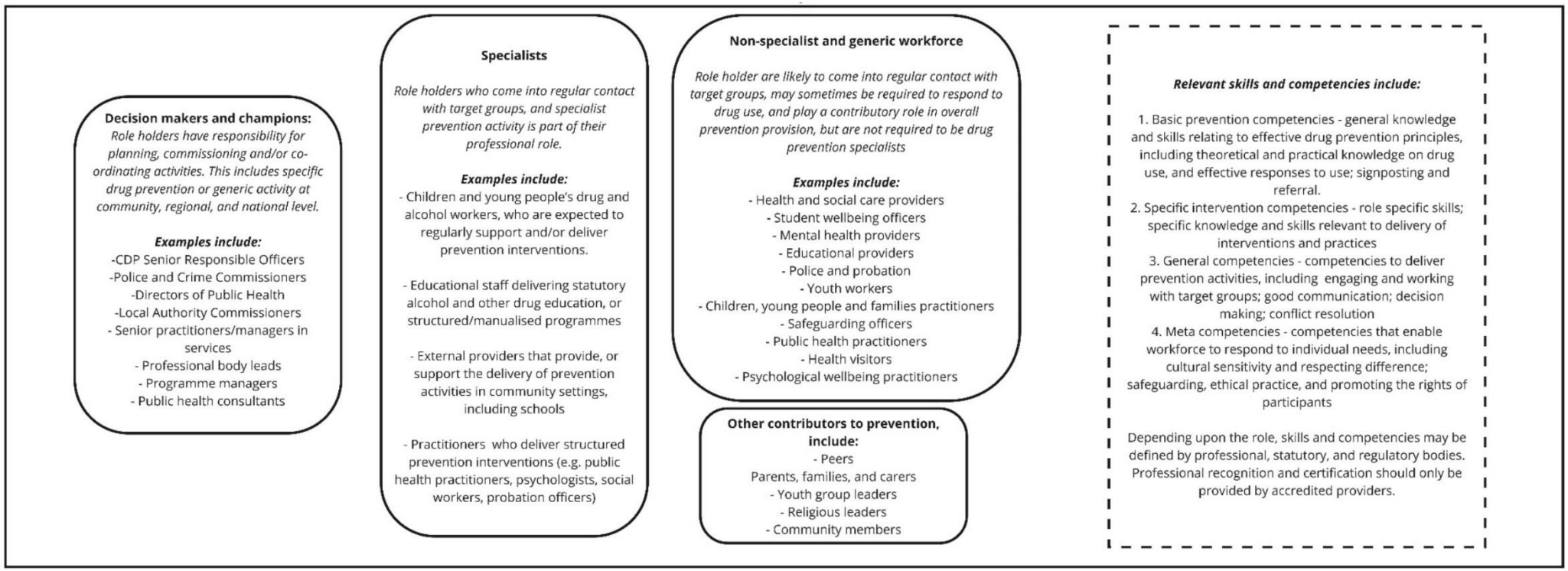


Figure 7 – The Prevention Workforce

2.47 Figure 7 outlines the key workforce roles needed to develop and establish a drug prevention system. These include decision makers, leaders and champions; specialists; non-specialists; and other contributors to a prevention system.

Developing the prevention workforce: normalising evidence-based practice

2.48 A competent and skilled workforce is a fundamental component of a whole-system approach to prevention (ACMD, 2022; EMCDDA, 2019). In the UK there is no recognised 'drug prevention workforce', as useful contributions come from various professions (Sumnall, 2022). However, as there is currently no specific training on drug prevention or certification of providers, this also means that anyone with appropriate permissions can deliver prevention, whether or not they have the necessary skills or competencies.

2.49 A further challenge is to 'normalise' what has been learned from prevention research on 'what works' into the everyday work of all those who support, plan and deliver prevention programmes, rather than it being considered a one-off activity. This knowledge needs to be translated and cascaded to other professionals in order to foster a 'culture of prevention' (Sloboda et al., 2023).

2.50 There are three potential end user groups for prevention training, tailored towards the likely level of specialism required and frequency of activity:

i. those delivering specialised prevention interventions (e.g. manualised programmes, and other interventions described in the UNODC/WHO International Standards)

ii. those who deliver prevention as part of their wider professional remit (e.g. commissioners and decision makers; social workers; youth workers; teachers; health professionals; criminal justice professionals etc); and,

iii. those with responsibilities for the informal socialisation and support of young people (e.g. parents, carers, family, religious leaders, peers etc). Although this third group are not classed as 'professionals', they are an important part of whole system approach to prevention. Prevention training for these groups should be tailored towards the likely level of specialism required and frequency of activity (Sloboda et al., 2023).

2.51 Capability frameworks and several Level 1-3 awards covering youth, health and social care, and labelled substance use work are available through regulated providers and (voluntary) registration bodies. Some apprenticeships

in health and social care also include standards for drug and alcohol work, including for young people. The ACMD Prevention Committee recognises the utility and value of these types of qualifications, but they do not sufficiently address current gaps in prevention knowledge and practice.

2.52 International training pathways and syllabi such as the European Prevention Curriculum and the ISSUP Universal Prevention Curriculum have been developed that align with evidence and expertise on effective prevention. These are not currently delivered in the UK, and whilst they would require adaptation to ensure cultural and structural compliance, they may provide a foundation for the development of prevention training packages.

Approaches to Developing Prevention Competencies and Training

2.53 The *Capability framework for the drug and alcohol treatment and recovery workforce* identifies core capabilities for roles in the drug and alcohol sector. Role profiles and capabilities are described for 15 core roles, including Children and young people's drug and alcohol workers. The role description makes some reference to prevention:

> … *CYP D&A* [Children and Young People's Drug and Alcohol] *workers regularly support universal and targeted prevention interventions, supporting evidence-based educational programmes in schools (such as those found in the personal, social, health and economic education curriculum), one-to-one psychoeducation, and targeted work with vulnerable young people, including in-reach and outreach work with the local community.*

However, the skills and competencies required to deliver these activities are not described, and the emphasis on 'supporting' interventions suggests this is considered a supplementary and non-specialist activity.

2.54 As drug prevention is the responsibility of professionals working across many different sectors and roles, the addition of a core 'drug prevention worker' role to the framework may not necessarily be the best way to achieve ambitions for prevention. Instead, any professional involved in prevention activities, including CYP Drug and Alcohol workers, should be trained against specific prevention competencies to assure the quality of their work.

2.55 The EUPC provides training on competencies outlined in the EDPQS:

- General competencies including communication skills, management, social and personal skills
- Basic intervention competencies (e.g., knowledge of effective prevention approaches, interactive strategies and development issues)

- Specific intervention competencies linked to selected interventions (e.g., teaching effective parenting strategies, and decision-making skills)
- Meta-competencies which cut across the other competencies and include skills required to adapt prevention interventions to meet the needs of the target audience (e.g., cultural sensitivity, community organisation, planning and resource development, monitoring and evaluation). This should include ethical practice outlined earlier in this report.

2.56 Development of specific competencies requires a dedicated programme of work, but examples of basic prevention competencies could include:

- Knowledge of alcohol and other drugs, drug trends, legislation
- Knowledge of risk and protective factors for drug use, including motives for use
- Understanding of the contextual and social issues affecting development of young people's drug use
- Understanding the national and local drug context, culture and trends
- Understanding of the aims and objectives of prevention strategies and interventions
- Able to work with children and young people across a range of age groups and understand the differences in care and support needs related to childhood, adolescence, and young adulthood
- Knowledge of neurodiversity, and its impact on social and educational outcomes
- Interactive group work and ability to deliver to large groups of people
- Able to work inter-professionally across the system, and build relationships across the system
- Able to provide prevention-related information, advice, and guidance to children and young people, carers, families, education providers, health professionals and others.

2.57 Certification of specialist providers is important in boosting the skills and proficiency of professionals engaged in prevention work. Training is needed on theories, evidence-based prevention principles and interventions, and best practice issues. The EMCDDA (2019) suggests this could be achieved in a number of ways:

- voluntary training offered by a variety of academic and non-academic institutions
- defining common training outcome criteria based on international standards; and/or restricting authorisation for prevention work to accredited prevention professionals.

Developing a 'Prevention Culture': a Role for Local Prevention Champions

2.58 Embedding prevention within a wider system of activity requires the participation and collaboration of organisations and individual professionals who might not traditionally consider themselves to be part of a drug prevention response. As with other approaches to system change and mobilisation, local 'Champions' will be required to drive the prevention agenda within local systems. The Champion role has been successfully implemented in a range of contexts, including mental health (Devaney et al., 2020), community health (Office for Health Improvement and Disparities, 2022), and to support the uptake of clinical evidence in practice (Wood et al., 2020).

2.59 Champions typically do not undertake direct work with young people/service users but aim to influence organisational culture and system processes to improve quality (including supporting decision makers). An equivalent Prevention Champion role would use their position and influence to encourage and support collaborative evidence-based prevention activities across local systems, and being accountable to system leaders. In England, this could be at the level of Combating Drugs Partnerships (and equivalent structures elsewhere such as the Alcohol and Drug Partnerships in Scotland and Area Planning Boards in Wales), but as these are not always contiguous with local authority boundaries, alternative organisational approaches may be required.

F. Evidence, research and quality control

2.60 Quality Standards are statements of expected requirements, and include principles and sets of rules that are used to help organise prevention systems, services and implement interventions. They are evidence-based, developed through consensus, and provide measurable statements related to content, processes or structural aspects of quality assurance, such as environment and staffing composition. Quality Standards can be used informally for self-reflection and self-development, but are also formally applied for benchmarking, auditing, review and regulation. Funding decisions are sometimes made on the basis of meeting Standards. Quality control approaches can help to embed a culture of continuous improvement in the prevention field, and ultimately lead to better outcomes for target groups. In the European drugs prevention field, the EDPQS (EMCDDA, 2011) have been used as the basis of several quality improvement programmes, whilst the UNODC/WHO International Standards in Prevention cover intervention approaches. The Further Enhancing the Implementation of Quality Standards in drug demand reduction in Europe (FENIQS-EU; https://feniqs-eu.net/) project provides guidance and toolkits to support implementation of Quality Standards in practice.

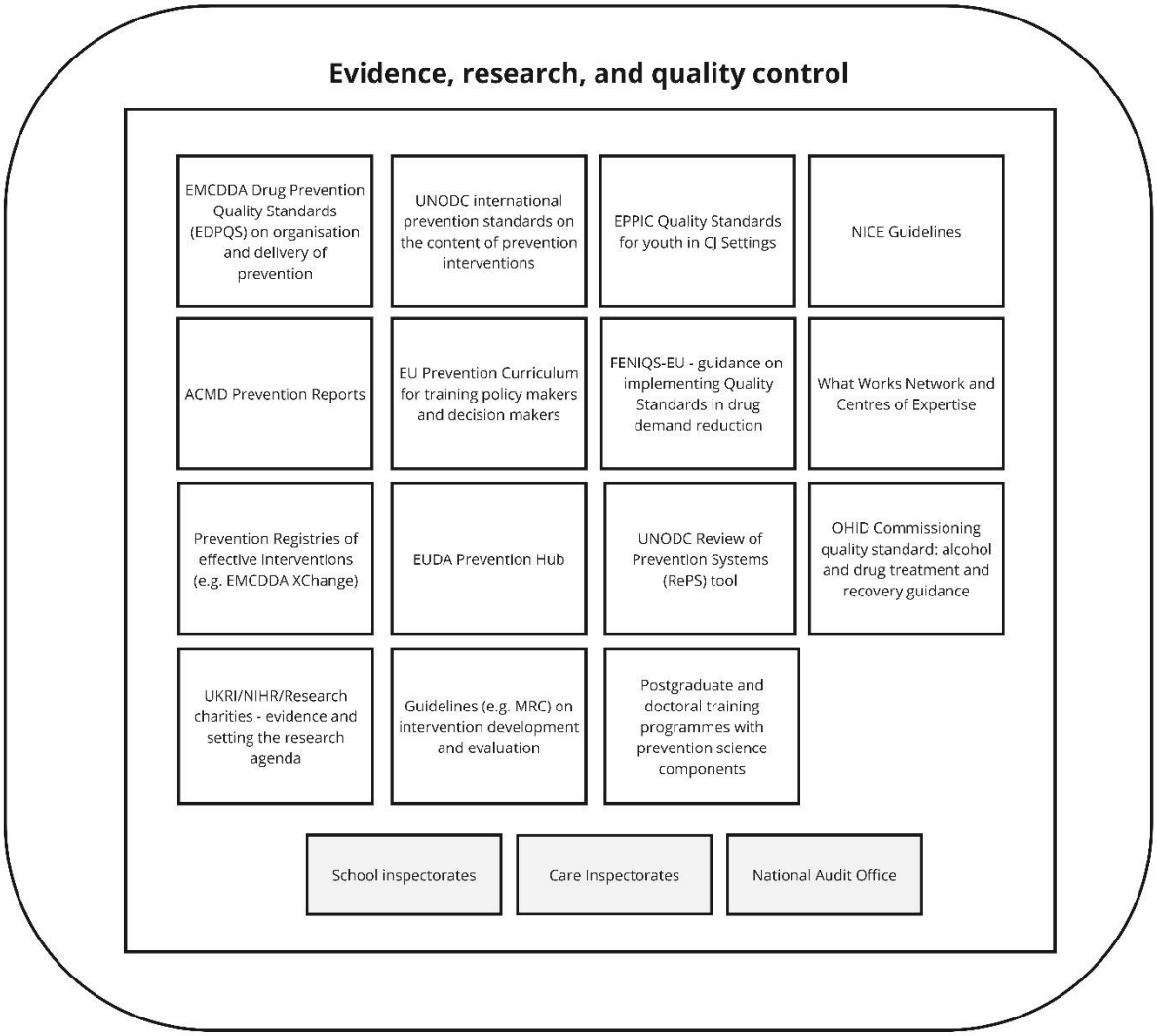


Figure 8 – Evidence, research, and quality control

2.61 There is a lack of UK research activity on the design, evaluation, implementation and scalability of drug prevention and addressing this should be a priority if drug prevention is to be successful. The recent Innovation Fund to Reduce Demand for Illicit Substances (RDIS) is welcomed, but may not be sufficient to address all these gaps. Although some drug prevention research is funded through the main UK research funding bodies, it only comprises a small proportion of the overall substance use portfolio. The Addiction Mission and the Mental Health Research Incubator are initiatives designed to improve research capacity in the substance use field. Neither programme currently includes prevention research, but may provide models to improve work in this area.

2.62 Despite the existence of databases, standards and guidelines in drug prevention, there are currently few mechanisms to help embed this evidence in routine decision making and practice. Passive approaches such as

publishing materials can raise awareness, but rarely change practice. Instead, action should focus on sustained programmes of activity that synthesise and disseminate knowledge in ways that are most appropriate for different target groups. This type of work should not just focus on effective approaches, but also on general capacity building, including identification of individual and system barriers and facilitators (Sumnall, 2019). The UK What Works Network, is an example of this type of activity in practice, but does not currently cover drugs. This is a network of organisations covering different policy areas, that helps to embed evidence in decision making and practice. Activity is not just limited to collating and sharing evidence but also includes commissioning research in response to evidence gaps, assessment of policies and practices against outcomes, and applied work to inform decision making by practitioners, commissioners and policymakers. This approach would be well suited to drug prevention research.

2.63 Internationally, and specific to drug prevention, the Australian Government Department of Health funded Positive Choices portal is an example of a targeted dissemination initiative and is designed to enhance access to and implementation of evidence-based prevention strategies across different stakeholder groups, including policy makers, commissioners and service providers (Stapinski et al., 2022). Early evaluation suggests a relatively high awareness and utility of the resource, with increased orientation towards evidence-based prevention strategies (Stapinski et al., 2022).

Research

2.64 There are significant gaps with respect to our understanding of prevention interventions and the systems through which they should be delivered. There is a clear need for a national research strategy for drug prevention with associated dedicated funding.

2.65 Prevention is a long-term activity and it may take several years for prioritisation of evidence-based prevention in commissioning activities to become fully embedded in local delivery systems. The beneficial impact on drug use of policies designed to support healthy early years development will not be seen until adolescence. This means drug prevention should be evaluated over the long term, and the development of key system processes and outcome monitoring mechanisms should be included as part of this work. There are many specific research questions that need addressing, however, some of the more important ones identified by the Prevention Commitee include:

- are currently delivered prevention activities consistent with evidence-based guidelines?

- have currently delivered interventions been evaluated (including economic evaluation) and reviewed following evaluation?
- are currently delivered interventions adapted in light of unintended adverse impacts?
- are currently delivered interventions adapted in light of new and emerging evidence?
- are young people responding positively to prevention messages and strategies?
- do drug education courses offered as part of out of court disposals/diversionary activities have a preventative effect?
- are young people avoiding drug use, and is the age of onset of use changing?
- are use of some drugs being maintained over longer periods of time, and what prevention activities could be used to address this?
- what are the best ways to prevent drug use in young people with experiences of early years adversity (ACEs)?
- what are the best ways to prevent young people using drugs to cope with or self treat mental health problems?
- what are the best ways to address young people experiencing multiple risk behaviours, including drug use?

G. Monitoring and evaluation

How do you assess a Prevention System?

2.66 The United Nations Office on Drugs and Crime (UNODC) Review of Prevention System (RePS) tool has been developed to review national and local prevention systems. It assists in the review of:

- the extent to which national or local drug prevention systems are in line with internationally agreed standards on effective drug prevention; and
- the quality and coherence of the system components.

2.67 The RePS tool includes a set of indicators that allow for qualitative assessment of system structure. The tool has recently been successfully piloted in Norway to support quality improvement in prevention policy (UNODC, 2023) and could be a model used to assess an emerging UK prevention system.

2.68 Drug prevention strategies are diverse and complex with impact measured over longer timescales than many other interventions. It may take several years for prioritisation of evidence-based prevention to become fully embedded in local delivery systems and the benefit of policies, such as supporting healthy early years development, may not be seen until adolescence and beyond. The outcome monitoring of drug prevention activity must be considered in these longer timeframes.

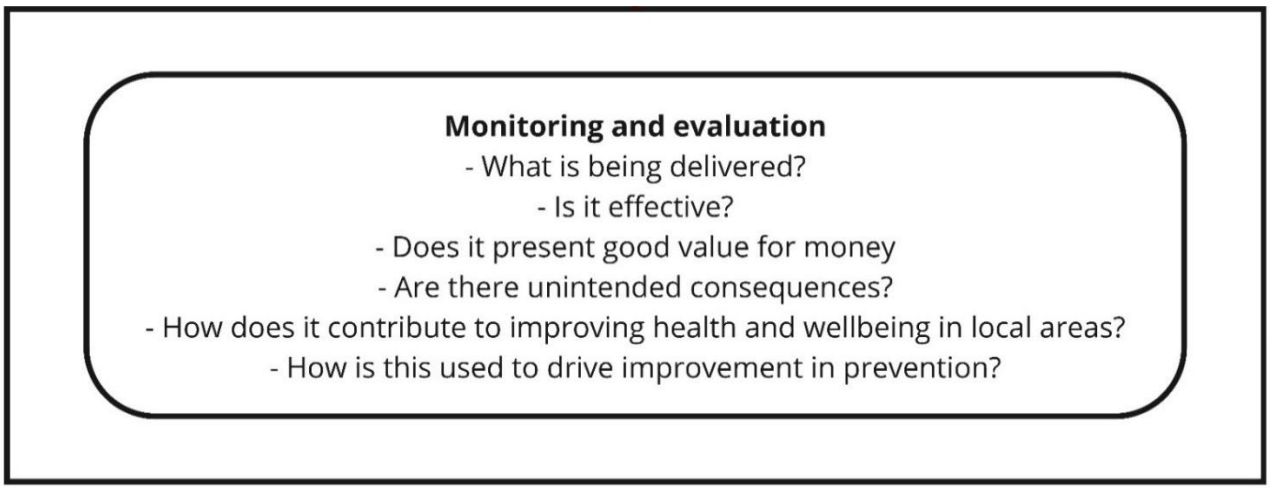


Figure 9 – Monitoring and evaluation

2.69 There are several existing frameworks that can provide guidance on development and evaluation of drug prevention interventions. One of the most frequently referred to is the MRC-NIHR framework for evaluating complex interventions (Skivington et al., 2021). This is relevant to development of drug prevention systems as it asks a broader range of questions than just those relating to intervention outcomes. These include:

- what other impacts the intervention has (both positive and negative)
- assessing its value relative to the resources required to deliver it
- theorising how it works
- taking account of how it interacts with the context in which it is implemented
- how the intervention contributes to system change, and
- how the evidence generated can be used to support real world decision making.

2.70 Although there are clear benefits in taking a systems-based perspective to drug prevention, there are challenges in evaluating changes in the system and the outcomes that it produces (McGill et al., 2021). Some outcomes are unknowable in advance, and cause-and-effect relationships are only evident in retrospect. Unlike evaluations of individual interventions (in which, (i) a direct effect of the intervention on the outcome is expected; and (ii) exposure to, and monitoring of outcomes can be controlled), effects of changes in systems can take longer to emerge, can be indirect, and as it is not known who has been the recipient of the change, there may not be a clear target group in which outcomes can be monitored.

2.71 To understand changes in drug use as part of a system-wide evaluation, there needs to be improvements in monitoring of non-treatment engaged populations of people who use drugs (and other prevention-related outcomes). At present, whilst local areas may undertake surveys of drug use, these are rarely comparable and differ with respect to sampling and methodology,

frequency of delivery, and assessments of drug use. The absence of a standard data-set for non-structured drug and alcohol interventions also makes it hard to evaluate the impact of routinely delivered prevention interventions.

2.72 One of the common outcomes measured in drug prevention is the prevalence of population drug use and its age of onset. Nationally, official general population drug prevalence data are drawn from sources such as the Crime Survey for England and Wales (CSEW), Scottish Health Survey, and the All Ireland Drugs Prevalence Survey. However, these do not allow for local area estimates of drug use, and there are indications that these types of survey may underestimate drug use in young people (Charles et al., 2021).

2.73 Data on substance use in school pupils are provided through the English schools Smoking, Drinking and Drug Use among Young People in England survey (SDD11-15), the Scottish Health and Wellbeing Census, which replaced the Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) in 2021, and the Welsh Student Health and Well-Being Survey. In Northern Ireland, the last young people's drug survey was conducted in 2014/15. These provide national and regional estimates on substance use amongst secondary school pupils aged up to 18 (depending on survey), but due to costs, are not annual surveys and cannot be used for local evaluation.

2.74 One model that could be adopted for evaluation is the Smoking and Alcohol Toolkit (Kock et al., 2021). These are run monthly in the UK to understand population-wide influences on smoking, vaping, and alcohol use. These studies allow for detailed consideration of the effect of changes in policy on legal substance use. However, alcohol drinking, vaping, and smoking are higher prevalence behaviours, and regular surveys may not be appropriate or affordable for some types of drug use.

2.75 Whilst survey questionnaires used in studies such as the CSEW and SDD11-15 could be applied at a local level to assess drug use, these do not provide sufficiently detailed data on prevention-related outcomes, including risk and protective factors, patterns of substance use, harmful substance use, and co-occurring risk behaviours. Some local areas have established longitudinal birth cohort studies (e.g., *ALSPAC* in South West England; *C-Gull* in the Liverpool City region; *Born in Bradford* in Bradford) to provide comprehensive insights into certain populations as they age, to inform understandings of health development and associated policy and practice, but these are very expensive to set up and maintain, and cover a range of topics.

2.76 Historic examples of surveys of young people's behaviour that could be updated for use at a local level to assess prevention activity include the

Department for Education's *Tell Us* series, which was a census of secondary school children at local authority level, and the *Belfast Youth Development Survey*, which was a longitudinal study of adolescent risk behaviour with a prominent focus on substance use. Currently, *OxWell*; *#BeeWell*; and the *Born in Bradford Age of Wonder* surveys are being delivered in schools at local authority level, and these ask students about topics such as their mental health, wellbeing and school experience. Some of these surveys include substance use outcomes, and have both longitudinal and cross-sectional elements. This allows for investigation of outcomes of interest across adolescence, and detailed exploration of emerging topics.

2.77 Other methodologies and metrics of drug use could be utilised for prevention monitoring. These include hospital admission statistics, A&E attendances and Emergency Admissions. Relevant datasets include the National Pupil Database to estimate substance-related exclusion; the Ministry of Justice – Department for Education linked dataset, which links education (e.g., exclusion), the SAIL databank, which provides anonymised linked health and social care data in Wales, and police national computer (PNC) records. Developments in environmental monitoring methodologies (e.g., wastewater analysis) can provide additional intelligence on drug use, but implementation is currently limited to large urban areas and does not allow for estimates of drug consumption in particular population groups.

H. Implementation factors

2.78 Implementation factors describe the policy environment, data, infrastructures, and resources required to organise and deliver evidence-based prevention approaches. They contribute to the development of a 'prevention culture' that determines the success, or otherwise, of the prevention system.

2.79 Development of a prevention culture leads to a shared understanding, and orientation towards evidence-based prevention, leading to better readiness and ability to act towards shared goals. Those operating within this culture hold shared values, which determine the motivations, standards, actions, and goals of prevention to which they attribute intrinsic worth. There is ongoing collaboration, networks and partnerships, with the necessary infrastructures and capacity to support sustainability; the development of plans for implementation and sustainability; institutional support and commitment; and supportive leadership and championing of prevention at all levels of activity.

2.80 More specifically, national and local systems are required to monitor the prevalence and patterns of drug use; mechanisms to review and respond to

the evidence of need, of effectiveness and quality of interventions, and of adequacy of resources; and proper monitoring and evaluation of interventions to ensure that they are effective. The target population should be involved in co-producing prevention activity to enhance relevance and acceptability. Medium- to long-term investment is required for prevention activities to reach their potential, and regular reviews of planning and progress are required. Services responsible for delivery require adequate finance; individuals planning and delivering intervention require suitable, ongoing training; and evaluation requires adequate resources.

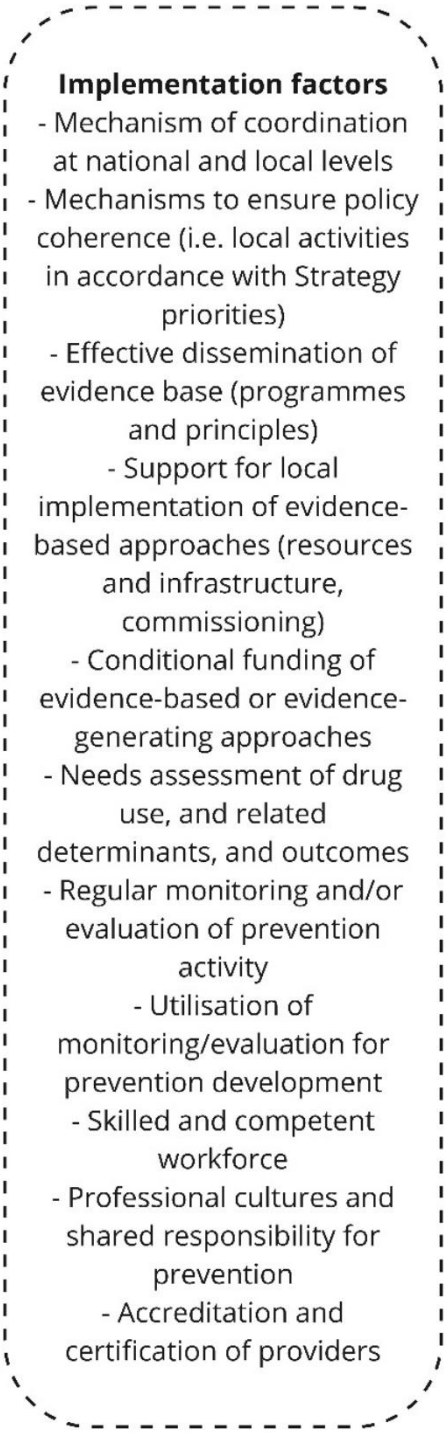


Figure 10 – Implementation factors

3. Evidence-Based Approaches

Recommended approaches to drug prevention for prioritisation

3.1 The ACMD Prevention Committee has identified a set of universal and targeted approaches to prevention that are recommended for prioritisation. The selection is based on balancing published evidence of impact, relevance to the likely needs of UK target groups, understandings of how the approaches are theorised to work, and whether they are likely to be feasible to deliver in a UK context. These recommendations align with the sets of guidance described in Section 2.18. All the recommendations should be delivered against local priorities including local needs and delivery structures. A co-design approach is suggested to engage key stakeholders, including target groups, in the design, implementation and evaluation of drug prevention activities.

3.2 In some communities, strong community concern about drugs, good access to prevention expertise, available local data, and strong stakeholder commitment to prevention might indicate a readiness to deliver recommended approaches. Other communities might be less prepared to act, may have limited access to expertise or may not have good leadership, community engagement or the required infrastructure for delivery. In these communities there may be less initial focus on intervention delivery, with resources instead focused more on engagement, data collection, and capacity building.

Recommended Universal Approaches

Whole-Community Approaches

3.3 Whole-community approaches to drug prevention (sometimes called ‘community mobilisation’) are not interventions *per se* but provide alignment with the complex system-based approach presented in this report. They are sometimes classed as ‘environmental interventions’ and may be delivered as part of wider ‘upstream’ approaches to improving health and wellbeing in local populations. Whilst some formal models have been developed (see the examples below) the general approach aims to engage community members and help them take actions to achieve a shared goal. They require identification of local champions, coordination of efforts to create partnerships, action groups to engage all parts of the community, and prioritise the involvement of local people (Tinner et al., 2024; UNODC & WHO, 2018). Whilst some community collaborations are spontaneous, large-scale activity

requires sustained long-term financial and technical support. Activity is based on a good understanding of community readiness to act using local data, and resources are provided to remove barriers to collaborative working. Funding for generic and labelled prevention interventions is provided and normally consists of multiple components which are coordinated across different settings (e.g., schools, families, policing and criminal justice, health and social care, local business, media and/or local government), with the aim of creating supportive environments that promote healthy behaviours.

3.4 Resources to support whole-community based approaches should be allocated on the basis of local need. Reductions in local authority funding (see Section 2.15) have not been distributed equally, with greatest decreases in funding reported in more deprived areas (Health Foundation, 2025). There is a strong association in the UK between area level deprivation, and health and social harms, including substance related harms (Marmot et al., 2020; ONS, 2024)

Example: The USA Communities That Care approach

The USA Communities That Care (CTC) approach is based on the premise that reducing adolescent health and behavioural problems requires strengthening of collaborative action within local prevention systems. The CTC approach aims to

(1) generate greater community ownership of prevention initiatives

(2) reduce duplication and fragmentation of community resources

(3) reduce interagency competition

(4) improve the sustainability of prevention measures; and,

(5) provide a mechanism for multiple services and organisation to address complex topics.

This proceeds through five programme activities providing training and technical activities, and resourcing the contributions of multiple stakeholders. Communities identify their own priorities based on local data, and through their improved capacity and readiness to act, are better able to provide effective and targeted action through evidence-based interventions and policy actions.

Analyses of CTC have noted evidence of improved collaborative processes, and increased adoption of evidence-based approaches to prevention that are implemented with high-fidelity and sustained over time (EMCDDA, 2017a; Oesterle et al., 2018). Sustained improvements in indicators of targeted behaviours have also been reported.

Example: The Icelandic Model

The Icelandic Model (sometimes referred to as the Icelandic Prevention Model, Youth in Iceland Model, or Planet Youth) aims to improve health and wellbeing, including substance use, by strengthening protective factors and reducing risk factors at the local community level through activity in four environments: family, peer group, school, and leisure outside school. It is based on five guiding principles:

- A universal prevention approach designed to enhance the social environment
- Community and schools-based interventions are the basis of action
- Community stakeholders are empowered to make practical decisions using local, high-quality, and accessible data
- Researchers, policy makers, practitioners and community members are integrated in programme teams
- An emphasis on long-term intervention and the requirement for adequate resources.

Surveys in schools provide information about risk and protective factors and then relevant interventions are identified and implemented, such as recreational and extracurricular activities and sports, time spent together as families, curfews, and encouragement of parental monitoring and communication. Much of the evidence of the effectiveness of the Icelandic Model comes from observational studies in Iceland (see Kristjansson et al., 2020 for an overview), although there is increasing research from other countries, including Canada, Spain, USA, and Lithuania (Asgeirsdottir et al., 2021). However, no randomised controlled trials have been conducted and much of the research is descriptive and observational (Koning et al., 2021). Evaluation of Planet Youth in Scotland is ongoing, which will help to better understand if the model can be transferred to different policy and cultural contexts.

Whole-School Approaches

3.5 Like whole community approaches, whole-school approaches are not specific interventions, but provide a framework for a range of complementary activities to improve health, wellbeing, and educational outcomes. The approach was first developed by the World Health Organization (WHO) in the 1980s and recognises the complex and multifaceted ways in which school systems shape the health and wellbeing of students (and staff and families). It provides a holistic approach that recognises the interplay between health and education, and how these are affected not just by what is delivered in the classroom, but also wider aspects of the school and community environment.

3.6 Though definitions of the approach vary, a whole school approach requires action across three main areas, with interaction between activities across domains:

- the formal curriculum, including health-based topics
- school ethos and environment, whereby the health and wellbeing of students are promoted through the values and attitudes promoted within the school, and the physical environment and setting of the school; and
- relationships between the school, families, services and organisations, and the wider community.

3.7 A whole-school approach to drug prevention does not just focus on the topic of substance use, but includes it as part of wider activities to improve multiple aspects of health and wellbeing. Specific aspects of the school environment, such as good school connectedness, are likely to operate as a protective factor for a range of outcomes such as educational disengagement, drug use and poor mental health (Bond et al., 2007). Joint guidance from UNESCO, UNODC and WHO provides a basis to understand how drug prevention can fit within a whole school approach (UNESCO et al., 2017):

- Comprehensive drug education – delivered as part of statutory curriculum requirements, including personal and social skills development, social and emotional competencies, and activities to encourage supportive and confidential disclosure and help-seeking where students have additional needs
- Provision of labelled universal, selective, and indicated drug prevention interventions – where a need has been identified (e.g., national policy priorities, local concerns about a drugs issue; in response to school survey data; prior to Summer or Christmas holidays; as part of a wider whole-community initiative). The guidance listed in Section 2.18 provides examples of evidence based interventions
- Creating a supportive school environment – fostering a school culture that promotes positive behaviour, healthy relationships, and open communication between students, parents, and staff
- Staff training and development – to provide support to staff with responsibilities for delivery of RSHE (and equivalent curricula), and to help all staff to support students who disclose drug use in accordance with school safeguarding policies
- Involving parents, carers, and families – through ‘parents evenings’, informational sessions, and linking classroom-home learning and behaviours (e.g., encourage and inform parental conversations about drugs)
- Implementing supportive policies and practice – in relation to use of substances in school (or disclosure of use off-site), and responses to drug-related incidents of actual substance use. This includes retention of students in school rather than exclusion in response to drug incidents - where it is safe

and appropriate to do so. School policies should extend to staff, visitors, parents/carers, and include alcohol, tobacco, and nicotine

- Collaboration with community and other external providers – who may provide additional specialised support and resources for drug prevention initiatives. This would include labelled (e.g., local young people's drug services; mental health support teams, violence reduction partnerships) and unlabelled provision (e.g., charities providing emotional wellbeing services).

Example: National Healthy Schools Programme

The National Healthy Schools Programme was a national government programme designed according to a whole-school approach and was intended to encourage closer working between health and education providers. The programme had four themes: PSHE (including alcohol and other drugs education), healthy eating, physical exercise, and emotional health and wellbeing. The associated National Healthy School Standard (NHSS) provided an accreditation process for schools, supported by national advisors and local coordinators. After the national programme ended in 2013, some local authority areas continued with the programme, and these have developed further in response to other initiatives such as the Healthy Child Programme. Evaluation of the NHSS suggested that pupils in secondary schools that had achieved the Level 3 Standard (indicating those schools that had begun to implement the model) were less likely to report use of drugs (Schagen et al., 2005). Although the Healthy Schools Programme concept is still popular in the UK, the ACMD Prevention Committee is unaware of any work that has evaluated drug and other prevention-related outcomes in contemporary delivery.

3.8 Examining whole-school approaches more broadly, one systematic review identified positive effects on a range of health-related outcomes, but a lack of research on drug use (Langford et al., 2015). One example of an evaluated UK whole-school approach is the Learning Together intervention (Bonell et al., 2018), which addressed aspects of the school environment associated with bullying, but which were also theorised to be protective against drug use. Intervention components comprised implementation of restorative practice (with training for staff), school action groups (which brought together staff and students) and a 'social and emotional skills curriculum'. The randomised controlled trial that evaluated the intervention found lower rates of bullying within intervention schools, and a lower likelihood of students having been offered or tried drugs.

Parents and Carers: Drug Conversations and Prevention in the Home

3.9 For most children and adolescents, the school and home environments are the two most common places where prevention is delivered. Despite the increasing independence of young people across adolescence, parents and carers remain an important influence on young people's substance use (Marceau, 2023; Newton et al., 2017). Parents and carers can play an important role in preventing initial use and reducing harmful outcomes for both young people and other family members (Copello et al., 2006).

3.10 Building parents'/carers' confidence that they can contribute to prevention activity is important (Koning et al., 2011, 2012). Interventions should aim to build knowledge and understanding of substance use in parents/carers, develop self-efficacy (i.e., belief in ability to perform these actions successfully), and encourage reflection on their own substance use behaviours. Activities should support open and honest communication between parents/carers and children about substances and related safety issues. Parents/carers should be provided with guidance on how to initiate conversations with their children, listen actively, and provide support without judgement. Universal interventions focusing on improving parents'/carers' communication skills around substance use should include all family members if possible as they are most effective within the context of high levels of parent-child connectedness (i.e., strong relationships) (Carver et al., 2017). More structured approaches can help parents/carers develop the skills and confidence to address drug-related issues, including setting boundaries, and monitoring children's behaviour.

3.11 One review examined combined child and parent/carer programmes to prevent substance use among adolescents (12-17 years old) (Newton et al., 2017). The authors identified 22 studies that fit their inclusion criteria, and all but one of these were universal interventions, with the majority delivered in the US. Approaches included elements such as social influence and/or life skills training for children. Parents were taught skills such as monitoring, child-parent bonding, and communication skills. Some included other interventions such as engagement with school staff and delivery of complementary and reinforcing community-based work and media campaigns. They were delivered in diverse settings including in schools during school hours, in schools out of hours (e.g., as part of parents' evenings), and mixed school and home interventions.

3.12 Most programmes demonstrated some positive effects on delaying and/or reducing alcohol and/or other drug use (outcomes were assessed immediately after the intervention and up to a period of 78 months). Whilst longer-term follow-ups were associated with significant effects, caution is warranted due to the small number of studies reviewed following up particpants over extended periods of time.

3.13 Whilst parents/carers can make important contributions to prevention (Kuntsche & Kuntsche, 2016; Newton et al., 2017), engagement can sometimes be challenging, particularly for those parents/carers of children who are at highest risk of drug use. In addition to material support and incentives (e.g., transport, childcare, meal costs) to encourage participation in structured programmes, strategies for improving engagement include offering multiple formats including online resources, informal workshops, seminars, or informational sessions to educate parents about drug use and effective prevention techniques. Partnerships beyond schools with local community organisations, healthcare providers, or other support agencies can increase the reach of prevention work. Cultural, socioeconomic, and other factors should always be taken into account when designing activities, to ensure they are accessible and relevant to diverse parent/carer populations.

Example: Australian Positive Choices

The Australian Government Department of Health funded Positive Choices website is part of a national prevention initiative designed to enhance access to and implementation of evidence-based prevention strategies in communities (Stapinski et al., 2022). This includes resources specifically targeting parents/carers, including factsheets and learning materials, advice on initiating supportive conversations about drugs (in the context of risk taking and safety), responding to drug concerns, and how to access more structured support. Early evaluation suggests a relatively high awareness and utility of the resource in target groups, with increased orientation towards evidence based prevention strategies (Stapinski et al., 2022).

Recommended Selective Approaches

Programmes Targeting Multiple Health Risk Behaviours and Comorbidities

3.14 Risk behaviours cluster in adolescence (e.g., substance use, poor diet, physical inactivity, gambling, sexual activity, antisocial behaviour, aggression) (ACMD, 2018; Whitaker et al., 2021; Wright et al., 2020), and their co-occurrence increases the risk of harm more than the additive effects of single behaviours (Akasaki et al., 2019; Ding et al., 2015). Whilst clusters are not heterogenous across populations, their existence provides a rationale for targeting multiple risk behaviours in prevention work. This may be a more

(cost) effective approach to prevention than targeting single behaviours as they may share common determinants/risk factors. There may also be transfer effects, whereby the lessons, skills, and knowledge learned in relation to one behaviour are applied to improve others (ACMD, 2022; Champion et al., 2019; Whitaker et al., 2021).

3.15 Whilst there is evidence that universal school-based interventions are effective in reducing multiple risk behaviours, including drug use, there is currently a lack of evidence that other types of approach, including selective interventions are similarly effective, despite improving other types of health outcome (Champion et al., 2019; MacArthur et al., 2018). This may be because studied interventions were too brief, did not provide opportunities for skills development, or were not based on effective prevention techniques and behaviour change theories. A recent randomised controlled trial incorporating cognitive-behavioural and motivation-enhancement techniques, also found no effect on six targeted risk behaviours (alcohol use, tobacco smoking, recreational screen time, physical inactivity, poor diet, and poor sleep) at two years follow up, although health-related knowledge was improved (Champion et al., 2023). The authors suggested that poor engagement with the intervention app, and insufficient time focused on each behaviour may have been one reason for lack of observed effect.

3.16 There is some evidence that combined interventions for substance use and mental health may be effective at improving both outcomes. Delivered through schools, the Australian online *Climate Schools–Combined* intervention increased knowledge about cannabis use, reduced increases in anxiety, and reduced increases in alcohol use (use of illicit drugs, including cannabis were not measured as outcomes) at 30 months (Teesson et al., 2020). This combined intervention approach was found to be more effective than interventions targeted only on substance use or mental health.

Indicated interventions – an area requiring development

3.17 Indicated prevention is a relatively new branch of prevention and so there is currently limited evidence available on the effectiveness of indicated prevention approaches. Whilst this means it is not possible to recommend specific interventions, research into indicated prevention approaches should be a priority.

3.18 One promising pilot study suggested that this type of approach may be effective when targeting externalising disorder traits. University students who completed an online personalised programme that provided feedback on their personality traits linked to internalising disorders (anxiety and depression) and externalising disorders (ADHD and conduct disorder) were found to be less likely to use cannabis when followed up three months later compared to students given a brief motivational interview, and a no-intervention control group (Choi et al., 2023).

3.19 The *Preventure* programme is another personality-targeted intervention delivered in schools (Lynch et al., 2023). It is designed to reduce and prevent substance use and mental health symptoms among adolescents. It has been shown to successfully reduce growth in general psychopathology, a trait underlying both substance use and mental health problems, among high-risk students (high for anxiety sensitivity, negative thinking/hopelessness, impulsivity, and sensation seeking) from early-to-mid-adolescence (over 3 years) (Lynch et al., 2023). It is hypothesised that by reducing this liability to psychopathology, the intervention is likely to prevent the development of multiple mental health and substance use disorders.

3.20 Young people who are neurodiverse or who have mild educational and learning needs may have a greater likelihood of using substances to manage behaviour or co-occuring mental health symptoms, and a higher risk for developing substance use related problems than their peers (van Duijvenbode et al., 2019; Weir et al., 2021) There is a lack of evidence on effective approaches for these groups, and prevention interventions designed for the general population may not always be appropriate for their needs. The Dutch *Take it personal!* intervention was specially designed to target four personality traits in this group: sensation-seeking, impulsive behaviour, anxiety sensitivity and negative thinking. A pilot study undertaken in prevention services supporting adolescents with mild intellectual disabilities in the Netherlands, found that the intervention reduced substance use frequency and binge drinking at 3 months follow up (Schijven et al., 2020).

Family-Based Interventions Targeting Young People's Drug Use

3.21 Family-based interventions that prevent or target young people's drug use typically work by enhancing knowledge, skills and understanding within the family, and improving parent/caregiver practices (Allen et al., 2016). They are

most effective when they include both the parent/carer and the child in sessions. These programmes have mostly been evaluated with children aged 0-12 years who have behavioural problems. There is a large evidence base showing that parenting programmes can be effective and cost-effective at improving child conduct problems, parental mental health, and parenting skills in the short term (Barlow et al., 2016; Barlow & Coren, 2018). Early-onset behavioural problems are considered a risk factor for adolescent drug use, therefore a reduction in behavioural problems may have preventative effects. However, there is a paucity of research examining the longer-term outcomes of parenting programmes for children. It is therefore unclear whether these types of interventions reduce behaviour problems in adolescents, and/or reduce drug use.

3.22 There is a well-established link between poverty and poor outcomes in children (Costello et al., 2003; Duncan et al., 2017; Wickham et al., 2017). This is particularly evident when poverty accumulates with childhood adverse experiences (see section on ACEs above), wherein children exposed to persistent poverty and childhood adversity are almost three times as likely to use drugs in later life (Adjei et al., 2022). Children living in persistent poverty perceive lower levels of emotional support, further increasing their risk of poor outcomes including drug use (Adjei et al., 2024). There is evidence therefore to suggest a range of integrated and synergistic interventions to improve health outcomes of children and adolescents (Roberts et al., 2016). Parenting interventions have been found to be effective at enhancing the parent-child relationship and improving child and adolescent outcomes (Barlow et al., 2012), with families who experience socioeconomic disadvantage benefitting most in the short-term (Gardner et al., 2017). However, stressful financial situations and family adversity may result in contexts wherein high levels of sustained emotional support may be difficult to achieve (Furlong et al., 2012). As such, family-level interventions may work best when accompanied by ‘upstream’, structural and policy-level interventions (Lorenc et al., 2013) along with ongoing support for disadvantaged families.

3.23 A number of family interventions developed for children up to the age of 18 years and their families, have examined child drug use outcomes (e.g., Solihull Programme, Strengthening Families). Delivery of these programmes in either home or school settings (Allen, 2016) have been reported to reduce young people’s drug use (Allen, 2016; Kumpfer & Magalhães, 2018), and improve prosocial behaviour (Douglas & Johnson, 2019), whilst family-level interventions for multiple risk behaviours were found to have little or no effect on a range of drug use outcomes (MacArthur et al., 2018). Of note, Strengthening Families, a well-known family-based intervention shown to be effective in some US studies, was not effective when implemented in Wales, Poland, Sweden, or Germany (Segrott et al., 2022); highlighting the

importance of evaluating implementation of prevention programmes in new settings.

Family-Based Interventions Supporting Young People Affected by Others' Drug Use

3.24 Family-based interventions that reduce family-level risk factors associated with child drug use play an important part in prevention (Barrett et al., 2023; McGovern et al., 2023; McGovern et al., 2018; McGovern et al., 2020; McGovern et al., 2022; McGovern et al., 2021a). There is a large body of evidence showing that parental use of substances influences their child's own use of substances (McGovern, Gilvarry et al., 2018, McGovern, Gilvarry et al., 2020), with both maternal and paternal substance use being associated with an increased risk (McGovern, Bogowicz et al., 2023). Integrated parenting interventions combining components that target substance use with those that seek to enhance parenting skill and parent-child relationships have been found to reduce the frequency of parental substance use (McGovern, Newham et al., 2021a, McGovern, Newham et al., 2022). These interventions appear most effective when children are not present in sessions (McGovern, 2021a, McGovern, 2022). Families affected by parental substance use often experience cumulative adversity, but there is a lack of interventions that have been found to have combined positive effects. It is likely that families affected by cumulative adversity may benefit from integrated and coordinated services for substance use, mental health and domestic violence (Kedzior et al., 2024).

3.25 Reducing parental substance use is likely to play an important part in preventing child substance use. However, this alone may not be sufficient (McGovern et al., 2021b; Public Health England, 2021), and a focus upon reducing parental risk factors alone may not be sufficient to improve child outcomes (McGovern et al., 2021b). Children may still require intervention in their own right (Barrett et al., 2023; Muir et al., 2022). This may be through assessment and care planning for children affected by family adversity, including parental substance use, and be delivered as practical, emotional and diversionary support. Children may benefit from supportive conversations with a trusted adult, whilst approaches that enhance knowledge of substance use and provide environments within which supportive peer-to-peer relationships are fostered might be effective at improving child substance use outcomes.

4. Devolved Administration Approaches

4.1 Delivery of drug prevention activity in the UK is varied and disconnected. At present there is no integrated, overarching UK prevention approach across the four Home Nations, although all have an ambition to promote drug prevention approaches. Each nation has identified similar problems, including funding, local coordination, attracting and retaining staff, and evaluation.

4.2 Although drug prevention was an important focus of previous UK drug strategies (2010, 2017), few prevention programmes have been delivered in the UK. Unlike drug legislation, drug prevention is a devolved matter and so each of the nations has developed their own strategies, utilising their own health, social care and education delivery systems. Prevention activity has been secondary to treatment, harm reduction, and recovery in all four countries, and data on prevention provision, including coverage of evidence-based programmes and the impact of prevention activities, is currently not routinely collected and is therefore poorly understood across all four nations.

Scotland

4.3 The aim of the Scottish Government's National Mission (launched in January 2021) is to reduce drugs deaths and improve the lives of people affected by drugs. The Mission includes outcomes on preventing and mitigating the harms experienced by children and families and ensuring communities are resilient and supportive.

4.4 Public Health Scotland are currently leading on the development of national whole system approach to substance use harm prevention for children and young people. Publication is expected later in 2025.

4.5 Work was conducted between 2019 and 2020 to understand the suitability of applying the 'Icelandic Model' whole-community approach in Scotland, which informed the subsequent pilot and national roll out of the approach in Scotland Carver et al., 2021). Planet Youth was piloted in five local authorities from 2021 and in 2023, funding was received from Scottish Government for continued work, including wider implementation and evaluation findings are expected later in 2025.

4.6 In terms of school-based prevention, Scotland's Curriculum for Excellence covers substance use as part of the health and wellbeing area and includes education about substance use from primary 1 (age 4-5 years). While the Curriculum for Excellence is Scotland wide, there is variation across local authority areas regarding the provision of prevention activities, who these target, who delivers them and their content.

4.7 Drug and alcohol services in Scotland are devolved to Integrated Joint Boards (IJBs) and in practice are commissioned by Alcohol and Drug Partnerships (ADPs). Each ADP will carry out its own programme of prevention related activity, alongside education on substance use issues in schools.

Specific interventions

4.8 Scotland has a relatively high number of prevention activities being implemented compared with other devolved administrations. Of 128 Scottish prevention programmes, the most common categories were skills based (35%), and school/educational (25%), with the majority (63%) being universal approaches. Furthermore 37% had evaluation embedded, although it is unclear whether findings from these have been published.

4.9 Significant barriers in Scotland identified by Public Health Scotland in response to the ACMD's Call for Evidence included:

- **A lack of funding and resources, budget cuts to public and third sector services at national and local levels:** Funding is frequently allocated to other areas or priorities
- **Multiple, siloed funding streams:** Despite commonality in approaches and desired outcomes, there may be multiple sources of funding for approaches
- **Workforce training and development:** There is a lack of guidance and training in substance use and harm prevention
- **Limited available evidence on implementation:** One of the gaps in research is around the translation of knowledge into practice.

4.10 There are also no recognised competencies for labelled drug prevention roles, which needs to be addressed.

Wales

4.11 *The Welsh Substance Misuse Delivery Plan 2019-22* outlined national priorities, including a focus on prevention to improve population health and wellbeing. Public Health Wales are currently developing an outline for a

prevention strategy and have initiated evidence reviews into risk and protective factors for substance use, including early initiation. Work is also starting on scoping a comprehensive needs assessment for drugs to inform a prevention strategy.

4.12 The School Health Research Network collects data on young people's substance use every two years as part of its student health and wellbeing survey. A new school-level dashboard will further support schools' use of data from the survey.

4.13 Drug prevention generally is a topic that is of lower priority than treatment, harm reduction or enforcement and this is reflected in the funding, resource, specialism, and status of the topic. There are no national drug-specific prevention activities although there are programmes in Wales that have a prevention element, including a range of universal and selective approaches (e.g. the Wales Police Schools Programme). Furthermore, there are a range of public health priorities that may contribute to the prevention of drug use, for example, policies to tackle ACEs, and the DAN 24/7 information service.

Northern Ireland

4.14 The Public Health Agency (PHA) in Northern Ireland is responsible for the commissioning of substance use services. Northern Ireland's drug strategy *A Strategic Framework to Tackle the Harm from Substance Use (2021-31)* was co-produced with a wide range of stakeholders including government departments, health professionals, community and voluntary sector representatives, as well as service users and their families.

4.15 Drug prevention is identified as a component of an integrated and collective approach to drug use. The Strategic Framework notes that:

- Many of the underlying causes of, and harms arising from, substance use are not something that can be tackled by the Department of Health alone
- Tackling multi-faceted societal problems will require the whole Executive to operate collectively, and five population-level outcomes have been developed in the Strategy to tackle these. Examples include: poverty and deprivation; homelessness; employment and economic development; mental health and trauma; paramilitarism, community relations and justice; educational attainment; inequalities; and the legacy of the past.

4.16 Evidence submitted to the ACMD suggested that delivery of prevention activity is not-coordinated. For example, schools tend to bring in speakers to deliver one-off drug awareness talks, whereas other organisations also deliver

drug and alcohol education and awareness programmes in localities but these are not commissioned by PHA.

4.17 Significant barriers faced in Northern Ireland reported to the ACMD include:

- Devolved bodies being aware of various strategies and initiatives but not of how they integrate and cumulatively impact
- There is a dearth of evidence of what would be effective preventive interventions for drug use for young people. This is particularly at a universal and targeted level
- Service providers can find it difficult to attract and retain staff. There is a shortage of practitioners accredited in (family) systemic therapies so many of the NICE guidelines (e.g., CG115) and UK clinical guidelines recommended interventions for young people cannot be delivered
- The continued coercive control of communities by paramilitary groups and their involvement in the drug supply in Northern Ireland
- The overprescribing of tradable prescription drugs within Northern Ireland, compared with the rest of the UK. This overprescribing presents particular issues when people come into custody
- Inflationary pressures and service demand may limit the reach of services. The current commissioning process may only be able to buy less capacity in service delivery, including prevention options.

5. Conclusions

5.1 **The value of drug prevention**: There is international evidence that delivery of drug prevention programmes can reduce the number of young people using drugs, and reduce drug related harms. Drug prevention can also have benefits in other areas associated with healthy development.

5.2 **No allocation of dedicated funding:** There is no dedicated (ring-fenced) yearly funding for drug prevention measures. Whilst prevention is explicitly mentioned in the Government's 10-year drug strategy and in the strategies of the devolved governments, public health bodies are yet to earmark spending on labelled or unlabelled evidence-based drug prevention approaches. See recommendation 3.

5.3 **Lack of evidence on many specific interventions in UK settings (universal, selective, indicated):** Although there is good evidence from international implementations, there is a lack of evidence regarding the effectiveness of these activities in UK settings. There is also lack of research on the effectiveness of most approaches that are currently being delivered at local levels. Adaptation and evaluation of international interventions and approaches with evidence of effectiveness will save time and reduce costs compared to developing brand new approaches. See recommendations 4 and 5.

5.4 **Lack of national coordination:** There is currently no coordinated prevention system or framework in the UK. Although still limited overall, the UK Home Nations are at different stages of maturity in their prevention system. See recommendations 1, 2 and 6.

5.5 **Lack of sufficient overview of prevention activity:** Whilst there are numerous examples of activity described as 'prevention', there is no rigorous systematic monitoring of these prevention activities, their effectiveness, or their value for money. See recommendations 1, 2, 5 and 6

5.6 **Lack of robust evaluation:** A large number of prevention programmes have not been robustly evaluated. This suggests that the Government and taxpayers do not currently have clarity on which programmes generate best outcomes. This lack of evaluation also perpetuates the ongoing challenge of building a UK evidence base.

5.7 **Workforce:** There is currently no UK-wide competence framework for staff working in labelled and unlabelled prevention activities. See recommendation 7.

6. Recommendations

6.1 This report recommends that the UK Government considers the funding of a comprehensive, appropriately funded, evidence-based national drug prevention programme. The benefits of such a programme have the potential to expand beyond reductions in drug use, leading to improvements in health, wellbeing, and life chances.

6.2 Based on the report's findings and conclusions, the following specific recommendations have been made to support the development of an evidence-based, whole-system response to prevention. The recommendations have been divided into two groups:

- Develop, implement, and evaluate a whole-system drug prevention approach
- Specific drug prevention interventions

Develop, implement, and evaluate a whole-system drug prevention approach

Recommendation 1: Understanding the current UK prevention landscape

Government to undertake a stocktake of current prevention activity across the UK, and review alignment of prevention activity with internationally agreed evidence-based prevention standards using the UNODC Review of Prevention System (RePS) tool.

Recommendation intended for: JCDU, DfE, OHID, Combating Drugs Partnerships and equivalent bodies in the devolved administrations

Measure of implementation:

A stocktake will provide baseline data, and a mechanism upon which future development can be monitored. As a minimum, the stocktake should capture:

- Types of prevention activities taking place
- Funding mechanisms and levels of funding
- Evaluation mechanisms and results

- Quality and coherence of the drug prevention system in accordance with international standards.

This exercise should first be piloted across a sample of local Combating Drugs Partnerships (CDPs)/Alcohol and Drug Partnerships (ADPs)/Area Planning Boards (APBs).

Recommendation 2: Monitoring quality

Government to develop a national prevention quality standard and maintain a UK-wide quality dashboard to monitor local delivery of drug prevention activities.

Recommendation intended for: OHID, JCDU, and equivalent bodies in devolved administrations

Measure of implementation:

A national dashboard consisting of Key Performance Indicators (KPIs) of activities and outcomes with mandatory returns from Combating Drug Partnerships (CDPs) in England and the appropriate bodies in the devolved administrations. This should align with a published quality standard for prevention activities.

Recommendation 3: Funding

Government to provide local authorities with ring-fenced, long-term funding specifically for drug prevention according to local need.

Recommendation intended for: LA with oversight by JCDU/OHID and equivalent bodies in devolved administrations

Measure of implementation:

Maintaining funding over a sustained period (minimum 5 years) would allow for embedding of prevention activities and strengthening of local prevention systems.

Funding for prevention should be ringfenced within local budgets with accompanying funding for evaluation.

Prevention funding should be allocated separately to money allocated for treatment, recovery, and harm reduction services.

Recommendation 4: Local leadership

Government to encourage local authorities within CDPs, or equivalent partnerships in devolved administrations, to embed strong local leadership for prevention activities, for example, a coordinator or champion to develop evidence-based drug prevention activity.

Recommendation intended for: LAs and CDPs with oversight from JCDU and equivalent bodies in devolved administrations.

Measure of implementation:

The local Senior Responsible Owner should provide the necessary leadership for the delivery and monitoring of these commitments across multiple local structures.

The coordinator should support the Senior Responsible Owner and could work as part of wider public and community health teams.

Duties for the coordinator should include development of local prevention strategies, and support commissioning and delivery of prevention work as part of a broader portfolio of activity.

JCDU or the equivalents in the devolved nations should keep a record of the coordinators and support networking, and knowledge exchange.

Recommendation 5: National leadership

Based on the role of the current national Recovery Champion, Government should consider establishing a similar role for prevention. The role holder would support the Government at national and local levels, and help strengthen prevention action to champion and make prevention more visible. If this recommendation is not accepted, then Government should ensure that prevention responsibilities are included within the portfolio of relevant senior roles to ensure parity with treatment, harm reduction, and recovery.

Recommendation intended for: Home Office and JCDU, and equivalent bodies in devolved administrations.

Measure of implementation:

Establishment and maintenance of a role. Annual reporting to Government

Recommendation 6: Competence Framework

Government to develop a UK-wide competence framework for evidence-based prevention activities to include labelled and unlabelled work.

Recommendation intended for: JCDU, OHID, DfE, Local Authorities, CDPs and equivalent bodies in devolved administrations.

Measure of implementation:

The ACMD does not recommend the establishment of a dedicated drug prevention practitioner role, as drug prevention activity is the responsibility of professionals working across many sectors.

Instead, any professional involved in prevention activities should be trained against relevant competencies (labelled and unlabelled) to assure the quality of their work.

Training should be based on the model provided by the European Prevention Curriculum (EUPC), adapted for the UK. All staff with responsibilities for delivery of prevention work should complete non-specialist training.

Staff delivering labelled prevention work should be certified by an accredited body to demonstrate specialist competencies. We recommend restricting labelled prevention work to certified providers, including external providers in educational settings.

A quality mark should be introduced to indicate that provider organisations meet standards of evidence-based prevention, with development of associated quality criteria.

Specific prevention interventions

Recommendation 7: Specific interventions

Government to prioritise investment in the development and delivery of evidence-based universal, selective and indicated approaches, including those recommended in this report, so they are properly resourced and implemented.

Recommendation intended for: CDPs, Local Authorities with oversight from JCDU, OHID and devolved administrations

Measure of implementation:

Approaches include the interventions highlighted in this report (see below):

- Universal approaches
    - Whole-community approaches

    - Whole-school approaches (including links to England-only mental health support teams)
    - Parent/carer-based prevention
- Selective interventions
    - Interventions targeting multiple health risk behaviours and comorbidities, in particular common mental health disorders
- Indicated interventions
    - Family-based interventions targeting children and young people's drug use
    - Family based interventions to support children and young people affected by others' drug use (e.g., parental drug use)
- Evidence and practice underpinning delivery of recommended interventions should be embedded into learning modules as part of the training and competencies recommended.

In addition, adaptation of interventions shown to be effective internationally and novel interventions with embedded evaluation should be considered.

The ACMD supports delivery of interventions that correspond with the UNODC/WHO International Standards on Drug Use Prevention, but only when they are properly resourced and implemented.

Recommendation 8: Evaluation, innovation and research funding

Government to increase funding to support a dedicated long-term approach to evaluation, innovation and research to develop the UK drug prevention evidence base.

Recommendation intended for: HM Treasury, JCDU, Home Office, Local Authorities and devolved administrations

Measure for implementation:

Considering the lack of evidence base for many prevention interventions, all prevention activities should have mandatory embedded robust and independent evaluation.

A long-term approach to innovation and research should prioritise the development, testing, and evaluation of the effectiveness and cost effectiveness and impact of interventions, their scalability, and the systems changes required to support delivery.

This could be based on, for example, the 'What Works Network' approach, and in particular the work undertaken by organisations such as the Youth Endowment Fund in the field of violence prevention. The Washington State Institute for Public Policy

may provide a useful model in terms of evaluating the cost-benefit of drug use prevention programmes.

Annex A: ACMD Prevention Committee membership, at time of publication

Professor Anne Campbell	Professor of Substance Use and Mental Health, and Co-Director of the Drug and Alcohol Research Network at Queens University, Belfast
Angela Hall	Commissioner in North Yorkshire and member of the English Substance Use Commissioners Group.
Dr Brendan Collins	Senior Lecturer - Public Health Economics, Department of Public Health, Policy & Systems, University of Liverpool
Professor Derek Tracy	Chief Medical Officer, South London and Maudsley NHS Foundation Trust
Dr Hannah Carver	Senior Lecturer in Sociology, Social Policy and Criminology, University of Stirling
Professor Harry Sumnall	Professor in Substance Use, Liverpool John Moores University (LJMU)
Jennifer Rushworth-Claeys	Director of Young Person Services, WithYou
Professor Karen Duke	Professor in Criminology, University of Middlesex
Mohammed Fessal	Chief Pharmacist, Change Grow Live
Nicholas Hickmott	Early intervention lead, We are With You
Professor Owen Bowden-Jones	Chair of ACMD Prevention Committee Chair of Advisory Council on the Misuse of Drugs; Consultant Psychiatrist, Central North-West London NHS Foundation Trust
Professor Ruth McGovern	Senior Lecturer in Public Health Research at the Population Health Sciences Institute. Research: Social and psychological interventions
Professor Steve Allsop	Professor National Drug Research Institute at Curtin University
Dr Jeremy Segrott	Senior Lecturer, Centre for Trials Research, Cardiff University.
Dr Lindsey Hines	Lecturer in Psychology, University of Bath
Professor Vashti Berry	Professor in Prevention Science, University of Exeter NIHR Applied Research Collaboration South West Peninsula (PenARC)

Annex B: ACMD membership, at time of publication

Professor Judith Aldridge	Professor of Criminology at University of Manchester
Professor Owen Bowden-Jones	Chair of Advisory Council on the Misuse of Drugs; Consultant Psychiatrist, Central North-West London NHS Foundation Trust
Professor Anne Campbell	Professor of Substance Use and Mental Health, and Co-Director of the Drug and Alcohol Research Network at Queens University, Belfast
Dr Caroline Copeland	Senior Lecturer in Pharmacology & Toxicology, King's College London. Director, National Programme on Substance Use Mortality
Professor Colin Davidson	Professor of Neuropharmacology, University of Central Lancashire
Mr Mohammed Fessal	Chief Pharmacist, Change Grow Live
Professor Amira Guirguis	Professor of Pharmacy, MPharm Programme Director and Deputy Pro Vice Chancellor at Swansea University
Dr Hilary Hamnett	Associate Professor in Forensic Science, University of Lincoln
Mr Jason Harwin	Director and Co-founder of E-T-E Solutions Limited
Professor Graeme Henderson	Honorary Professor of Pharmacology, School of Physiology, Pharmacology & Neuroscience, University of Bristol
Professor Katy Holloway	Professor of Criminology, University of South Wales
Dr Carole Hunter	Chair SDF Board. Doping Control Officer UK Antidoping
Professor Stephen Husbands	Professor of Medicinal Chemistry, University of Bath
Professor Roger Knaggs	Professor in Pain Management and Clinical Pharmacy Practice, University of Nottingham
Mrs Sapna Lewis	Senior Lawyer, Welsh Government Legal Services Department
Mrs Fiona Spargo-Mabbs	Director and Founder, Daniel Spargo-Mabbs Foundation. Chair, Drug Education Forum.
Dr Richard Stevenson	Emergency Medicine Consultant, Glasgow Royal Infirmary
Professor Paul Stokes	Professor of Mood Disorders and Psychopharmacology, King's College London
Professor Harry Sumnall	Professor in Substance Use, Liverpool John Moores University (LJMU)
Professor Simon Thomas	Emeritus Professor of Clinical Pharmacology and Therapeutics, Newcastle University

Professor Derek Tracy	Chief Medical Officer, South London and Maudsley NHS Foundation Trust
Ms Rosalie Weetman	Public Health Lead (Alcohol, Drugs and Tobacco), Derbyshire County Council and Programme Manager, Drug and Alcohol Improvement Support Team
Dr David Wood	Consultant Physician and Clinical Toxicologist, Guy's and St Thomas' NHS Foundation Trust and Reader in Clinical Toxicology at King's College London
Professor Karen Ersche	Professor of addiction neuroscience at the University of Cambridge and an adjunct Professor of Translational Addiction Research at the Central Institute of Mental Health in Mannheim at the University of Heidelberg in Germany
Professor Sunjeev Kamboj	Professor of translational clinical psychology at University College London and an honorary consultant clinical psychologist in the North London Foundation NHS Trust.
Dr Lorna Nisbet	Principal Investigator for Forensic Toxicology at the Leverhulme Research Centre for Forensic Science, University of Dundee.
Jon Privett	Detective Sergeant and Expert Witness in Drug Trafficking, Metropolitan Police Service

Annex C: Quality of evidence

This report drew on evidence from peer-reviewed literature (UK and international publications), government reports and considered international approaches. Evidence gathered was considered in line with the ACMD's standard operating procedure for quality of evidence (ACMD, 2020).

The ACMD welcomed submissions via a public Call for Evidence.

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