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A Review of the Existing Literature and Evidence on Young People Experiencing Harms from Alcohol and Drugs in Scotland



HEALTH AND SOCIAL CARE



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Health & Social Care Analysis

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Executive Summary

This report provides a review of the existing literature and evidence base relating to alcohol and drug harms experienced by children and younger people (<25 years) in Scotland. It provides an up-to-date overview of the latest data on prevalence and harms related to alcohol and drug use among children and younger people. It then explores the risk factors contributing to harms among this population, and identifies a number of groups particularly vulnerable to these harms. The review then outlines the treatment and recovery services available to younger people in Scotland, before exploring the wider evidence base on effective alcohol and drug services for younger people. It draws to a close by highlighting a number of key areas for future research.

The key findings are;

- there are signs of increasing harms from alcohol and drugs among younger people, with the emergence of a particularly strong trend for drug-related hospitalisations and deaths;
- the profile of drugs causing harms, particularly hospital admissions, among younger people are markedly different to those among older age-groups;
- a range of risk factors can be identified which increase the likelihood of developing harms from alcohol and drug use, rooted foremost in socioeconomic determinants, and;
- there is wide geographic variation in provision of treatment and recovery services for younger people experiencing harms from alcohol and drugs in Scotland, and little evidence of tier 3 and 4 services addressing the specific needs of younger people.

From these key findings a number of recommendations are made, which relate to;

- addressing the (primarily structural) social determinants of alcohol and drug use;
- improving access to alcohol and drug treatment services for younger people, and;
- improving the provision of such services in light of the different developmental needs and different drug-profile causing harms in younger people.

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1. Background and Overview

1.1 Overview

The level of harms from alcohol and drugs in Scotland are high in comparison to the rest of the UK and Europe, and cause avoidable damage to people's lives, families and communities.

The country is in the midst of a drug death crisis. The 1,339 drug-related deaths reported in 2020 was the highest number ever recorded in Scotland for the sixth consecutive year, was around five times higher than across the rest of the UK, and was higher than any other European country¹. This crisis is also reflected in rising drug-related hospital admissions and harms. Alcohol-related harms also remain high in Scotland, with 1,190 alcohol-specific deaths in 2020² and over 35,000 hospital stays in 2019/20³.

While these trends have been driven primarily by older (although still young) age-groups, it is important to note that alcohol and drug-related problems often emerge at a younger age. Over 70% of those accessing Tier 3 and 4 treatment services⁴ for problem drug use in 2015/16 started using drugs under the age of 25, with a median age of 15⁵. Three-quarters (75%) of those who died from drug-related causes in 2015/16 had been using drugs for 10 years or more, and 43% for 20 years or more⁶. Further, the data presented throughout this report also shows worrying signs of increasing alcohol and drug-related harms among those of younger ages. Taking action on the determinants of problematic alcohol and drug use among younger people is therefore vital to prevent the emergence of another cohort of individuals vulnerable to these avoidable harms as they grow older.

1.2 Policy Background

Preventing harms from alcohol and drugs among children and younger people is a broad agenda which cuts across many Ministerial portfolios. Reducing the harms caused by drugs and alcohol (alongside tobacco), forms one of the Scottish

¹ National Records of Scotland (July. 2021). Drug-related deaths in Scotland in 2020. Available at: [Drug-related deaths in Scotland in 2020, Report \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk/publications/drug-related-deaths-in-scotland-in-2020-report)

² NRS Scotland (Aug. 2021). Vital Events – Deaths – Alcohol Deaths - Alcohol-specific deaths. Available at: [Alcohol-specific deaths 2020, Main Points \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk/publications/alcohol-specific-deaths-2020-main-points)

³ ISD (Nov 2019). Alcohol-Related Hospital Statistics Scotland 2018/19. Available at: [Alcohol related hospital statistics - Scotland financial year 2019 to 2020 - Alcohol related hospital statistics - Publications - Public Health Scotland](https://www.isdscotland.org/Health-Topics/Alcohol-Misuse/Publications/2018-06-26/2018-06-26-SDMD-Report.pdf)

⁴ Tier 3 and 4 Treatment services refers to structured community and residential treatment

⁵ NHS National Services Scotland, Information Services Division (Jun. 2018). Scottish Drug Misuse Database: Overview of Initial Assessments for Specialist Drug Treatment 2016/17. Available at: <https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2018-06-26/2018-06-26-SDMD-Report.pdf>

⁶ NHS National Services Scotland, Information Services Division (Jun. 2018). The National Drug Related Deaths Database Report: Analysis of Death Occurring in 2015 and 2016. Available at: <https://www.isdscotland.org/Health-Topics/Drugs-and-Alcohol-Misuse/Publications/2018-06-12/2018-06-12-NDRDD-Report.pdf>

Government's six Public Health Priorities, outlined in 2018⁷. This work is in line with the Scottish Government drug and alcohol strategies published in 2018;

- *Rights, Respect and Recovery*⁸, which sets out Scotland's strategy to improve health by preventing and reducing alcohol and drug use, harm and related deaths;
- *Alcohol Framework 2018: Preventing Harm*⁹, which provides an updated framework setting out Scotland's national prevention aims on alcohol, endorsing the World Health Organisation's Safer initiative of five evidence-based strategies that governments should prioritise to tackle alcohol-related harm¹⁰.

Both of these strategies place a central focus on actions aimed at protecting young people from short and longer-term harms from drugs and alcohol. This project has been explicitly developed to support Action 4 from the *Rights, Respect and Recovery Action Plan*¹¹;

'We will develop a comprehensive approach to early intervention among young people who are at risk, through deprivation, inequality or other factors, of developing problem alcohol and drug use.'

Further, on 20th January 2021, the First Minister made a statement¹² to parliament which set out a National Mission to reduce drug deaths through improvements to treatment, recovery and other support services.

Preventing harms among children and young people from alcohol and drugs also contributes to a wide range of the national outcomes set out in the National Performance Framework. This is most directly relevant in the areas of 'children and young people' (that we 'grow up loved, safe and respected so that we realise our full potential') and 'health' (that 'we are healthy and active'), but also holds clear relevance for outcomes across Communities, Education, Human Rights and Poverty.

Preventing harms from alcohol and drugs among children is also central to the Getting it Right of Every Child (GIRFEC) approach and its eight indicators of wellbeing¹³. These indicators aim to ensure that every child and young person is;

⁷ Scottish Government and COSLA (2018) Public Health Priorities for Scotland. Available at: <https://www.gov.scot/publications/scotlands-public-health-priorities/>

⁸ Scottish Government (Oct. 2019). Rights, Respect and Recovery: Action Plan. Available at: <https://www.gov.scot/publications/rights-respect-and-recovery-action-plan/>

⁹ Scottish Government (Oct. 2019). Alcohol framework 2018: Preventing Harm. Available at: <https://www.gov.scot/publications/alcohol-framework-2018-preventing-harm-next-steps-changing-relationship-alcohol/>

¹⁰ World Health Organization (2018) SAFER initiative. Available from: https://www.who.int/substance_abuse/safer/launch/en/

¹¹ Scottish Government (Oct. 2019). Rights, Respect and Recovery: Action Plan. Available at: <https://www.gov.scot/publications/rights-respect-and-recovery-action-plan/>

¹² Scottish Government (Jan 2021). Drugs policy - update: statement by the First Minister - 20 January 2021. Available at: <https://www.gov.scot/publications/update-drugs-policy/>

¹³ Scottish Government (2019). Getting it right for every child (GIRFEC). Available at: [Getting it right for every child \(GIRFEC\) - gov.scot \(www.gov.scot\)](https://www.gov.scot/publications/getting-it-right-for-every-child-girfec/)

safe, healthy, achieving, nurtured, active, respected, responsible and included (SHANARRI), with this work primarily relevant to keeping children safe, healthy, achieving and responsible.

1.3 Aims

In supporting Action 4 of the RRR framework, this report aims to:

1. Provide an up-to-date overview of the latest data pertaining to younger people (<25 years) experiencing harms from drugs and alcohol use.
2. Draw on the Scottish, UK and international literature to give a greater understanding of the nature and extent of the health and social harms being experienced by younger people through hazardous or harmful alcohol and/or problem drug use, both in the short and longer term.
3. Explore the risk factors underpinning these harms, and the population groups most vulnerable to them, and;
4. Deepen our understanding of the range, nature and suitability of existing treatment and recovery services for younger people experiencing harms from alcohol and drug use in Scotland.

While parental problematic alcohol and drug use forms a considerable issue in Scotland – and provides a risk factor for the development of problematic alcohol and drug use in their children – this report places primary focus on hazardous/harmful alcohol and problem drug use as undertaken by children and younger people.

1.4 Methodological Approach

The report draws on a rapid review of the existing literature and evidence base relevant to children and younger people experiencing harms from alcohol and drug use. Given the broad scope of such a project, the relatively brief time frame within which the report was compiled did not allow for a fully comprehensive or systematic review of the relevant literature. A focus was placed on key data sources relevant to children and young people in the Scottish context. The multifaceted nature of this review also meant that the use of a strict set of methodological criteria or filters would have been difficult across the range of factors studied.

1.5 Structure of report

Following this introduction, Chapter 2 provides the latest data the prevalence of alcohol and drug use and associated harms experienced by younger people in Scotland. Chapter 3 then explores the risk factors for harms from alcohol and drugs in this population and identifies a number of younger populations vulnerable to alcohol and drug harms. Chapter 4 examines the existing treatment and recovery services available to younger people across Scotland, explores barriers to their uptake and examines evidence of the kind of services work among this population. Chapter 5 summarises the key points of the report, and draws out recommendations for policy and further research.

2. Alcohol and Drug Use Prevalence and Harms: Latest Data and Trends

2.1 Overview and Key Findings

This section provides the latest data on the prevalence of alcohol and drug use among children and younger people (<25 years) in Scotland, with a focus on problematic use as opposed to experimental or occasional use. It also provides the latest data on health-related harms and wider harms experienced by this population group from alcohol and drugs.

The key findings are that;

- The proportion of children (<16 years) drinking alcohol increased between 2015 and 2018 following a long period of decline.
- Drug use among children has remained relatively unchanged since 2006, but has increased among boys since 2013.
- Among children, alcohol-related hospital stay rates have decreased steadily over time, but drug-related hospital stay rates have trebled since 2010/11.
- Alcohol consumption is at its lowest level among younger people (16-24 years) since records began. However, AUDIT scores suggest that hazardous drinking and possible alcohol dependence are higher among those aged 16-24 years than any other age group.
- While alcohol-specific deaths remain very low among those under the age of 25 years, with 3 reported deaths in 2020, the wider measure of alcohol-attributable deaths shows that alcohol was implicated in nearly one in five deaths among those aged 15-24 years in 2015.
- Having declined between 2007/08 and 2016/17, alcohol-related hospital stay rates have since increased among younger people (15-24 years) over three consecutive years.
- Drug use (including experimental, occasional and recreational use) is more common among younger people than older age groups, decreasing with age. However, it is older (but still young) age groups – particularly 35-45 year-olds – who are experiencing the most harms, with considerably higher rates of both hospital stays and deaths.
- Drug-related deaths among younger people (<25 years) have more than doubled since 2017, with 78 deaths recorded in 2020.
- Recent years have seen the emergence of a trend towards increasing drug-related hospital admissions among younger people (15-24 years). While both sexes have seen increases in drug-related hospitalisations in recent years, these trends have been particularly driven by an increase among males
- The profile of drugs implicated in drug-related hospital stays among this age-group is markedly different than those of older age groups, while the profile contributing to deaths is more in line with adult data.

2.2 Alcohol and Drug Use Prevalence

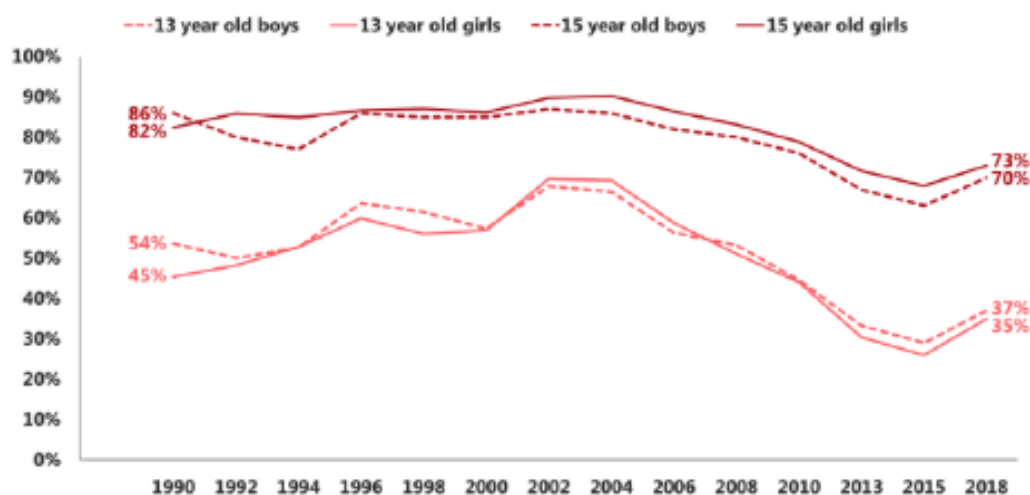
2.2.1 Alcohol and Drug Use among Children

The Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2018¹⁴ provides the latest data on the prevalence of alcohol and drug use among 13 and 15 year old children across Scotland. This survey data is limited by potential response bias and underreporting, and does not allow for strong conclusions to be drawn regarding hazardous/harmful alcohol use and problem drug use (although any use among children risks both short- and longer term health and social harms).

Following a sustained decline, a greater proportion of children are consuming alcohol

- The proportion reporting having ever had an alcoholic drink had been steadily decreasing since 2004, but increased considerably across all groups between 2015 and 2018 (Figure 2.1). For 13 year-olds, rates increased from 29% to 37% for boys and 26% to 35% for girls. For 15 year-olds, rates increased from 63% to 70% for boys and 68% to 73% for girls.
- Drinking in last week was reported by 6% of 13 year olds and one-in-five (20%) 15 year olds (Figure 2.2). Having broadly declined since 2004, there has been an increase between 2015 and 2018 for boys of both ages (from 4% to 7% for 13 year-olds and from 16% to 20% for 15 year-olds), and for 13 year-old girls (from 4% to 6%).

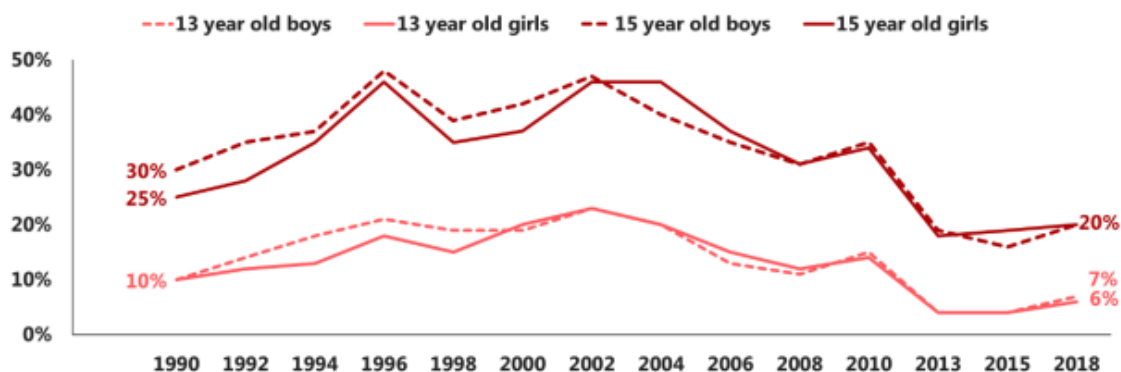
Figure 2.1 – Proportion of Pupils who have Ever Drank an Alcoholic Drink (1990-2018)



Source: SALSUS 2018

Figure 2.2 – Proportion of Pupils Drinking in Last Week (1990-2018)

¹⁴ Scottish Government (2019). Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2018. Available at: <https://www.gov.scot/collections/scottish-schools-adolescent-lifestyle-and-substance-use-survey-salsus/>

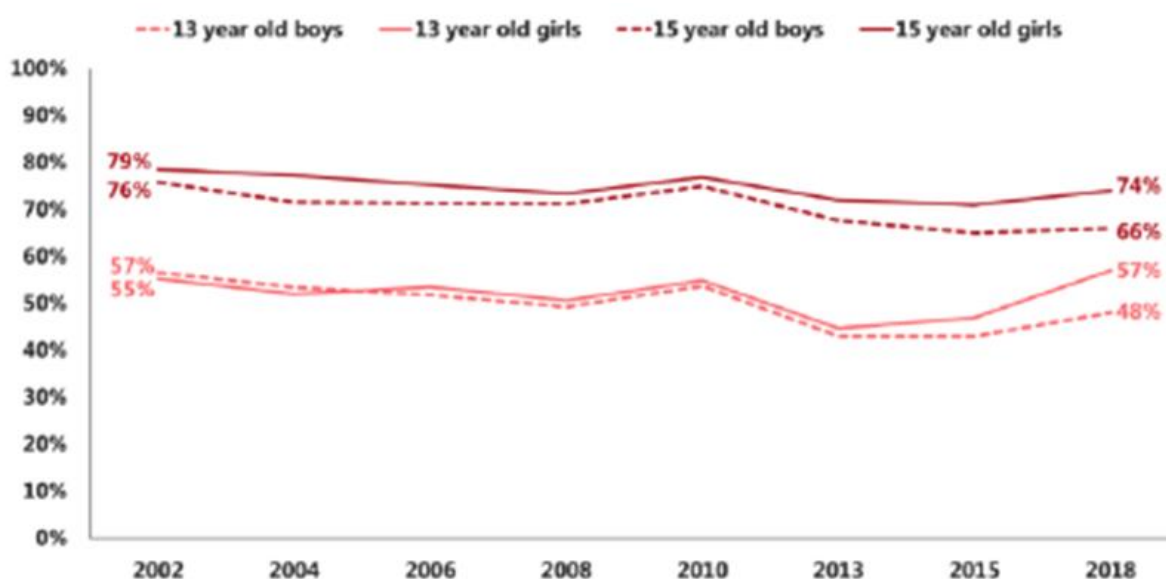


Source: SALSUS 2018

More children are consuming alcohol in risky consumption patterns

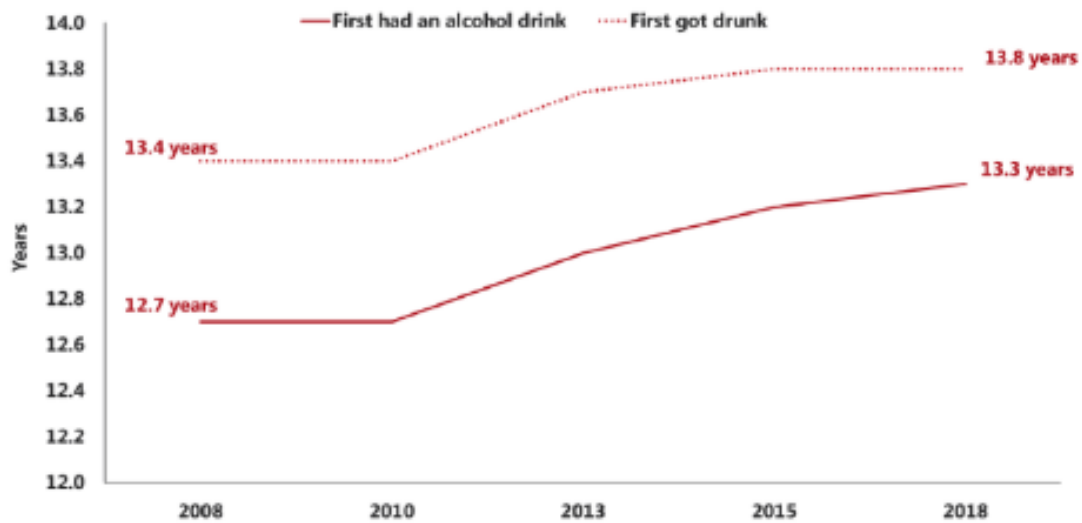
- Having declined slightly between 2002-2015, the proportion having been drunk at least once increased among all groups except 15 year-old boys between 2015 and 2018 (Figure 2.3). Just over half (53%) of 13 year-olds and around two-thirds (70%) of 15 year-olds had ever been drunk. Four percent of 13 year-olds and one-in-five (21%) 15 year-olds reported having been drunk more than 10 times. Among those drinking in the last week, over half (52%) of 13 year-olds and 57% of 15 year-olds had been drunk, with rates among 13 year-old boys having increased from 43% to 51%.
- The long-term trend towards an increasing age of first getting drunk has halted. While the age at which children first tried alcohol increased by 2 months to 13 years and 4 months in 2018, following long-term trends, the age at which pupils first got drunk (13.8 years) has not changed since 2015 (Figure 2.4).

Figure 2.3 – Proportion of pupils who have ever had an alcohol drink who have ever been drunk (2002-2018)



Source: SALSUS 2018

Figure 2.4 – Mean age at which 15 year-old pupils who have ever had an alcoholic drink first had an alcoholic drink and first got drunk (2008-2018)



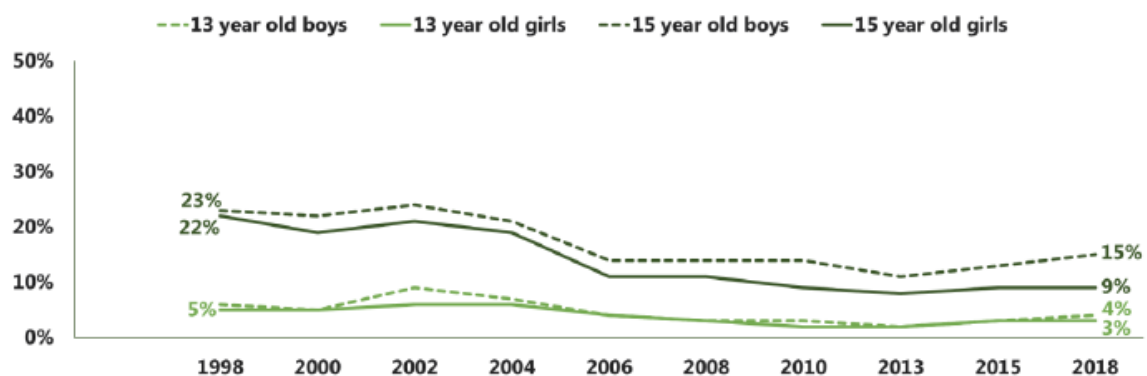
Source: SALSUS 2018

Drug use among children has remained relatively steady over time

While having remained steady since 2006, drug use among boys has been increasing since 2013¹⁵.

- In 2018, 6% of 13 year-olds and 21% of 15 year-olds reported having ever used drugs. While drug use in the last month has remained relatively steady since 2006 (Figure 2.5), prevalence rates have increased among boys since 2013 (from 2%-4% of 13 year-old boys and from 11%-15% of 15 year-old boys between 2013 and 2018).

Figure 2.5 – Proportion of Pupils who Used Drugs in the Last Month (1998-2018)

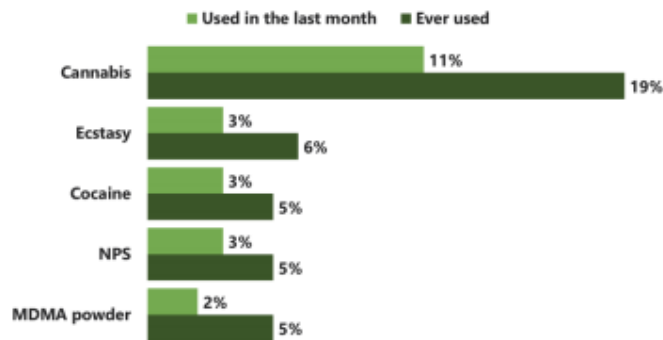


Source: SALSUS 2018

¹⁵ Scottish Government (Nov. 2019). Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS): drug use report 2018. <https://www.gov.scot/publications/scottish-schools-adolescent-lifestyle-substance-use-survey-salsus-drug-use-report-2018/>

- **Drug Use Profile** – Cannabis was the most widely used drug among 15 year old children (19% ever, and 11% in the last month), followed by ecstasy (6% ever and 3% in last month) cocaine (5% and 3%), MDMA powder (5% and 2%) and Novel Psychoactive Substances (NPS) (5% and 3%). There have been no statistically significant changes in these rates since 2015 (Figure 2.6).

Figure 2.6 – Drugs used in last month and ever (15 year-olds) (2018)



Source: SALSUS 2018

- **Poly-Drug Use** – Among those who had ever used drugs, 16% of 13 year-olds and 15% of 15 year-olds had used more than one drug the last time they used drugs. Rates have remained steady across both ages between 2015 and 2018.
- **Consumption with Alcohol** – Thirty-one percent of 13 year-olds and 42% of 15 year-olds who had ever used drugs were drinking alcohol the last time they used drugs. Rates had notably decreased between 2010 and 2013, but has since risen among 15 year old boys. Rates were higher in girls than boys.
- **Problem Drug-Use Indicators** – Of those who had ever used drugs, one in ten (10%) 13 year-olds and 7% of 15 year-olds reported feeling like they needed help due to their drug use. These proportions have remained stable over time, with no significant differences between boys and girls.

2.2.2 Alcohol and Drug Use Prevalence (15-24 Years)

Younger People: Alcohol Use

The Scottish Health Survey (SHeS) 2019¹⁶ provides the latest data on alcohol consumption among those aged 16 and over in Scotland. Again, this survey data is somewhat limited by underreporting and response bias.

The data showed;

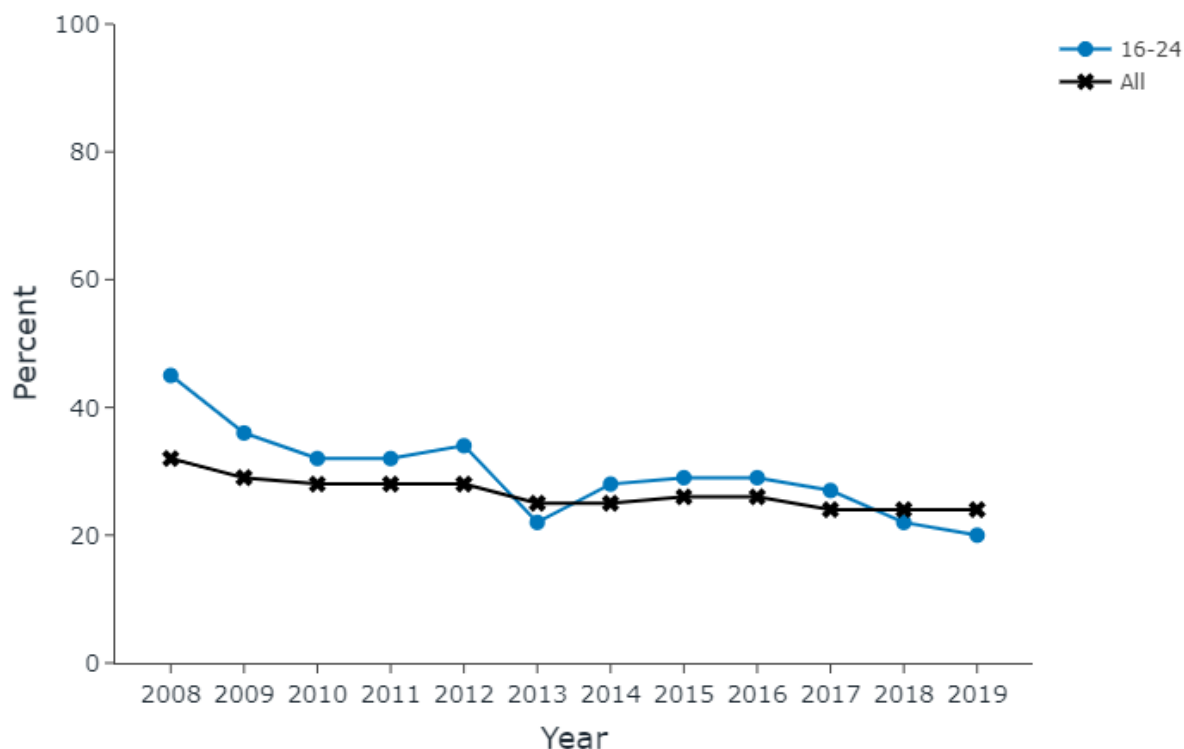
- In 2019, self-reported alcohol consumption among younger people (16-24 years) reached its lowest level since recording began in 2008. The reported average consumption of 10.0 units per week (drinkers only) was less than half of that in 2008 (21.6 units).
- An increasing proportion are abstinent. Sixteen percent are non-drinkers; more than double that in 2008 (7%).
- Younger people continue to consume less alcohol than other adult groups. The average per-week consumption was lower than the average seen across all ages (12.0 units). Of other adult groups, only those over 75 consume less.
- Younger people drink less frequently than older age groups – Zero percent of respondents stated that they drank on five or more days in the previous week; lower than all older age-groups.
- The proportion binge drinking has declined across the past decade but remains high – In 2019, the proportion drinking more than 4 units (males) or 3 units (females) on their heaviest drinking day was 32%, far lower than the 52% in 2009. Twenty-two percent reported drinking over 8 units (males) or 6 units (females) on their heaviest drinking day, again considerably lower than in 2008 (35%). However, the proportion drinking over 8 or 6 units was the joint highest figure across all ages, with greater prevalence among males (25%) than females (18%).

SHeS also reports on hazardous, harmful and dependent drinking. Defining hazardous/harmful drinking as the consumption of more than 14 units per week, the survey found that;

- Fewer younger people are engaging in hazardous or harmful alcohol consumption than previously – Having peaked at 45% in 2009, hazardous/harmful alcohol consumption among those aged 16-24 has declined over the past decade to 20% in 2019 (Figure 2.7). This was lower than the average of 24% across all ages. Rates were twice as high among males (28% in comparison to 13% among females).

¹⁶ Scottish Government (Sept. 2020). Scottish Health Survey 2019 – Volume 1: Main Report. Available at: <https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/>.

Figure 2.7 – Hazardous/Harmful Alcohol Consumption 2008-2019 (Age 16-24 years and all ages)



Source: Scottish Public Health Survey 2019

Using the Alcohol Use Disorders Identification Test (AUDIT) in order to determine the levels of hazardous, harmful or dependent alcohol use¹⁷, the survey reports;

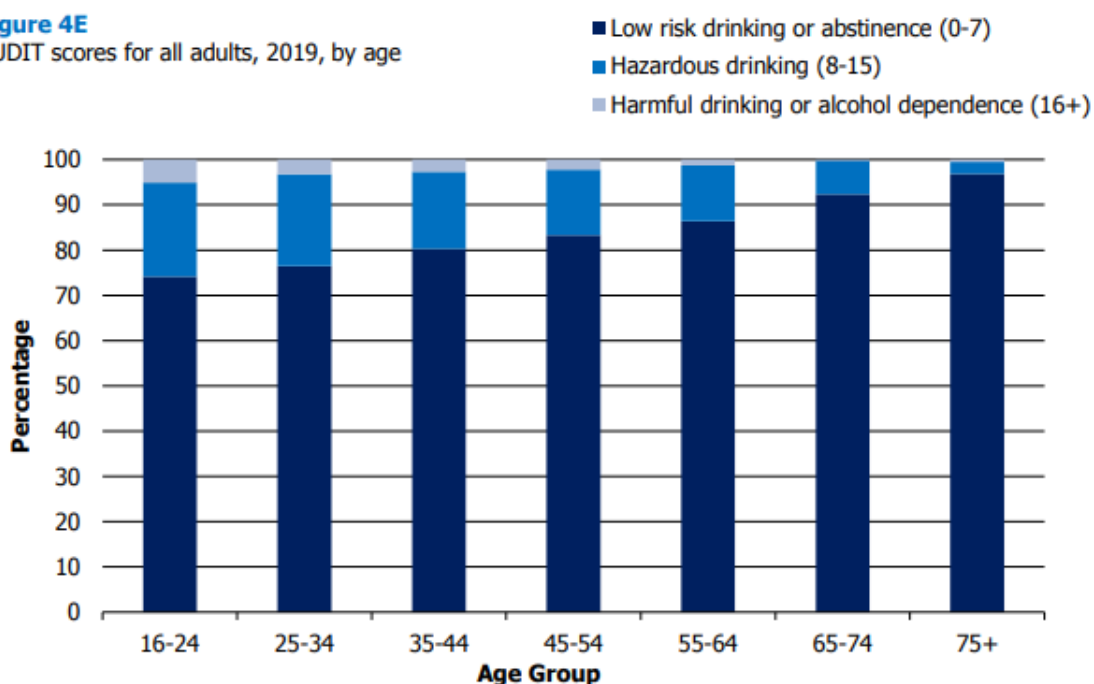
- Hazardous drinking is most common among younger people - 16-24 year-olds exhibited the highest rates of hazardous drinking (21%); greater than the average across all ages (14%) (Figure 2.8). Hazardous drinking was slightly greater among males (22%) than females (21%), with this gap considerably smaller than other age groups (Figure 2.9).
- Harmful drinking is relatively rare among younger people – Comparable with the low rates seen across all ages, 1% of those aged 16-24 years engaged in harmful drinking.
- Dependant drinking is more common among younger people – Those aged 16-24 years (4%) were more than twice as likely to exhibit drinking patterns suggestive of alcohol dependence than any other age-category. Rates of possible alcohol dependence were similar among males and females.

¹⁷ AUDIT is widely considered to be the best screening tool for detecting problematic alcohol use. It comprises ten indicators of problem drinking: three indicators of consumption, four of use of alcohol considered harmful to oneself or others, and three of physical dependency on alcohol. Given the potentially sensitive nature of these questions, they were administered in self-completion format for all participants. A Score of 0-7 indicates 'low risk drinking/abstinence', 8-15 indicates 'hazardous drinking', 16-19 indicates 'harmful drinking', and possible alcohol dependence is indicated by a score of 20 or more.

Figure 2.8 – AUDIT Scores for all adults by age (2019)

Figure 4E

AUDIT scores for all adults, 2019, by age



Source: Scottish Public Health Survey (SHeS) 2019

A recent study by Public Health Scotland¹⁸ triangulated self-reported data from SHeS 2015 with alcohol sales data to adjust alcohol consumption estimates to a more realistic level. This analysis suggested that;

- the 21.61 grams per day reported by males aged 16-24 was around half of their estimated actual consumption of 37.39 grams, and;
- the 12.29 grams reported by females aged 16-24 was considerably smaller than the adjusted estimate of 21.27 grams per day¹⁹.

While the 9.9 litres of pure alcohol sold per adult in Scotland in 2019 was lower than in 2015 (10.8 litres), similar adjustment would result in considerably higher estimates for consumption in 2019.

¹⁸ ScotPHO, NHS Public Health Scotland (2018). Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland. Available at:

<https://www.scotpho.org.uk/media/1597/scotpho180201-bod-alcohol-scotland.pdf>

¹⁹ One unit is equivalent to 8 grams of pure alcohol.

Younger People: Drug Use

The *Scottish Crime and Justice Survey (SCJS) 2018/20*²⁰ provides the most recent prevalence data for drug use among those aged 15-24 years. Given the criminal justice orientation of the survey, it is likely to be even more limited by underreporting.

- Drug use is far more common among younger people – Nearly one in ten (23.5%) of those aged 16-24 had taken drugs in the 12 months prior to survey. This was the highest proportion of any age group, and over ten times higher than among those aged 60 and over (1.6%).
- Cannabis is by far the most commonly used drug – Cannabis was the most frequently used in the previous 12 months (21.4%), followed by cocaine (7.9%), ecstasy (5.6%), ketamine and LSD (both 3.6%). Drug use was higher among males (30.4%) than females (25.1%). 4.9% of those aged 16-24 years reported having ever used ‘legal highs’.
- Most young people first try drugs in their teens – Most of those aged 16-24 years first used drugs aged 16-19 years (54.3%), followed by 10-15 years (12.7%) and 20-24 years (8.7%). 0.9% used drugs when less than 10 years old.²¹

2.3 Alcohol and Drug Harms

2.3.1 Alcohol-Related Health-Harms

Alcohol-Related Hospital Admissions

Information Services Division’s *Alcohol-Related Hospital Statistics Scotland 2019/20*²² provides the latest data on alcohol-related hospital statistics for Scotland.

For those aged 15-24 years, the data shows that;

- Alcohol-related hospital stay rates are increasing again – After a sustained decline between 2007/08 and 2016/17, the past three years have seen an increase in stay rates. In 2019/20, the hospital stay-rate was 351.7 per 100,000 (Figure 2.9). While far lower than in 2007/08, this is a 15.4% increase on the rates in 2016/17.
- Hospital admissions remain lower than any older age group – They are around a third of the stay-rates among those aged 55-64 years, and around half of the Scottish average across all ages.

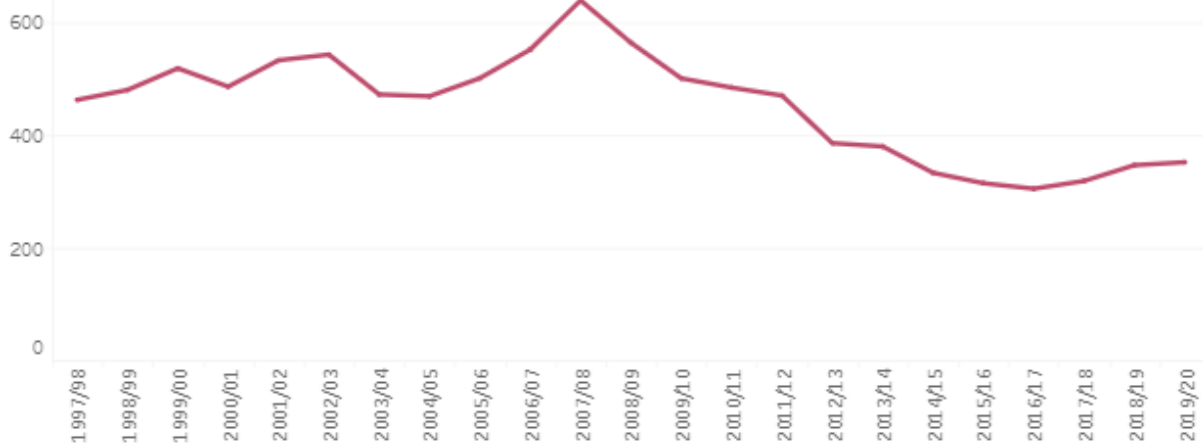
²⁰ Scottish Government (Mar. 2021). *Scottish Crime and Justice Survey 2018/20: main findings*. Available at: <https://www.gov.scot/publications/scottish-crime-justice-survey-2018-19-main-findings/>

²¹ Scottish Government (Mar. 2019). *Scottish Crime and Justice Survey 2017/18: main findings*. Available at: <https://www.gov.scot/publications/scottish-crime-justice-survey-2018-19-main-findings/>

²² ISD (Nov 2020). *Alcohol-Related Hospital Statistics Scotland 2019/20*. Available at: [Alcohol related hospital statistics - Scotland financial year 2019 to 2020 - Alcohol related hospital statistics - Publications - Public Health Scotland](https://www.gov.scot/publications/alcohol-related-hospital-statistics-scotland-financial-year-2019-to-2020-alcohol-related-hospital-statistics-publications-public-health-scotland/)

- Rates are considerably higher among males – Across the time series, males have had far higher hospital stay rates than females; 385.2 and 318.2 per 100,000 in 2019/20, respectively.

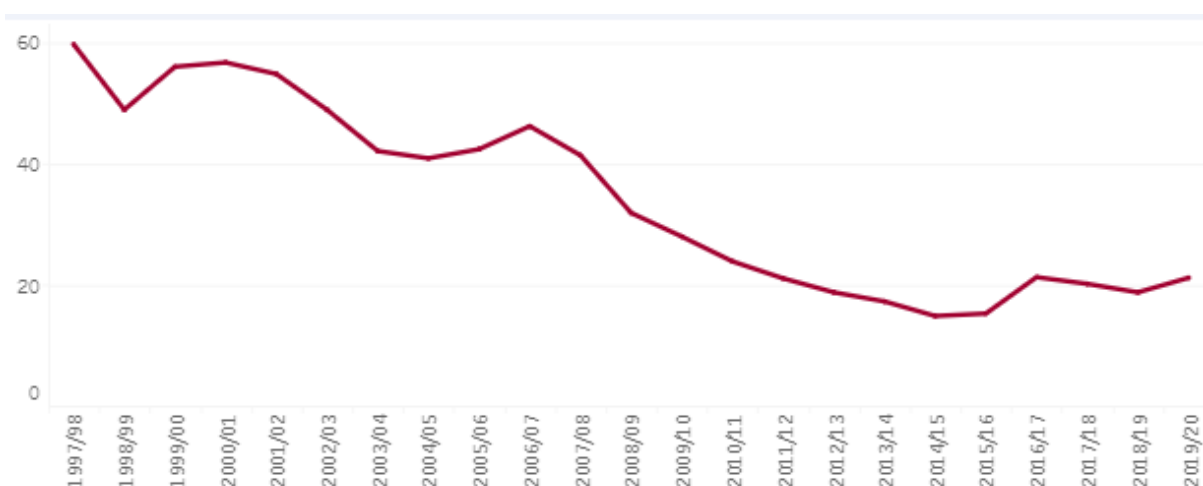
Figure 2.9 – General acute hospital stay rates (per 100,000) for all alcohol conditions (15-24 years) (2019/20)



Source: ISD Hospital Admissions 2019/20 Data Visualisation Tool

Hospital stay rates among those under 15 years are considerably lower than all other age groups. Alcohol-related hospital stays have declined among those aged under 15 years since the time series began in 1997/98. Having peaked in 1997/98, hospitalisation rates are now at 21.2 per 100,000, with the previous year having seen a reversal of the general trend towards decline seen across recent years (Figure 2.10). In 2019/20, the stay rate was 20.7 and 21.7 per 100,000 for boys and girls, respectively.

Figure 2.10 – General Acute Hospital stay rates (per 100,000) for all alcohol conditions (0-14 years) (2019/20)



Source: ISD Hospital Admissions 2019/20 Data Visualisation Tool

Alcohol-Attributable Hospital Admissions

ScotPHO²³ adopted the wider measure of 'alcohol-attributable' hospital admissions, which include an appropriate proportion of deaths from 30 chronic and acute conditions. Their most recent analysis of 2015 data showed that;

- Around one in fourteen hospital patients aged 16-24 years were hospitalised due to an alcohol-attributable condition. Among those aged 16-24 years, 2,969 patients were admitted with an alcohol-attributable condition; 6.7% of all 16-24 year olds hospitalised that year.
- Around one in ten of all male patients aged 16-24 years were admitted due to an alcohol-attributable condition. Ten percent (n=1,790) of male patients aged 16-24 were admitted to hospital due to an alcohol-attributable condition; the highest proportion across any age and sex category. This compared to 4.5% (n=1,179) of female patients aged 16-24 years.
- Mental and behavioural disorders were the main causes of alcohol-attributable hospitalisation admissions for males aged 16-24. These accounted for 2.4% of all hospital admissions (n=244), followed by other unintentional injuries (1.7%, n=298), and all injuries (1.1%, n=196).
- Intentional self-harm and ethanol poisoning were the main causes of alcohol-attributable hospitalisation admissions for females aged 16-24 years. These contributed 0.8% (n=221) and 0.8% (n=220), respectively, followed by mental and behavioural disorders (0.7%, n=187).

Alcohol-Specific and Alcohol-Attributable Deaths

Alcohol-specific deaths among those under 25 remain very low, with most deaths seen in people in their fifties and sixties. In 2020, there were 3 alcohol-specific deaths in those under 25 years; 0.25% of the total of 1,190 across all ages²⁴. Both of these deaths were in individuals aged 20-24 years; one male, one female.

In line with their reporting on hospital admissions, ScotPHO²⁵ used the wider measure of 'alcohol-attributable deaths' as part of their reporting of 2015 data on mortality. Among individuals aged 16-24, there were 38 alcohol-attributable deaths; 18.0% of the total deaths for this age group in 2015. Deaths were five times as high among males (n=32) than females (n=6), and accounted for around twice the proportion of total deaths (20.6% and 10.7%). The three leading causes of death among males aged 16-24 in 2015 were intentional self-harm (n=12, 7.7% of total deaths), road/pedestrian traffic accidents (n=9, 5.8%), and poisoning (n=7, 4.5%). Deaths among females were led by intentional self-harm (n=2, 3.6%), road/pedestrian traffic accidents (n=2, 3.6%, n=2), poisoning (n=1, 1.8%), and epilepsy and status epilepticus (n=1, 1.8%).

²³ ScotPHO (2018). Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland. Available at: <https://www.scotpho.org.uk/media/1597/scotpho180201-bod-alcohol-scotland.pdf>

²⁴ NRS Scotland (Nov. 2020). *New Definition: Alcohol-Specific Deaths*. Available at: <https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-theme/vital-events/deaths/alcohol-deaths>

²⁵ Tod, E. et al. (2018). *Hospital admissions, deaths and overall burden of disease attributable to alcohol consumption in Scotland*. Available at: <https://www.scotpho.org.uk/media/1597/scotpho180201-bod-alcohol-scotland.pdf>

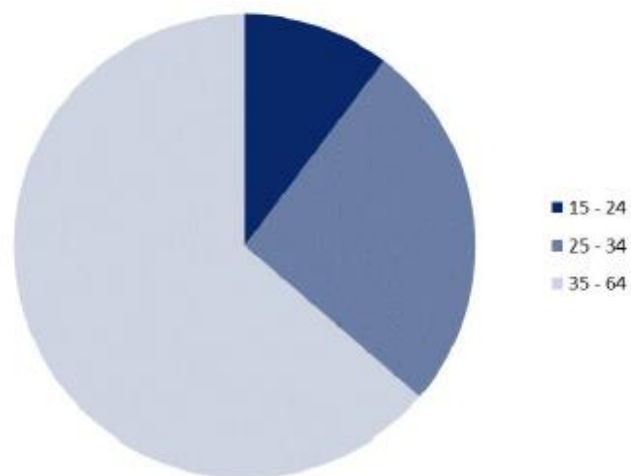
2.3.2 Drugs-Related Health Harms

Problem Drug Use Prevalence

Public Health Scotland's *Prevalence of Problem Drug Use in Scotland: 2015/16 Estimates*²⁶ defines problem drug use as the problematic use of opioids (including methadone) and/or the illicit use of benzodiazepines, and implies routine and prolonged use. This data doesn't capture the different profile of drugs causing harms among younger people, and predates the recent increase in harms noted in the following section.

Both the number of young people with problem drug use and their proportion of the total across all ages has declined over time. In 2015/16, around one in ten (9.21%, n=5,900) of the estimated total of problem drug users were aged 15-24 (Figure 2.11); in 2009/10, compared to around one in five (19%, n=7,900) of the total of 57,300 in 2009/10²⁷. This was the lowest prevalence across the three age-categories for which data was available (between 15 and 64 years). Rates were four times higher in males (1.42% of the total population compared to 0.33%), with this gender divide the greatest of any age group.

Figure 2.11 – Proportion of Total Population with Problem Drug Use 2015/16 by age (n=57,300)



Source: *Problem Drug Use in Scotland: 2015/16 Estimates*

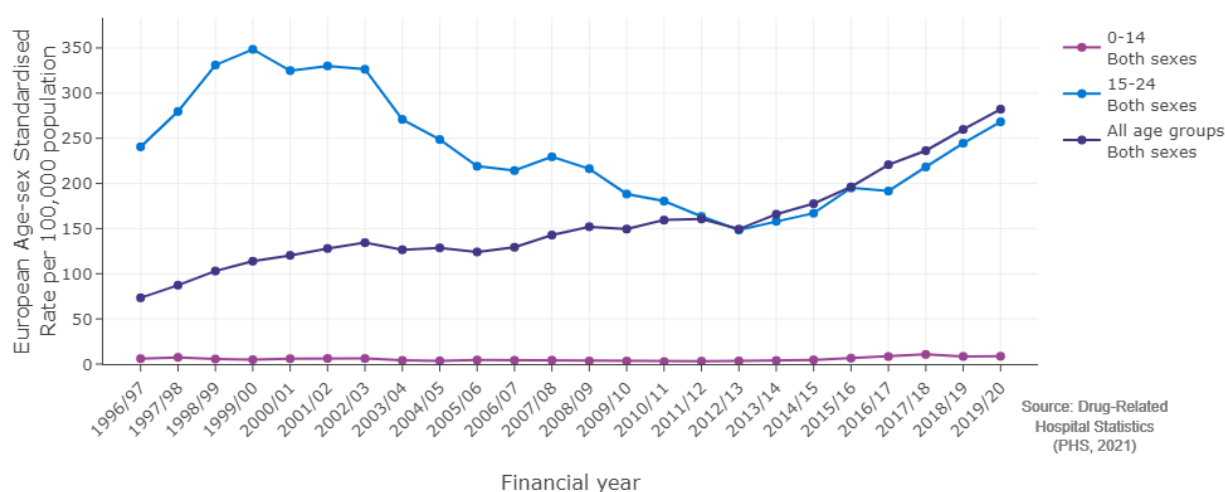
Drug-Related Hospital Admissions

²⁶ ISD Scotland (March 2019). Prevalence of problem drug use in Scotland: 2015/16 Estimates. Available at: <https://beta.isdscotland.org/find-publications-and-data/lifestyle-and-behaviours/substance-use/prevalence-of-problem-drug-use-in-scotland-201516-estimates/5-march-2019/>

²⁷ ISD Scotland (Nov. 2011). Estimating the National and Local Prevalence of Problem Drug Use in Scotland 2009/10. Available at: http://drugslibrary.wordpress.stir.ac.uk/files/2017/05/prevalence2009_10.pdf

Public Health Scotland present data on hospital activity relating to illicit drug use in Scotland between 1996/97 and 2019/20²⁸. A trend has emerged towards increasing drug-related hospitalisations among younger people. Having declined between 2002/03 and 2012/13, rates among 15-24 year-olds have seen a sustained increase in the years since. In 2019/20, there were 1,716 drug-related hospitalisations among 15-24 year olds in Scotland (268.5 per 100,000); an 80% increase on the rate in 2012/13 (Figure 2.12). While both sexes have seen increases in drug-related hospitalisations in recent years, these trends have been particularly driven by an increase among males. Rates remain lower than older groups; less than half of those among aged 34-44, having been around three times as high as this age-category in 1996/97.

Figure 2.12 – Drug-Related Hospital Admissions Across Scotland (0-14y, 15-25y, all age groups), 1996/97 to 2019/20



Source: ISD Scotland Interactive Dashboard, Drug-Related Hospital Statistics (PHS, 2021)

The profile of drugs causing harms among young people includes emerging trends and is markedly different from those of older ages. Among those aged 15-24, recent years have seen particularly sharp increases in hospital stays from sedatives/hypnotics, cocaine and cannabinoids. While opioids provide the greatest contribution to hospital stays across all ages they provide a far smaller contribution among young people. However, having followed a trend of general decline for two decades, they have risen for two consecutive years until 2019/20.

For those aged 15-24, the 2019/20 drug-related hospitalisations data²⁹ shows;

- **Sedatives/Hypnotics³⁰ (including benzodiazepines)** - Rates have nearly trebled in three years to 36.5 per 100,000 in 2019/20; their highest since

²⁸ Public Health Scotland, Information Services Division (June 2021). Drug-related hospital statistics Scotland 2019/20. Available at: [Summary - Drug-related hospital statistics - Scotland 2019 to 2020 - Drug-related hospital statistics - Publications - Public Health Scotland](#)

²⁹ Public Health Scotland (Jun. 2021). Drug-Related Hospital Statistics: Scotland 2019 to 2020. [Summary - Drug-related hospital statistics - Scotland 2019 to 2020 - Drug-related hospital statistics - Publications - Public Health Scotland](#)

³⁰ The 'Sedatives/hypnotics' group of drugs includes 'prescribable' benzodiazepines (drugs such as diazepam), 'street' benzodiazepines (for example, etizolam and alprazolam) and z-hypnotics (for example, zopiclone).

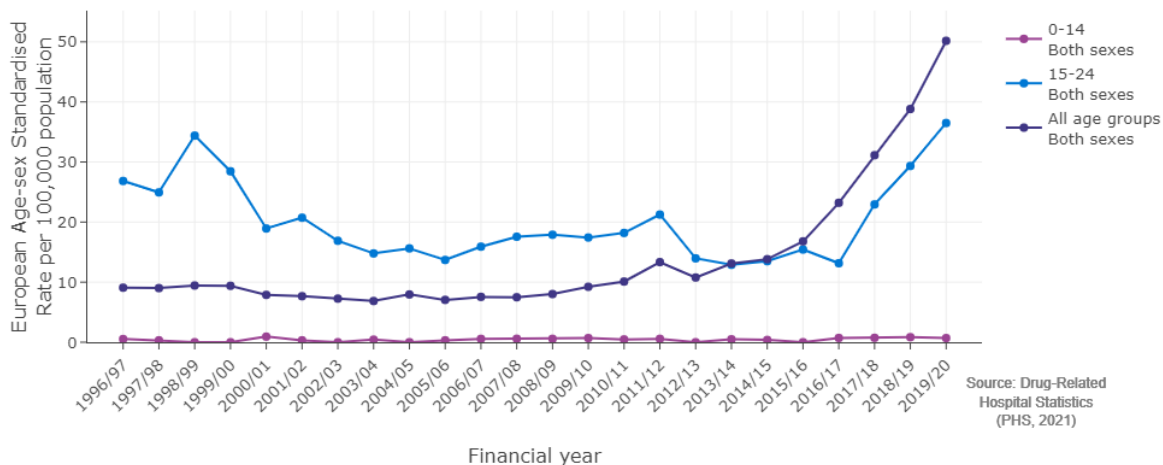
recording began in 1996/97 (figure 2.13). While they contributed only 7.0% of hospitalisations in 2016/17, they now contribute nearly double that (13.6%) in 2019/20. Rates among males are double that of females.

- **Cocaine** – In 2019/20, cocaine hospitalisation rates were the highest since recording began for the fifth consecutive year (Figure 2.14). Rates have increased year-on-year from 2011/12. The rate in 2019/20 (72.1 per 100,000) is more than three times higher than in 2011/12, and more than twenty times higher than in 1996/97. Having only contributed 1.4% of all drug-related hospitalisations among those 15-24 years in the three years between 1996/99 it now contributes more than a quarter (27.1%) of hospitalisations. Rates are more than double that of all ages, with rates among young males around twice as high as females.
- **Cannabinoids** – Hospital stays for cannabinoid use rose to their highest ever level for the fifth consecutive year, with 2018/19 to 2019/20 having seen the sharpest increase (59.3%) (Figure 2.15). The rate of 80.48 per 100,000 is nearly around two and a half times that of 2012/13, and four times higher than in 1996/97. While having contributed only 8.5% of drug-related hospitalisations in 1999/00, they now account for 29.9%. Rates are more than double the rate seen across all ages, and are more than twice as high among males than females.
- **Opioids** – Opioid hospitalisations rates peaked in 2001/02, and declined every year between 2007/08 and 2017/18 (Figure 2.16). 2019/20 has seen the first consecutive two-year increase in the hospitalisation rate from opioids since the late 1990s (from 27.20 in 2017/18 to 39.53 per 100,000 in 2019/20). They made up 14.9% of hospitalisations in 2019/20; four times lower than the 45.3% in 2009/10, but having risen slightly for two consecutive years. Of adult groups, rates are lowest rate among those aged 16-24. Rates are higher among females (19.44 per 100,000) than males (12.53 per 100,000).
- **'Other Stimulants'**³¹ – Rates have remained considerably higher than across other age categories since recording began (Figure 2.17). While having declined steadily since peaking in 2015/16, the rate of 26.43 per 100,000 in 2018/19 remains around three times the rate across all ages. They contribute around one in ten (9.6%) of drug-related hospitalisations among those aged 15-24 years; nearly four times higher than across all age groups, although having steadily declined since 2014/15. While rates were nearly three times as high among males in 2018/20, this has narrowed considerably in 2019/20 due to a sharp fall among males and an increase among females.
- **Multiple/other drug use**³² – While remaining lower than half of their peak of 124.66 per 100,000 in 1999/00, hospitalisation rates from multiple/other drugs have risen annually since 2011/12 to 40 per 100,000 in 2019/20, and contribute over one in four (25.2%) of drug-related hospitalisations (Figure 2.18). Rates are three times higher in males than females (103.73 and 31.55 per 100,000). Rates are slightly higher than across all ages, and are nearly three times higher in males than in females.

³¹ The 'other stimulant' category includes stimulants other than cocaine (e.g. caffeine, amphetamine, methamphetamine, BZP, PMA)

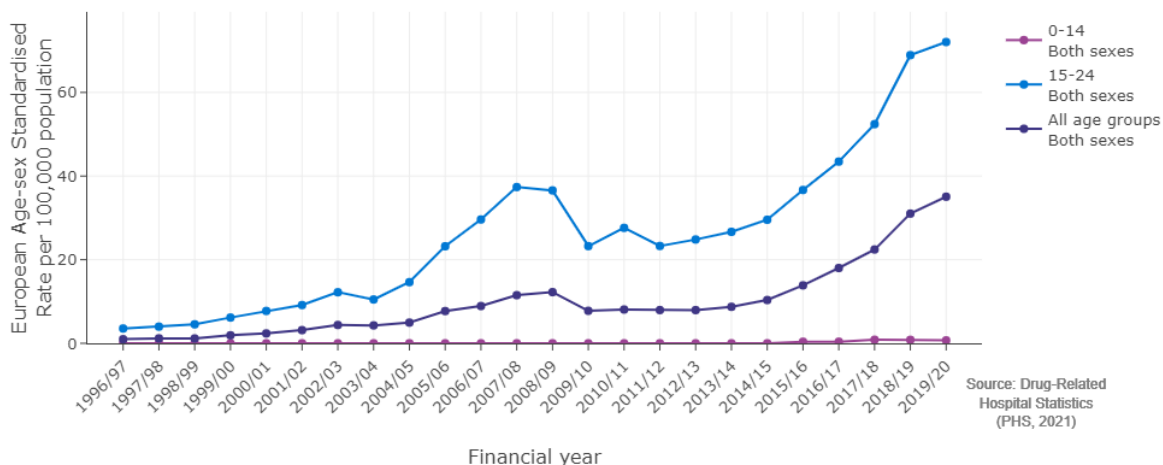
³² The 'multiple/other' drugs category includes hallucinogens, volatile solvents, multiple drug use and use of other psychoactive substances (e.g. ecstasy). This category may be used to indicate poly drug use when individual substances are not known or cannot be coded using existing diagnosis (ICD10) codes.

Figure 2.13 – Hospital Stay Rates from Sedatives/Hypnotics Use (0-14y, 15-24y, all-age groups), 1996/97 to 2019/20



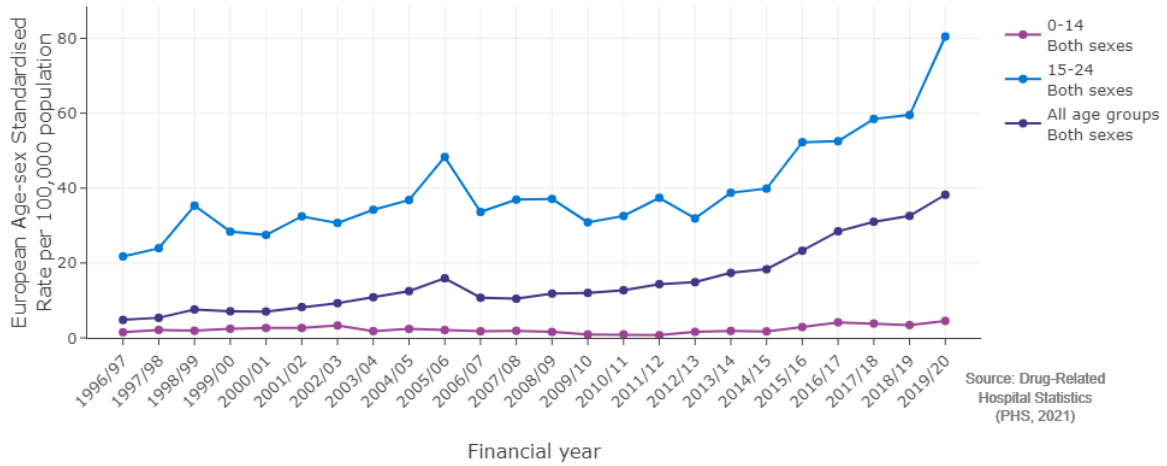
Source: ISD, Drug-Related Hospital Statistics (PHS, 2021)

Figure 2.14 – Hospital Stay Rates from Cocaine Use (0-14y, 15-24y, all-age groups), 1996/97 to 2019/20



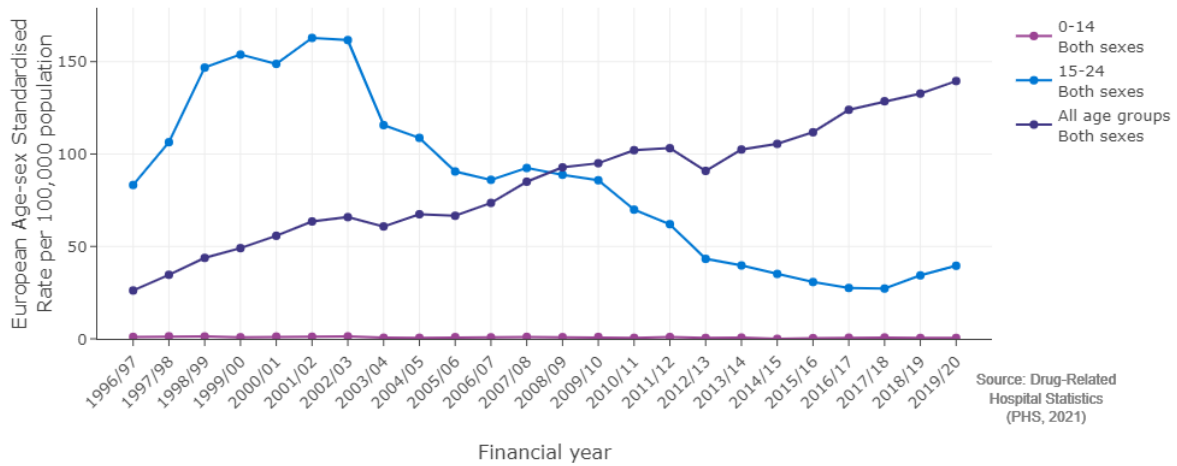
Source: ISD, Drug-Related Hospital Statistics (PHS, 2021)

Figure 2.15 – Hospital Stay Rates from Cannabinoid Use (0-14y, 15-24y, all-age groups), 1996/97 to 2019/20



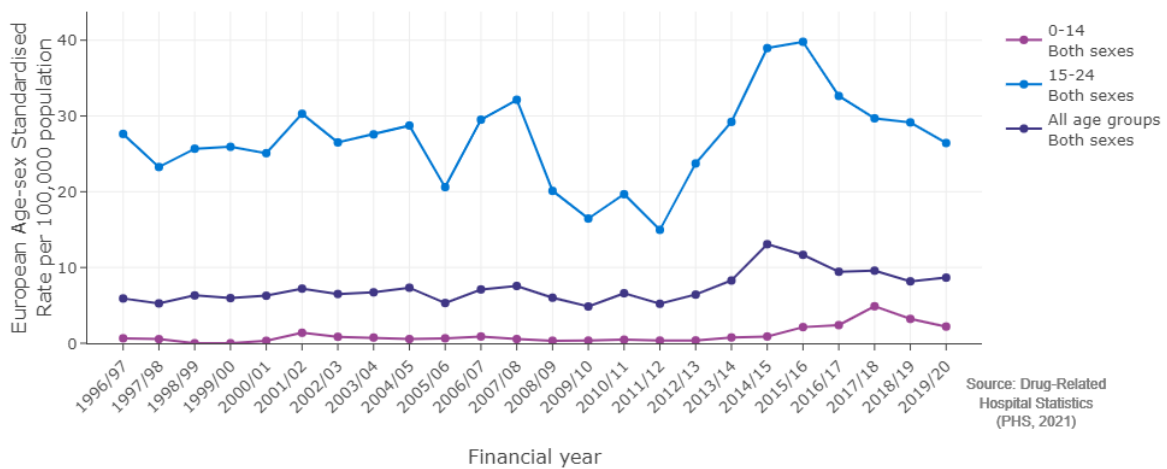
Source: ISD, Drug-Related Hospital Statistics (PHS, 2021)

Figure 2.16 – Opioid-Related Hospital Stay Rates (0-14y, 15-24y, all-age groups), 1996/97 to 2019/20



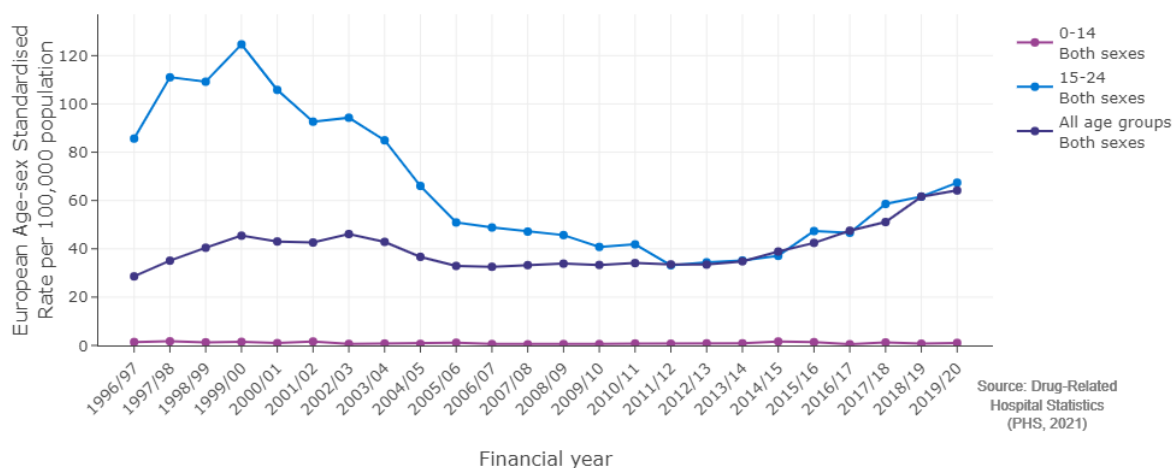
Source: ISD, Drug-Related Hospital Statistics (PHS, 2021)

Figure 2.17 – Other Stimulant-Related Hospital Stay Rates (0-14y, 15-24y, all-age groups), 1996/97 to 2019/20



Source: ISD, Drug-Related Hospital Statistics (PHS, 2021)

Figure 2.18 – Multiple/Other Drug-Related Hospital Stay Rates (0-14y, 15-24y, all-age groups), 1996/97 to 2019/20

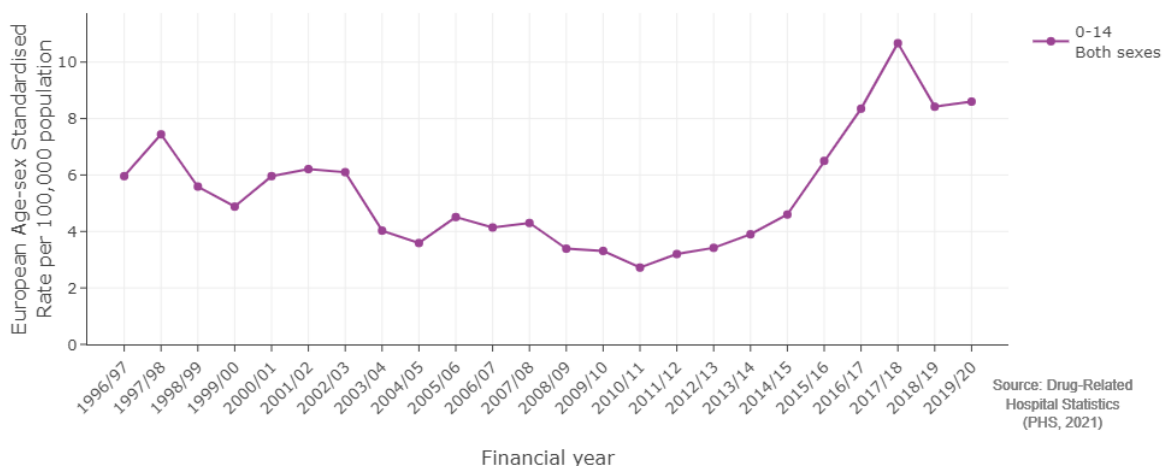


Source: ISD, Drug-Related Hospital Statistics (PHS, 2021)

While drug-related hospital stays are far less common among those aged 0-14 years, there has been a marked increase in rates between 2010/11 and 2019/20.

- In 2019/20, 75 children under the age of 15 were hospitalised across Scotland due to their drug use. While remaining lower than their peak in 2017/18 (10.67 per 100,000), rates in 2019/20 (8.60 per 100,000) remain three times as high as in 2010/11 (Figure 2.19). Rates among boys are higher than girls (9.34 and 7.86 per 100,000).

Figure 2.19 – Drug-Related Hospital Stay Rates (0-14 years), 1996/97 to 2019/20



Source: ISD, Drug-Related Hospital Statistics (PHS, 2021)

- **Cannabinoids** – The 2018/19 rate (3.42 per 100,000) is the highest since the time series began, and is four times higher than in 2011/12. The contribution to overall stays from this age has doubled since 2011/12 to 52.0% in 2018/19; far higher than the 13.9% seen across all ages. Rates among boys were slightly higher than girls (5.02 and 4.05 per 100,000).
- **Other stimulants** - Having peaked in 2017/18 (4.88 per 100,000) after a thirteen-fold increase since 2012/13, rates have since halved to 2.20 per

100,000 in 2019/20, while remaining far higher than they were across the time series until 2012/13. The contribution to overall drug-related stays has risen from 10.0% in 2009/10 to around a quarter (24.0%) in 2019/20; far higher than the 3.2% seen across all ages. Rates among boys were higher than girls (2.74 and 1.67 per 100,000).

- **Cocaine** – While 1996/97 to 2014/15 saw no hospital stays from cocaine use, rates rose to 0.37 in 2015/16 before doubling to 0.85 per 100,000 in 2017/18. Rates have declined slightly to 2019/20 (0.70 per 100,000). In 2019/20, they contributed nearly one in ten (8.0%) drug-related hospital stays. Rates by sex fluctuate annually due to the low numbers involved.
- **Sedative/Hypnotic Use** – Having fluctuated across the time series, hospital stay rates due to sedative/hypnotic use have remained relatively steady across the past three years. In 2019/20, rates were 0.69 per 100,000. Again, the rates by sex fluctuate annually due to the low numbers involved.
- **Opioid Use** – Hospitalisations due to opioid use are very low among this age group, with a rate of 0.48 in 2019/20, accounting for only 4.0% of total drug-related hospital stays among this age group. Rates are around half of 2009/10 rates (1.01 per 100,000). Again, the rates by sex fluctuate annually.
- **Multiple/Other Drugs** – Hospital stay rates from multiple/other drugs have, again, fluctuated considerably across the time series, to 1.04 per 100,000 in 2019/20. This is double the rate in 2009/10 (0.57 per 100,000), and contributes just over a tenth (12.0%) of hospital stays for this age group. The rates by sex again fluctuate annually due to the low numbers involved.

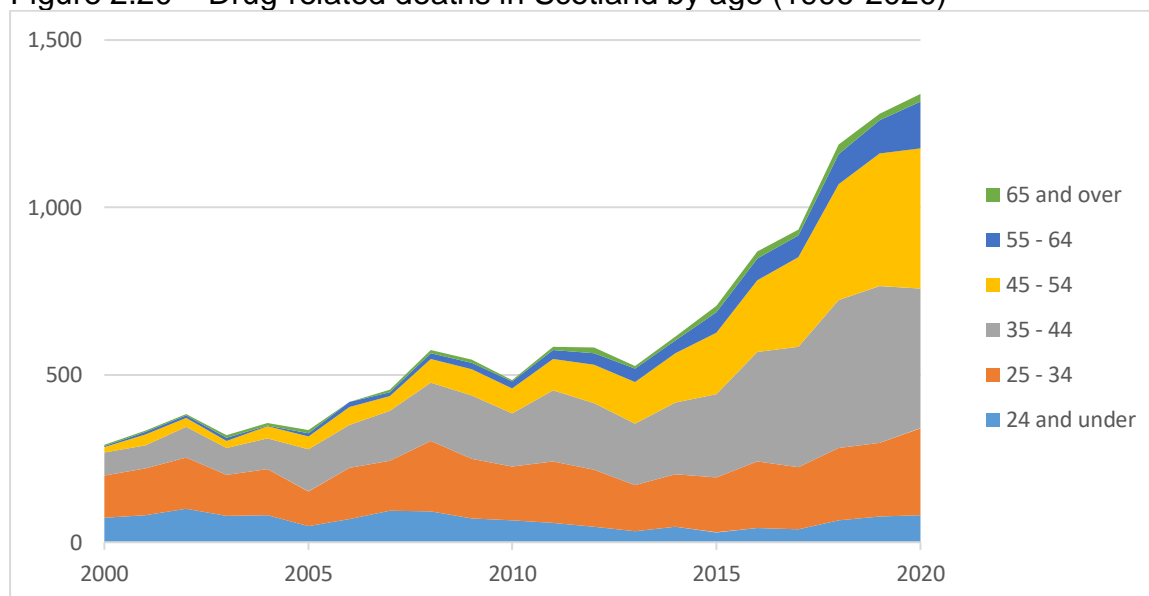
Drug-Related Deaths

Drug-related deaths among younger people have increased substantially across the last few years. The latest data from 2020³³ shows that;

- There were 78 drug-related deaths among those aged 15-24 – This was more than double the number seen in 2017 (n=36) and is a rate of 12.5 per 100,000. There were no drug-related deaths among those aged 14 and under.
- DRDs among young people provide a smaller contribution to overall total – While individuals under 25 years contributed 14.8% of all drug-related deaths in 2010, they contributed only 5.8% in 2020, reflective of the aging, but still young, cohort experiencing harms at the greatest rates.
- Young males much more likely to die a drug-related death – Among those aged 15-24, males accounted for three quarters (79.5%, n=62) of drug-related deaths; a greater proportion than that seen across all ages (72.7%).
- Deaths are caused by a slightly different profile of drugs than older ages – Data on the drugs implicated in these deaths shows that, compared to the average across all ages, deaths among those aged 15-24 were less frequently caused by all opioids (79.5% compared to 89.0% of total drug-related deaths across all ages). A similar proportion involved benzodiazepines (70.6% compared to 72.7%). Deaths were more likely to involve cocaine (48.8% compared to 34.2%) and ecstasy (20.5% compared to 3.0%), reflective of their greater prevalence rates among younger people.

³³ National Records of Scotland (July. 2021). Drug-related deaths in Scotland in 2020. Available at: [Drug-related Deaths in Scotland in 2020 | National Records of Scotland \(nrscotland.gov.uk\)](https://www.nrscotland.gov.uk/publications/drug-related-deaths-in-scotland-in-2020)

Figure 2.20 – Drug-related deaths in Scotland by age (1996-2020)



Source: NRS (2020)

While younger people provide a smaller contribution to the overall burden of mortality from drugs than previously, many of those within the 35 years and older cohort began using drugs at a younger age. Analysis of mortality data from 2015/16 by the *National Drug-Related Deaths Database*³⁴ highlights that four in ten (43%) were known to have been using drugs for over 20 years and three-quarters (75%) for over ten years.

2.3.3 Other Health and Social Harms

Hazardous or harmful alcohol and problem drug use among children and younger people is associated³⁵ with a number of other short and longer-term negative outcomes in a range of interlinking domains central to wellbeing. These include;

- **Criminal Justice** – Criminal involvement is closely associated with problematic alcohol and drug use. In the Scottish Prisoner Survey 2019, 41% of prisoners suggested that drug use was a problem for them on the outside, with 45% and 40% of prisoners reporting that they had been under the influence of drugs and alcohol, respectively, at the time of their offence³⁶.
- **Education** – UK studies have found that drug use and binge drinking during adolescence are associated with significantly poorer educational attainment³⁷.

³⁴ ISD (Jun 2018). The national Drug-Related Deaths Database (Scotland) Report: Analysis of Deaths Occurring in 2015 and 2016.

³⁵ There is a degree of reverse causality across a number of these domains, with negative outcomes in relation to a number of these domains also operating as risk factors for problematic alcohol and drug use.

³⁶ Scottish Prison Service. (2019). 17th Scottish Prisoner Survey 2019. Available at: [17th Prisoner Survey 2019 \(sps.gov.uk\)](https://www.sps.gov.uk/17th-prisoner-survey-2019)

³⁷ Wright, C.; Kipping, R.; Hickman, M.; Campbell, R. & Herron, J. (2018). Effect of multiple risk behaviours in adolescence on educational attainment at age 16 years: a UK birth cohort study. *BMJ Open*, e020182.

- **Employment** – Unemployment, again, has been found to be both a cause and a consequence of problematic alcohol and drug use among younger people. Previous reviews have highlighted a range of barriers to work for those with problem drug use, including lack of education and skills, health, socioeconomic disadvantage, mental health, criminal record, and stigma³⁸.
- **Future Problematic Alcohol and Drug Use** – US studies suggest that drug-use and binge drinking during adolescence carries an increased risk for drug and alcohol abuse and dependence in adulthood^{39,40}.
- **Homelessness** – Homelessness again forms both a risk factor for and a potential consequence of harmful alcohol and/or problem drug use. A 2006 Scottish study found that over a third of individuals entering treatment (36%) were homeless. This study showed that injecting drug use carries a higher risk of homelessness⁴¹. Further, the Scottish Government's 2018 Health and Homelessness in Scotland report showed that young people who had ever recorded homelessness were around ten times more likely to have been in drug treatment than the control group from deprived communities, and that the 'ever homeless' category was more likely to be in treatment at a slightly younger age than the control groups⁴².
- **Mental Health** – Again, mental health can has been found to form both a cause and a consequence of problematic alcohol and drug use. A UK review⁴³ found that there is relatively consistent evidence that drug use during adolescence predicts anxiety, depression and behavioural problems in early adult life.

³⁸ Sutton, L.; Cebulla, A.; Heaver, C. & Smith, N. (2004). Drug and alcohol use as barriers to employment : a review of the literature. Loughborough University, for Department for Work and Pensions.

³⁹ Bonomo Y A, Bowes G, Coffey C. *et al* Teenage drinking and the onset of alcohol dependence: a cohort study over seven years. *Addiction* 2004: 991520–1528.

⁴⁰ Chen, C.Y.; Storr, C.L. & Anthony, J.C. (2009). Early-onset drug use and risk for drug dependence problems. *Addictive Behaviours*, 34(3): 319-322.

⁴¹ Kemp, P.A. and Neale, J. (2006). Homelessness among problem drug users: prevalence, risk factors and trigger events. *Health and Social Care in the Community*, 14, 319-28.

⁴² Scottish Government (Jan 2018). Health and Homelessness in Scotland: research. Available at: <https://www.gov.scot/publications/health-homelessness-scotland/>.

⁴³ Goodman, A. (2010). Substance use and common child mental health problems: examining longitudinal associations in a British sample. *Addiction*, 105(8): 1484-1496.

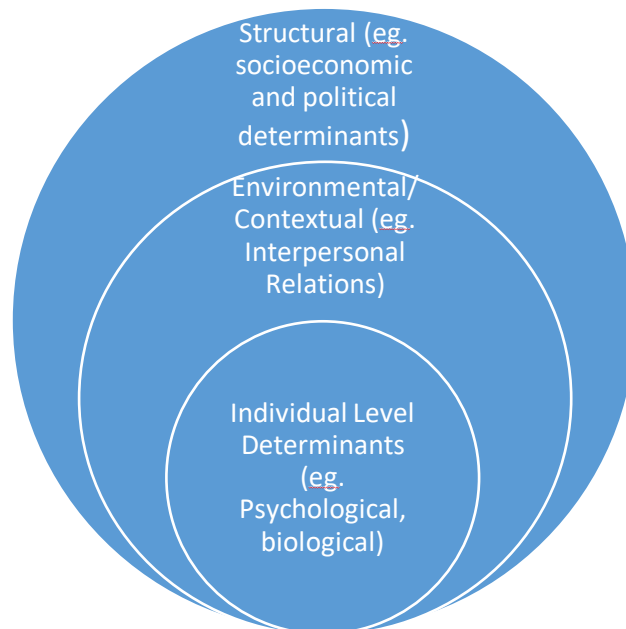
3. Problematic Use & Harms: Risk Factors and Vulnerable Groups

3.1 Overview

The vast majority of people who use drugs and alcohol do not develop problematic alcohol or drug use. The tendency to develop problematic use, and to experience harms, is associated with a number of risk factors and vulnerabilities. This section explores the literature on these risk factors, before identifying particularly vulnerable population groups and key periods of risk.

Problem alcohol and drug use among children and young people has been widely accepted to be multifactorial, with, typically, an interplay of various aspects of a young person’s life contributing to their problematic use of substances. Recent decades’ bio-psychosocial model⁴⁴ emphasises the interconnected and interactive nature of individual (biological and psychological), environmental (psychosocial, and contextual) and structural (societal and institutional) determinants in contributing to problematic alcohol and drug use. There is also a varying degree of reverse causation across each of these particular risk factors; mental health issues, for example, can both contribute to and be exacerbated or caused by alcohol and/or drug use. The determinants presented here are not exhaustive.

Figure 3.1 – Bio-psychosocial Determinants of Problem Alcohol and Drug Use among Children and Younger People



⁴⁴ Hawkins, J.D.; Catalano, R.F.; Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: implications for substance abuse prevention. *Psychol. Bull.* 112(1); 64-105.

3.2 Risk Factors

3.2.1 Structural Risk-Factors

Socioeconomic Deprivation and Poverty

When including recreational, occasional or experimental use, findings from the international and UK literature suggest a weak or non-existent relationship between background socioeconomic position and alcohol and drug use in children and adolescents⁴⁵, and in younger adults⁴⁶. Two Scottish school-based studies of adolescents, for example, found no association between family SES and either lifetime⁴⁷ or regular⁴⁸ drug use.

However, as the individual ages, a far stronger relationship emerges between deprivation and harms from alcohol and drugs, with this relationship stronger for *current* rather than *background* socioeconomic position⁴⁹. Studies conducted internationally show a clear and persistent socioeconomic gradient in acute and chronic alcohol- and drug-related morbidity and mortality. Analysis of Scottish Health Survey data between 1995 and 2012⁵⁰ found that deprivation was associated consistently with strikingly raised alcohol-attributable harms. Importantly, harms experienced by those of lower socioeconomic position were greater than those of higher socioeconomic position even after accounting for factors such as weekly consumption, drinking patterns, obesity and smoking status. Further, this study showed that reverse causation – that is, high-risk consumption leading to social disadvantage – did not explain these findings.

The latest data on alcohol- and drug-related hospital admissions across all ages (data is not available by age) shows demonstrates these socioeconomic inequalities;

- **Alcohol-Related Hospital Admissions (Stays)** – Individuals in the most deprived areas were seven times more likely to be admitted to general acute hospitals for an alcohol-related condition in Scotland in 2019/20 than those in the least deprived (1,078.7 per 100,000 population compared to 155.0)⁵¹.
- **Drug-Related Hospital Admissions (Stays)** – Individuals in the most deprived areas were more than sixteen times more likely to be admitted to

⁴⁵ Hanson, M.D. & Chen, E. (2007). Socioeconomic status and health behaviours in adolescence: a review of the literature. *J. Behav. Medicine*, 30(3): 263-285.

⁴⁶ Wiles NJ, et al. (2007) Socio-economic status in childhood and later alcohol use: a systematic review. *Addiction*. 102:1546-1563.

⁴⁷ West, P.; Sweeting, H. & Leyland, A. (2004). School effects on pupils' health behaviours: evidence in support of the health promoting school. *Research Papers in Education*, 19(3): 261-291.

⁴⁸ Karatzias, A.; Papadioti-Athanasiou, V.; Power, K.G. & Swanson, V. (2001). Quality of School Life. A Cross-Cultural Study of Greek and Scottish Secondary School Pupils. *European Journal of Education*, 36(1): 91-105.

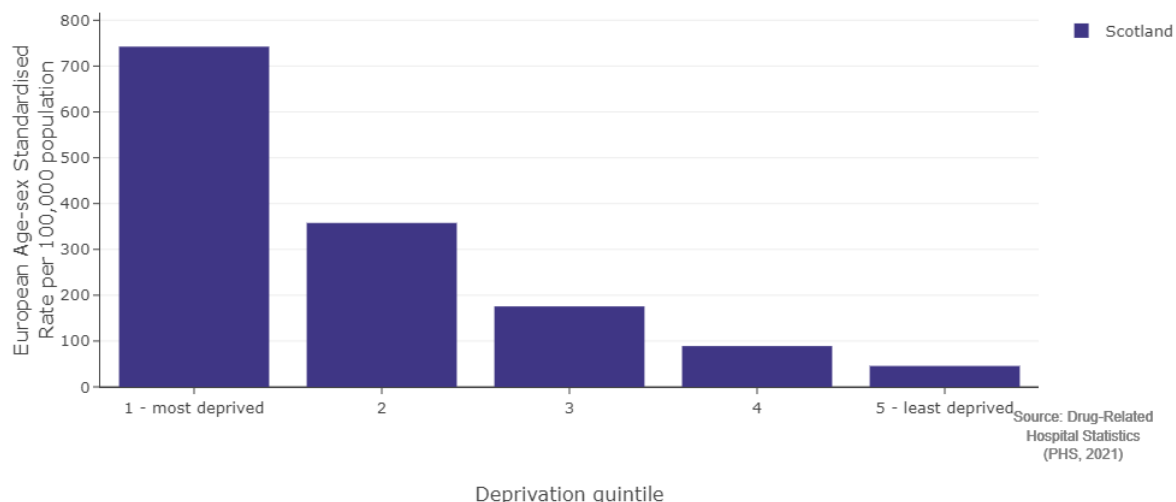
⁴⁹ Daniel, J.Z.; Hickman, M.; Macleod, J. et al. (2009). Is socioeconomic status in early life associated with drug use? A systematic review of the evidence. *Drug and Alcohol Review*, 28:142-153.

⁵⁰ Katikireddi, S.V.; Whitley, E.; Lewsey, J.; Gray, L. & Leyland, A.H. (2017). Socioeconomic status as an effect modifier of alcohol consumption and harm: analysis of linked cohort data

⁵¹ ISD Scotland (Nov. 2020). Alcohol-Related Hospital Statistics. Available at: <https://beta.isdscotland.org/find-publications-and-data/lifestyle-and-behaviours/substance-use/alcohol-related-hospital-statistics/>

general acute hospitals for an drug-related condition in Scotland in 2019/20 than those in the least deprived (742.42 per 100,000 compared to 45.65)⁵².

Figure 3.2 – Drug-Related Hospital Admission Rates, by Deprivation Quintile (1996/97 to 2019/20)



Source: ISD, Drug-Related Hospital Statistics (PHS, 2021)

These figures were also starkly apparent in the latest drug-related death data for 2020; after adjusting for age, people in the most deprived areas were 18 times as likely to have a drug-related death as those in the least deprived areas. That ratio has almost doubled in 20 years, from around 10 times in the early 2000s⁵³.

While the majority of harmful alcohol and problem drug users have experienced deprivation and poverty, individuals who are experiencing deprivation will not necessarily become problematic drug users. Poverty itself is not the primary driver of harmful alcohol or problematic drug use, but it increases the risk of exposure to a range of associated risk factors.⁵⁴ Further, it reduces access to a range of factors that support recovery, including education, secure housing and secure employment. A Welsh study found excess consumption to be higher among those in non-deprived areas but that those in deprived areas were more likely to binge drink, suggesting that patterns of use may also play a role⁵⁵. Findings from the qualitative literature in the UK suggest that the individual's motives for alcohol and drug use play a role in linking deprivation to problematic but not recreational use, with harmful drinking and problem drug use forming a mechanism of escape or coping mechanism for those most excluded from society⁵⁶.

⁵² PHS (June 2021). Drug-Related Hospital Statistics. Available at: [Data explorer - Drug-related hospital statistics - Scotland 2019 to 2020 - Drug-related hospital statistics - Publications - Public Health Scotland](#).

⁵³ NRS (July 2021). Drug-Related Deaths in Scotland. Available at: [Drug-related deaths in Scotland in 2020, Report \(nrscotland.gov.uk\)](#).

⁵⁴ Beckett, H. et al. (2004). Understanding problem drug use among young people accessing drug services: a multivariate approach using statistical modelling techniques. UK Government Home Office Online Report. Available at: <http://www.dldocs.stir.ac.uk/documents/rdsolr1504.pdf>

⁵⁵ Bellis, M.; Hughes, K.; Nicholls, J.; Sheron, N.; Gilmore, I. & Jones, L. (2015). The alcohol harm paradox: using a national survey to explore how alcohol may disproportionately impact health in deprived individuals. *BMC Public Health*, 16(111).

⁵⁶ MacDonald, R. & Marsh, J. (2002). Crossing the Rubicon: youth transitions, poverty, drugs and social exclusion. *International Journal of Drug Policy*, 13(1); 27-38.

3.2.2 Environmental and Contextual Risk-Factors

Environmental and contextual risk factors play an important role in shaping the likelihood of developing problematic alcohol and drug use among children and young people. It is important to note that these risk factors are shaped by the wider structural determinants outlined above. While focus is placed here on psychosocial risk factors, it is important to note that other environmental risk-factors, such as aspects of the neighbourhood environment, have been found to exert an effect.

Adverse Childhood Experiences

Adverse Childhood Experiences (ACEs) can be defined as stressful or traumatic experiences that occur during childhood (between 0 and 18 years of age)⁵⁷. The ten most widely recognised ACEs include: domestic violence; physical or sexual abuse; emotional neglect; parental separation; household alcohol and drugs misuse; mental illness, suicide or imprisonment affecting a household member⁵⁸. Analysis of data collected in the Growing Up in Scotland (GUS) cohort study suggests that by age 8, two-thirds of Scottish children will have experienced one or more ACE-related factors and one in ten will have experienced three or more ACE related factors. In the Scottish Health Survey 2019⁵⁹, over three-quarters (77%) of those aged 18-24 years reported one or more ACEs, while 15% reported having experienced 4 or more ACEs. Previous analysis of routine data⁶⁰ suggests that a high proportion of individuals experience one or more ACEs when growing up in Scotland.

Strong, graded associations between ACEs and future problematic alcohol and drug use have consistently been found across the literature. An English survey⁶¹ found that, in comparison with those with no ACEs, those with 4 or more ACEs were twice as likely to currently binge drink and eleven times more likely to have used heroin or crack cocaine. A 2015 Welsh study⁶² found even higher margins; those with 4 or more ACEs were 4 times more likely to be a high risk drinker, 11 times more likely to have smoked cannabis, and 16 times more likely to have used crack cocaine or

⁵⁷ Dong, M.; Anda, R.F.; Felitti, V.J. et al. (2004). The interrelatedness of multiple forms of childhood abuse, neglect, and household dysfunction. *Child Abuse and Neglect*, 28(7): 771-784.

⁵⁸ Existing measures of ACEs are relatively crude and limited in a number of aspects; they fail to capture the severity or duration of these events; they provide equal weighting to all included experiences (for example, parental separation and sexual abuse); they do not take into consideration the subjective perceptions of these experiences by children and younger people, and; they do not take into account resilience.

⁵⁹ Scottish Government (September 2019). Scottish Health Survey 2019 – Volume 1: Main Report. Available at: <https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/>

⁶⁰ Smith, M.; Williamson, A.E.; Walsh, D. & McCartney, G. (2016). Is there a link between childhood adversity, attachment style and Scotland's excess mortality? Evidence, challenges and potential research. *BMC Public Health*, 16(655)

⁶¹ Bellis MA, Hughes K, Leckenby N, Perkins C, Lowey H. National household survey of adverse childhood experiences and their relationship with resilience to health-harming behaviors in England. *BMC Medicine* 2014, 12:72.

⁶² Bellis MA, Ashton K, Hughes K, Ford K, Bishop J, Paranjothy S. Centre for Public Health - Liverpool John Moores University (2016). Welsh Adverse Childhood Experiences (ACE) Study - Adverse Childhood Experiences and their impact on health-harming behaviours in the Welsh adult population.

heroin. While such data is limited in Scotland, The Scottish Health Survey 2019⁶³ found that the prevalence of adults with an AUDIT score of 8 or more (indicating hazardous, harmful or possibly dependent drinking behaviour) was higher among those reporting one or more ACEs (17-19%) than those reporting no ACEs (11%).

A systematic review of the relationship between childhood socioeconomic position and ACEs concluded that there is a clear relationship between SEP in childhood and the risk of experiencing ACEs⁶⁴.

Interpersonal Relationships

A number of aspects associated with interpersonal family and peer relations play a substantial role in shaping problematic alcohol and drug use.

The family environment may influence a young person's substance use behaviour through a range of mechanisms.

- **Family Structure** – A number of studies in Scotland have found greater alcohol and drug use, both in adolescence and lifetime, among those from single-parent or step-parent families⁶⁵.
- **Caring Responsibilities** – Among both age groups in SALSUS 2018, those who had caring responsibilities were more likely to have drunk alcohol in the last week and to have taken drugs in the last month than those who did not⁶⁷.
- **Family Substance Use** – Children model their behaviour on those around them. A 2009 Scottish study showed that almost half of S1 pupils who reported having used illegal drugs stated that someone within their family was also using illegal drugs⁶⁸, compared to only one in ten of the non-using pupils. In the majority of cases, the drug using family member identified was a sibling or a cousin, although in one fifth of cases it was a parent, uncle or aunt.
- **Family Relationships** – The quality of family relationships appears to have an important influence on young people's substance use. Adolescents who have strong bonds with their parents are less likely to engage in problem substance use. The Edinburgh Study of Youth Transitions and Crime showed that those who did not use alcohol or drugs had significantly higher parental supervision than those who used substances, and that those who used a single substance had higher parental supervision than those who used

⁶³ Scottish Government (September 2019). Scottish Health Survey 2019 – Volume 1: Main Report. Available at: <https://www.gov.scot/publications/scottish-health-survey-2019-volume-1-main-report/>

⁶⁴ Walsh, D.; McCartney, G.; Smith, M. & Armour, G. (2019). Relationship between childhood socioeconomic position and adverse childhood experiences (ACEs): a systematic review. *J. Epidemiol & Community Health*, 73(12); 1087-1093.

⁶⁵ Alasdair Forsyth, Marina Barnard, Lesley Reid & Neil McKeganey (1998) Levels of Drug Use in a Sample of Scottish Independent Secondary School Pupils, *Drugs: Education, Prevention and Policy*, 5:2, 157-168

⁶⁶ McVie, S & Holmes, L 2005, *Family Functioning and Substance Use at Ages 12 to 17*. Centre for Law and Society, University of Edinburgh.

⁶⁷ Scottish Government (2019). Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2018. Available at: <https://www.gov.scot/collections/scottish-schools-adolescent-lifestyle-and-substance-use-survey-salsus/>

⁶⁸ McKeganey, N. & Norrie, J. (2009). Pre-teen drug users in Scotland. *Addiction Research*, 7(6): 493-507.

multiple substances⁶⁹. Parenting styles that exhibited the closest relationship to increased alcohol and drug use were lack of parental monitoring, high levels of parent/child conflict and a child's lack of willingness to disclose information to their parents.

As younger people become more autonomous so the influence of the peer group becomes more important and family relationships become less influential. International, UK and Scottish research has consistently found that peer substance use practices are a robust predictor of substance use in adolescence and emerging adulthood^{70,71}. The SALSUS 2018 found that, for 13 and 15 year-olds, the greater the number of unsupervised evenings with friends, the greater the likelihood they had drunk alcohol in the last week and used drugs in the last month. Peers may influence other young people to engage in or refrain from substance use directly or indirectly, through peer group structure; peer substance use; socialising norms, or; peer pressure⁷². Data from the Edinburgh Study of Youth Transitions and Crime⁷³ showed a dramatic incremental rise with age in the proportion of young people who said that most or all of their friends drank or took drugs. This may be increasingly due to 'social norms' as opposed to overt 'peer pressure'⁷⁴.

3.2.3 Individual-Level Risk Factors

A number of individual-level risk factors have also been identified across the literature. It must be noted that these are shaped within the structural contexts described above.

Experience of Mental Health Disorders

The experience of mental health issues is correlated with psychoactive substance use among adolescents⁷⁵ and young adults⁷⁶. It is well established that externalising disorders (including conduct disorder, oppositional defiant disorder, and attention-deficit and hyperactivity disorder) in early or middle childhood predict problematic

⁶⁹ McVie, S. & Bradshaw, P. (2005). *Adolescent Smoking, Drinking and Drug Use: Edinburgh Study of Youth Transitions and Crime, No. 7*. Edinburgh: University of Edinburgh.

⁷⁰ Pandina, R.J.; Johnson, V.L.; White, H.R. (2010). Peer influences on substance use during adolescence and emerging adulthood. In L. Scheier (Ed.), *Handbook of drug use etiology: Theory, methods, and empirical findings* (p. 383–401). American Psychological Association.

⁷¹ Allen, M., Donohue, W. A., Griffin, A., Ryan, D., & Turner, M. M. M. (2003). Comparing the influence of parents and peers on the choice to use drugs. *Criminal Justice and Behavior*, 30(2), 163–186.

⁷² Kirby, J.; van der Sluijs, W. & Inchley, J. (Dec 2008). *Young People and Substance Use: The influence of personal, social and environmental factors on substance use among adolescents in Scotland*. University of Edinburgh: Child and Adolescent Health Research Unit (CAHRU).

⁷³ McVie, S. & Bradshaw, P. (2005). *Adolescent Smoking, Drinking and Drug Use: Edinburgh Study of Youth Transitions and Crime, No. 7*. Edinburgh: University of Edinburgh.

⁷⁴ McIntosh J, MacDonald F, McKeganey N (2003) The initial use of drugs in a sample of pre-teenage schoolchildren: the role of choice, pressure and influence. *Drugs: Education, Prevention and Policy*, 10: 147-158.

⁷⁵ Weinberg, N. Z., Rahdert, E., Collier, J. D., et al (1998) Adolescent substance abuse: a review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37, 252–261.

⁷⁶ Farrell, M., Howes, S., Bebbington, P., et al (2001) Nicotine, alcohol and drug dependence and psychiatric comorbidity: results of a national household survey. *British Journal of Psychiatry*, 179, 432–437.

alcohol⁷⁷ and drug⁷⁸ use and dependence in adolescence and young adulthood. A longitudinal study of 11-15 year-old pupils in Scotland found that conduct disorders were the main predictor of hazardous alcohol use⁷⁹. For internalising disorders (including depression and anxiety), the evidence is less clear. Some report independent effects upon substance use or dependence (particularly in females), while others do not or report only weak or inconsistent effects⁸⁰.

Importantly, the COVID-19 pandemic and associated policies have likely contributed to a greater mental health burden. A longitudinal survey of over 2000 young people (13-25 years) with experience of mental health problems was undertaken in the UK by Young Minds across three periods in 2020⁸¹. The July survey found that 80% had found their mental health worsen due to the pandemic. The proportion reporting 'much worse' mental health had risen from 32% in March to 41% in July.

Early Use

Early alcohol and drug use (prior to the age of 15 years) increases the risk of problematic use in later life. Research exploring early onset of drug use with a representative sample of the US population⁸² has shown that;

- individuals who initiate drug use before the age of 14 years are at greatest risk for drug dependence and have a 34% prevalence rate of lifetime drug use disorders;
- as individuals continue to mature between 13 and 21 years, the likelihood of lifetime substance abuse and dependence drops 4-5% for each year that initiation of substance use is delayed, and;
- early onset drug use was a significant predictor of the development of lifetime alcohol dependence.

It is likely, however, that individuals with risk factors for early-initiation of substance use are also exposed to correlate risk-factors which contribute to the greater likelihood of developing problem substance use.

⁷⁷ Cohen P., Chen H., Crawford T. N., Brook J. S., Gordon K. Personality disorders in early adolescence and the development of later substance use disorders in the general population. *Drug Alcohol Depend* 2007; **88** (Suppl. 1): S71– S84.

⁷⁸ Fergusson D. M., Horwood L. J., Ridder E. M. (2007). Conduct and attentional problems in childhood and adolescence and later substance use, abuse and dependence: results of a 25-year longitudinal study. *Drug Alcohol Depend* 2007; **88** (Suppl. 1): S14– 26.

⁷⁹ Young, R.; Sweeting, H. & West, P. (2008). A longitudinal study of alcohol use and antisocial behaviour in young people. *Alcohol & Alcoholism*, 43(2): 204-214.

⁸⁰ Miettunen et al. (2013). Longitudinal associations between childhood and adulthood externalizing and internalizing psychopathology and adolescent substance use. *Psychological Medicine*, 44(8): 1727–1738.

⁸¹ Young Minds (2020). Coronavirus: Impact on Young People with Mental Health Needs. Available at: <https://youngminds.org.uk/about-us/reports/coronavirus-impact-on-young-people-with-mental-health-needs/>

⁸² Grant, B.F. & Dawson, D.A. (1997). Age of onset of drug use and its association with DSM-IV drug abuse and dependence: results from the National Longitudinal Alcohol Epidemiologic Survey. *J. Substance Abuse*, 10: 163-173.

Reasons for Use

Research suggests that the motives underpinning the use of alcohol and drugs predicts the likelihood of younger people developing problem use⁸³. A 1992 study formulated 3 motive types; coping motives, enhancement motives and social motives⁸⁴. A range of research has found that coping motives – the use of substances to cope with negative experiences or emotions (particularly when coupled with poor emotional control or regulation) – is associated with the development of problematic alcohol and drug use⁸⁵. A qualitative study in Northern England which focused on the transition from recreational drug use to problem drug use in young people found that recreational users described their use as offering “leisure and pleasure”, those with problem drug use spoke of “not having a care in the world” after using heroin, about it “taking all [their] worries away” and it “wiping away all the bad things that have happened”.⁸⁶

3.3 Vulnerable Groups

The literature highlights a number of groups more likely to develop problematic alcohol and drug-use and experience harms.

- **Care Experienced Children and Younger People** – While relatively dated, a 2001 study of young people leaving care (14-24 years) in Glasgow found that 84% and 60% had used cannabis and ecstasy at least once, respectively, and 14% were drunk almost every day⁸⁷. Two-thirds had started taking drugs (31%) and drinking alcohol (29%) while in care. Use was attributed to being ‘stressed out in care’ and as an attempt to forget negative experiences. Another showed that 45.8% of individuals resident in children’s units had used drugs in the last month⁸⁸. Those in foster care consume less alcohol have been found to be less likely to misuse drugs than children in residential care⁸⁹ due to those in residential care being exposed to factors including frequent movement of care placements, and rejection by adoptive or foster parents. US research found that care-experienced younger people were five times more likely to have received a ‘drug dependence diagnosis’ in the past year⁹⁰.

⁸³ Patrick, M.E. et al. (2011). Adolescents' Reported Reasons for Alcohol and Marijuana Use as Predictors of Substance Use and Problems in Adulthood. *Journal of Studies on Alcohol and Drugs*, 72(1): 106-116.

⁸⁴ Cooper, M. L., Russell, M., Skinner, J. B., & Windle, M. (1992). Development and validation of a three-dimensional measure of drinking motives. *Psychological Assessment*, 4(2), 123–132.

⁸⁵ Gold, A.K.; Stathopolou, G. & Otto, M.W. (2020). Emotion Regulation and Motives for Illicit Drug Use in Opioid-Dependent Patients. *Cognitive Behaviour Therapy*, 49(1): 74-80.

⁸⁶ MacDonald, R. & Marsh, J. (2002). Crossing the Rubicon: youth transitions, poverty, drugs and social exclusion. *International Journal of Drug Policy*, 13(1); 27-38.

⁸⁷ Ridley, J. and Mcluskey, S. (2001). Exploring the perceptions of young people in care and care leavers of their health needs. *Scottish Journal of Residential Child Care*, 2(1): 55-65.

⁸⁸ McKeganey, N. & Beaton, K. (2001). Drug and alcohol use amongst a sample of looked after children in Scotland Centre for Drug Misuse Research (unpublished)

⁸⁹ McCann et al. 1996. Prevalence of psychiatric disorders in young people in the care system. *BMJ*, (313):.

⁹⁰ Pilowsky, D. and Wu, L. (2006). Psychiatric symptoms and substance use disorders in a nationally representative sample of American adolescents involved in foster care. *Journal of Adolescent Health*, 38, 351-358.

In the UK in 2011/12, approximately 7% of young people accessing specialist alcohol and drug services reported that they were in care⁹¹.

- **Homeless Younger People** – Homelessness forms both a risk factor for and a consequence of harmful alcohol and problem drug use. Substance use in this population has been reported as two- to three-times higher than that of non-homeless young adults. Four out of five people start using at least one new drug after becoming homeless⁹². Estimates across European countries range from 30-70% prevalence rates for problematic drug use among homeless populations⁹³. While data is not available by age, in Scotland 12% of people accessing specialist drug treatment in 2018/19 were recorded as being homeless⁹⁴; likely an under-estimate, as it may not include less severe forms of housing insecurity and levels of missing data were high.
- **Young Offenders** – Again, criminal offending may predate and lead to problematic alcohol and drug use, or may be caused by it. As aforementioned, Scottish prison surveys have shown that a large proportion of individuals serving sentences engaged in problem drug or alcohol use on the outside.
- **Younger People with ACEs** – As highlighted in the section on risk-factors, younger people who have experienced traumatic experiences in childhood are at substantially greater risk from developing problematic alcohol and drug use.
- **Children in Families with Problem Drug Use** – Children of substance misusing parents face particular problems; chaotic domestic circumstances, poverty, poor housing conditions, violence and maltreatment, and can be vulnerable to not having their social, emotional or physical needs met.
- **Children and Young People Experiencing Deprivation** – Children and young people experiencing deprivation are exposed to a range of risk factors which increase their likelihood of developing problematic alcohol and drug use both in the short- and longer-term⁹⁵.
- **Younger People Experiencing Unemployment** - Empirical evidence has consistently suggested that unemployment may lead to psychiatric problems including substance use⁹⁶. Three lines of thought have emerged; the stress hypothesis; the income loss hypothesis, and the social selection/drift hypothesis.
- **Early School-Leavers** – A study in Ireland showed that substance use is significantly higher than among school-attending students, with early school-leavers up to 1.2 times more likely to drink alcohol, between 2.4 and 4.4 times

⁹¹ NHS National Treatment Agency for Substance Misuse. Substance misuse among young people 2011-12. Available at:

⁹² Fountain J, Howes S. (2002). *Home and Dry? Homelessness and substance use*. London: Crisis.

⁹³ EMCDDA (2008). Selected Issue 2008: Drugs and Vulnerable Groups of Young People. Available at: https://www.emcdda.europa.eu/attachements.cfm/att_64250_EN EMCDDA_SI08_vulnerable-young.pdf

⁹⁴ Public Health Scotland (2020). Scottish Drug Misuse Database. Available at: <https://beta.isdscotland.org/media/3878/2020-03-03-sdmd-report.pdf>

⁹⁵ Scottish Drugs Forum (2007). Drugs and Poverty: A Literature Review. Available at: http://www.sdf.org.uk/wp-content/uploads/2017/03/Drugs_Poverty_Literature_Review_2007.pdf

⁹⁶ Catalano, R. et al (2011). The Health Effects of Economic Decline. *Annual Review of Public Health*, 32.

more likely to use cannabis, and between 3.7 and 14.4 times more likely to use other drugs⁹⁷.

- **Children Excluded from School** – In SALSUS 2018, those who had ever been excluded were, for 13 year olds, five times and, at 15 years, twice as likely to have used drugs in the last month, as well as being more likely to have drunk alcohol in the last week⁹⁸.

3.4 Vulnerable Periods

While there is a large body of literature exploring risk factors and vulnerable groups, there is comparably little evidence on the periods at which younger people are most at risk from transitioning towards problematic alcohol or drug use. However, from the available evidence on risk factors and vulnerable groups, it is possible to determine a number of key trigger points and vulnerable periods within which younger people are likely to transition towards problematic alcohol and drug use, and to experience harms. This is not exhaustive, particularly given that different groups will experience different vulnerable periods and triggers.

- **Childhood and Early adolescence** – As highlighted above, a wide range of research highlights that early initiation of alcohol and drug use, particularly prior to 14 years of age, increases the risk of problematic alcohol and drug use, independent of other risk factors.⁹⁹
- **Early School Leaving** – As noted above, research among 15-18 year olds in Ireland found that those leaving school early were considerably more likely to engage in the use of other drugs than those still attending school¹⁰⁰.
- **Transition to Independent Living from Care** – The period of leaving the care system represents a critical point in the development of problematic substance use. A review found that, while drug use may have developed while in care, the transition towards independent living forms a critical period within which such use may develop towards problematic use¹⁰¹.

⁹⁷ National Advisory Committee on Drugs. (2010). Risk and Protection Factors for Substance Use among Young People: A Comparative Study of Early School-Leavers and School-Attending Students. Available at: https://www.drugsandalcohol.ie/14100/1/NACD_RiskYoungPeopleSchool.pdf

⁹⁸ Scottish Government (2019). Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) 2018. Available at: <https://www.gov.scot/collections/scottish-schools-adolescent-lifestyle-and-substance-use-survey-salsus/>

⁹⁹ Odgers, C.L. et al. (2013). Is It Important to Prevent Early Exposure to Drugs and Alcohol Among Adolescents? *Psychol. Sci.*, 19(10):1037-1044.

¹⁰⁰ National Advisory Committee on Drugs. (2010). Risk and Protection Factors for Substance Use among Young People: A Comparative Study of Early School-Leavers and School-Attending Students. Available at: https://www.drugsandalcohol.ie/14100/1/NACD_RiskYoungPeopleSchool.pdf

¹⁰¹ Ward, J. et al. (2003). One problem among many: drug use among care leavers in transition to independent living. London: Home Office. Research, Development and Statistics Directorate.

4. Children and Younger People and Treatment and Recovery Services in Scotland

4.1 Alcohol and Drug Treatment and Recovery Services for Younger People in Scotland

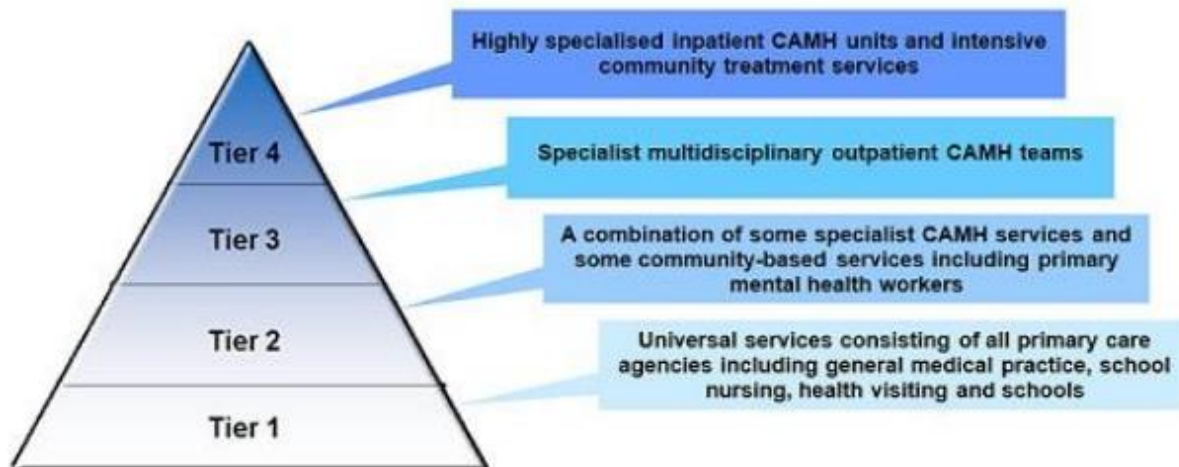
4.1.1 Provision of Alcohol and Drug Services in Scotland

The provision of alcohol and drug treatments services in Scotland follows a tiered model (a full description of these tiers are provided in Appendix I).

Pathways for Children (0-18 years)

NHS Scotland Child and Adolescent mental Health Services (CAMHS) form the core of referral and treatment pathways for problematic alcohol and drug use among children and young people (under 18 years of age) in Scotland. CAHMS are multi-disciplinary teams who provide assessment and treatment or interventions for children and young people experiencing mental health problems, including substance use. These CAMHS are provided within a stepped and matched, tiered care model (Figure 4.1)¹⁰²

Figure 4.1 – Tier Model for Treatment by NHS Scotland CAMHS



Source: ISD Scotland 2020

Pathways for Younger Adults

Alcohol and drug treatment services for adults are also delivered through the tiered model detailed in Appendix I. Specialised alcohol and drug-treatment services are primarily provided in tiers 3 (community-treatment) and tier 4 (residential treatment), with brief interventions and referrals occurring in tiers 1 and 2.

¹⁰² ISD (Nov. 2019). CAMHS Tier Model. Available at: https://www.isdscotland.org/Health-Topics/Mental-Health/Child-and-Adolescent-Mental-Health/_docs/CAMHS-Tier-Model.pdf?20:28:07

Alcohol and Drug Partnership (ADP) Annual Reports 2019/20

Scotland's Alcohol and Drug Partnerships (ADPs) Annual Reports for 2019/20 provide the latest information mapping the extent and nature of alcohol and drug support, treatment and recovery services for younger people. At the time of writing, ADP Annual Reports were available for 30 of 31 ADPs in Scotland¹⁰³.

- **Overall Provision** – 26 (84%) ADPs reported the availability of alcohol and/or drug treatment and support services specifically targeted towards children and young people (under the age of 25) with problematic alcohol and/or drug use within their ADP area.
- **Provider Types** – Just under half of ADPs (n=15, 48%) stated that these services were provided by third-sector organisations (in some cases commissioned by ADPs). Eight ADPs (26%) stated that tailored services were available from statutory providers, while two ADPs (6%) reported services offered by a mix of third-sector and statutory providers across their area.
- **Disparity of Services** – There was marked disparity in the services reported by ADPs in their open-ended answers as being available within their area, suggesting that the services available to young people in Scotland strongly depends on where they live.¹⁰⁴
 - **Tier 1** – Most commonly, ADPs reported services offering Tier 1 interventions including educational interventions and information-based prevention activities, and generalised support and advice while providing more targeted support on a needs-based basis.
 - **Tier 2** – Services offering Tier 2 interventions were described by a smaller number of ADPs. Some offered generalised or targeted mental health support; either through trained mental health services or through counselling and mental health support provided by volunteers, with some highlighting that these services were trauma informed. A wide range of other services were offered. Less frequently, ADPs described services offering transition planning and goal setting and Motivational Interviewing. A small number of ADPs described services which adopted a 'whole families approach', involving home visits and the provision of counselling services to family members of those experiencing alcohol and drug issues. Assertive referral to alternative activities for individuals at risk (including linkages with football clubs and providers in the creative arts) were also reported.
 - **Tier 3 and Tier 4** – No ADPs reported structured community (tier 3) or residential (tier 4) services which were tailored towards the specific needs of children and younger people.
- **Age-Barriers** – Within open-ended replies, the majority of ADPs reported that the services within their area operated a complex range of more specific age limitations. It was challenging to determine whether those who did not report age-boundaries were due to having no boundaries or due to non-reporting. The majority of these reported minimum age limits (typically admitting

¹⁰³ Aberdeenshire have not yet submitted an Annual Report for 2019/20.

¹⁰⁴ As these were open-text answers, it is challenging to draw strong conclusions from these as this likely does not provide a comprehensive list of the services available across each area. Further, it is unclear whether some of these activities are specifically tailored to younger people or whether the approach taken across all ages was available to those under the age of 25.

individuals over 15 years or over 12 years) or maximum age limits (of 18 or 21 years). Some described services as targeting those of a specific age range (typically around 12-18 years). Across the majority of ADPs, those over 18 were typically referred to generalised adult services.

Residential Rehabilitation

A recent Scottish Government mapping report of residential rehabilitation and specialist supported accommodation services for alcohol and drug issues, undertaken in December 2020¹⁰⁵, found that there were no residential services tailored towards the specific needs of children and younger people in Scotland. While residential services may not be suited to many of those of younger age (if still in full-time education, for example), the lack of services tailored towards younger people is concerning given the markedly different profile of drug use among this population group, and the focus on opioid and benzodiazepine addiction across many of the generalised adult services. Further, the report found that facilities across Scotland typically operated with minimum age requirements of 16 or 18 years.

4.2 Treatment and Recovery Services: Barriers to Children and Younger People

4.2.1 Attendance of Drug Treatment Services in Scotland

Children (0-18 years)

While data is not available solely for substance abuse services, data is available on the provision and availability of mental health treatment for children. The latest data from the quarter ending June 2021¹⁰⁶ shows that 4,552 children and young people started treatment at CAMHS during this quarter; an increase of 11.1% from the previous quarter. This was of a total of 10,193 children and young people referred in this quarter; more than twice as many as the 4,052 referred in the quarter ending June 2020. Just over seven out of ten (72.6%) waited less than 18 weeks for treatment; lower than the Scottish Government aim of 90% starting treatment within 18 weeks of referral. Waiting times varied considerably by NHS Board; from 98.8% being seen within 18 weeks in NHS Ayrshire & Arran, to only 36.4% being seen within 18 weeks in NHS Dumfries & Galloway. At the end of the quarter, there were 11,722 children and young people waiting for treatment at a CAMH service in Scotland. While it is not possible to determine how many of these children and young people had co-occurring substance use issues the data demonstrates that there are considerable pressures on the system.

¹⁰⁵ Scottish Government (Dec. 2020). Residential Rehabilitation in Scotland: Service Mapping Report 2019/20. Available at: <https://www.gov.scot/publications/residential-rehabilitation-scotland-service-mapping-report-2019-20/>

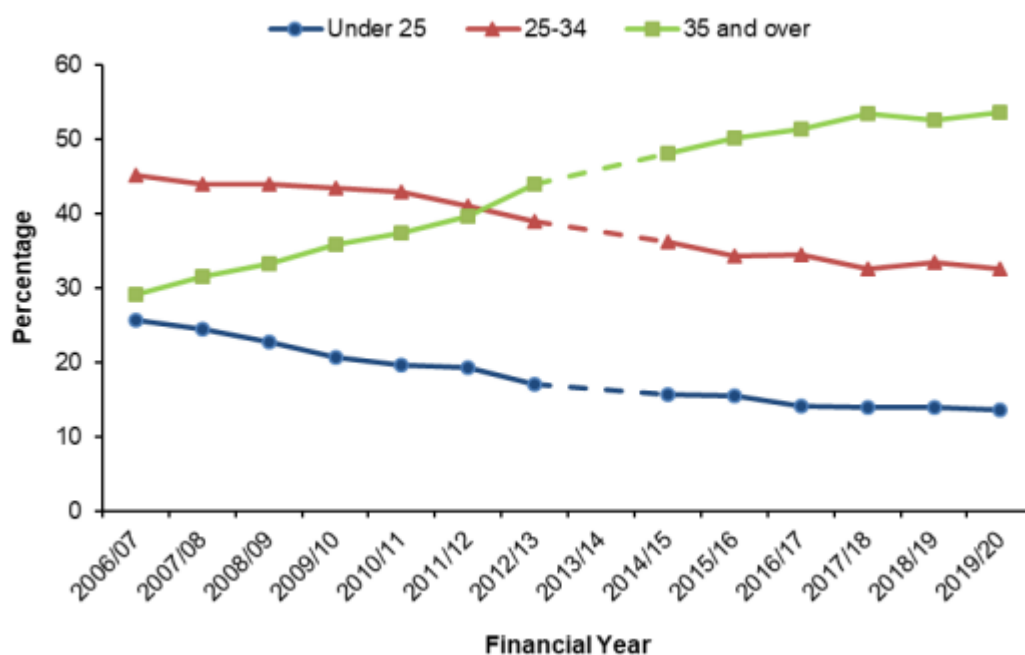
¹⁰⁶ [Child and Adolescent Mental Health Services \(CAMHS\) waiting times - Quarter ending 30 June 2021 - Child and Adolescent Mental Health Services \(CAMHS\) waiting times - Publications - Public Health Scotland](#)

Adults

While hospital admissions and drug-related deaths are rising among younger people, the Scottish Drug Misuse Database data for 2019/20¹⁰⁷ shows that fewer younger people are accessing Tier 3 and Tier 4 drug treatment services. This may be due to services not being suited to the particular needs of younger people, and, particularly, due to the different profile of drugs causing harms (primarily in relation to hospital admissions) among younger people. This was identified as an issue within the 2009 Audit Scotland report on alcohol and drug services in Scotland¹⁰⁸, and is a more pressing today given the transition in drug profile causing harms among younger people.

- Younger people make up a smaller proportion of overall clients recorded on Scottish Drug Misuse Database. While they contributed 26% in 2006/07, this has declined to 14% (n=1,490) in 2019/20 (Figure 4.2).
- Reported heroin use has declined sharply among younger people; the percentage of individuals aged under 25 years reporting heroin use in the month prior to assessment fell from 58% (1,587 out of 2,736) in 2006/07 to 18% (236 out of 1,313) in 2019/20.

Figure 4.2 – Percentage of individuals recorded on Scottish Drug Misuse Database (SDMD) by age group and financial year (2006/07 – 2018/19)



Source: ISD SDMD 2019/20

¹⁰⁷ ISD (March 2020). Scottish Drug Misuse Database Overview of Initial Assessments for Specialist Drug Treatment 2019/20. Available at: <https://publichealthscotland.scot/media/6315/2021-03-02-sdmd-report.pdf>

¹⁰⁸ Audit Scotland (2009). Report: Drug and alcohol services in Scotland. Available at: <https://www.audit-scotland.gov.uk/report/drug-and-alcohol-services-in-scotland>

4.2.2 Barriers to Children and Younger People seeking treatment

Relatively few children and younger people seek treatment for substance use problems. Compared to research highlighting the barriers faced by younger people accessing mental health services, research into the barriers that confront younger people seeking to access alcohol and drug treatment services is lacking. Wisdom and colleagues' 2010 review was structured around the following typology of barriers; structural, problem recognition, and negative perceptions surrounding treatment.

- **Structural Barriers** – Studies highlight logistical and material obstacles, including high cost, insufficient coverage, a lack of knowledge of services, geographic barriers and waiting lists. While data was not available for substance use treatment alone, data for CAMHS services, as highlighted above, found that a substantial proportion of children had to wait more than 18 weeks for treatment¹⁰⁹. The latest data from the Drug and Alcohol Treatment Waiting Times database¹¹⁰ shows that 95.3% of those starting their first drug or alcohol treatment waited 3 weeks or less (95.1% for alcohol treatment and 95.5% for drug treatment). Entry criteria may also work to exclude younger people¹¹¹. The ADP Annual Reports highlight age-barriers for young people's services, generating gaps in provision. Dundee City ADP stated that individuals between 18-25 were often disengaged at the point of referral as they were too old for youth services but felt that adult services were not appropriate.
- **Problem Recognition** – The recognition of problems in relation to alcohol and/or drug use forms the primary component in treatment seeking, and is shaped by contextual and cultural factors. Youth – particularly adolescence – is a period of change, instability, and risk-taking, often including experimentation with substances. In a country where this is normalised, individuals, their family and peers may view substance abuse as a 'phase' that the younger person will 'outgrow', or perceive it not to be severe enough for treatment¹¹². Lack of desire to stop using also forms a common barrier among younger people¹¹³.
- **Negative perceptions and attitudes towards treatment** – Negative views about treatment, both in the eyes of the caregiver or the younger person, form

¹⁰⁹ ISD (Dec. 2020). Child and Adolescent Mental Health Services (CAMHS) waiting times. Available at: <https://beta.isdscotland.org/find-publications-and-data/conditions-and-diseases/mental-health/child-and-adolescent-mental-health-services-camhs-waiting-times/>

¹¹⁰ Public Health Scotland. (Sept 2020). National Drug and Alcohol Treatment Waiting Times: 1 April – 30 June 2020. Available at: <https://beta.isdscotland.org/find-publications-and-data/lifestyle-and-behaviours/substance-use/national-drug-and-alcohol-treatment-waiting-times/>

¹¹¹ Wisdom, J.P. et al. (2011). Barriers and facilitators to adolescent drug treatment: Youth, family, and staff reports. *Addiction Research & Theory*, 2: 179-188.

¹¹² Cauce AM, Domenech-Rodriguez M, Paradise M. et al. (2002). Cultural and contextual influences in mental health help seeking: A focus on ethnic minority youth. *Journal of Consulting and Clinical Psychology*; 70: 44–55.

¹¹³ Ballon B, Kirst M, Smith P. (2004). Youth help-seeking experiences and their relation to help-seeking behaviours for substance use problems. *Addiction Research and Theory* 2004; 123: 241–260.

a barrier to accessing alcohol and drug services. These include stigma, negative attitudes towards services, and perceiving available services as unsuitable¹¹⁴. Stigma, in particular, has been assessed as an issue within the Scottish context¹¹⁵. This lack of suitability may be due to the adult-focussed service, which may often be suited to the particular drugs which younger people experience problems.

Further research to understand barriers from multiple perspectives – younger people's, caregivers', and providers' viewpoints – would be desirable in order to capture a fuller picture of obstacles confronting younger people in Scotland experiencing harms from alcohol and drugs.

4.3 What Works in Treatment and Recovery for Children and Younger People?

Research examining treatment and recovery among young people trails the adult literature¹¹⁶. There is therefore a need for further exploration of what kind of treatment and recovery services are effective for younger people in Scotland and more widely.

In 2020, Christie *et al* undertook a review of the existing literature on effective treatment of problem alcohol and drug use among young people. While undertaken in the US, there are a number of areas of relevance for the Scottish context. Existing research suggests that treatment services for younger people improve outcomes in the short to medium term, while emergent studies of longer-term outcomes showing modest benefit, particularly in those with moderate issues¹¹⁷. The literature also suggests that, for those with less complexity and comorbidity, increased intensity of treatment does not necessarily lead to better outcomes. Following a stepped-care approach, a more intensive approach should be used for more severe or complex problems, or where community treatment has failed. Treatment should also be flexible and informed by an understanding of the developmental challenges that young people face. As noted, younger people tend not to recognise their substance use as problematic as readily as adults, and are facing harms from a different profile of drugs than those of older age-groups in Scotland.

Drawing on the existing evidence-base relating to their efficacy, their review identified a number of treatment and service delivery principles which they suggest should be applied to treatment settings for young people. However, it must be foregrounded that these suggested treatment and recovery delivery principles primarily target individual and contextual determinants; generating a lasting reduction

¹¹⁴ United States Public Health Service (USPHS). (2005). United States Public Health Service. *Results from the 2005 National survey on drug use and health: National findings*. Available at: <http://www.oas.samhsa.gov/NSDUH/2k5NSDUH/2k5Results.htm>

¹¹⁵ Audit Scotland (2019). Drug and alcohol services An update. Available at: https://www.audit-scotland.gov.uk/uploads/docs/report/2019/briefing_190521_drugs_alcohol.pdf

¹¹⁶ Christie, G.I.G.; Cheetham, A. & Lubman, D.I. (2020). Interventions for Alcohol and Drug Use Disorders in Young People: 10 Key Evidence-Based Approaches to Inform Service Delivery. *Current Addiction Reports*. Available at: <https://link.springer.com/article/10.1007/s40429-020-00336-6>

¹¹⁷ Winters KC, Stinchfield R, Latimer WW, Lee S. Long-term outcome of substance-dependent youth following 12-step treatment. *J Subst Abus Treat*. 2007;33(1):61–9.

in harms from alcohol and drugs across the population requires changes to the structural (primarily socioeconomic) determinants of problem alcohol and drug use.

- **Promote screening, brief intervention and referral to treatment** – The evidence shows that screening, brief intervention and referral to treatment is effective in reducing alcohol- and drug-related problems, and should be promoted in primary care, medical, youth justice and school settings to address early problematic use and support young people into treatment.
- **Incorporate peer networks in service delivery** – Peer relationships form a key developmental factor for younger people and, as such, the evidence shows that a range of interventions which incorporate peers are effective in reducing problematic alcohol and drug use.
- **Support harm reduction** – The evidence demonstrates that incorporating harm reduction as a treatment outcome within services (including when abstinence is a treatment goal) is evidenced to improve outcomes. This can include progressive steps, such as using less of a substance, or using in a safer way, if the individual does not feel ready for abstinence at that point in time. However, the reasons underpinning this lack of readiness should be identified, and addressed within treatment.
- **Undertake proactive engagement** – The data highlights that those in adolescence and young adulthood are less likely than those across all ages to seek treatment. Service flexibility and responsiveness, a focus on establishing good therapeutic alliance, offering practical support and semi-formal contact, and family involvement are key steps. Younger people are more likely to engage with a service if it is interesting, responsive, confidential, respectful, trustworthy, and staffed by caring, committed and optimistic professionals, often those with lived experience of problematic substance use. Youth participation in service development, delivery and feedback are also supported by the evidence base.
- **Individual therapy should include motivational interviewing and cognitive behavioural therapy** – When working with young people on an individual basis, motivational interviewing (MI) and cognitive behavioural therapy (CBT) are generally the approaches best supported by evidence.
- **Addressing co-occurring problems is essential** – Comorbidity has been associated with poorer substance use treatment outcomes, including non-completion and earlier relapse, with a large body of existing evidence highlighting the importance of screening for co-occurring mental health and substance use problems among young people presenting to both addiction and mental health services.
- **Family interventions are fundamental** – Family involvement improves treatment outcomes; thus, it is best established from the outset of treatment if possible. The research shows that even minor levels of involvement are usually better than none, securing early changes in substance use and behaviour, and enhancing engagement in later treatment.
- **Computer and e-health interventions are developing** – Technology-based interventions offer the possibility of reaching individuals who otherwise might not seek treatment such as those in remote areas, those not perceiving a need for treatment, or others who may resist face-to-face treatment. For adolescents, interventions delivered via computer or mobile phone may be appealing as they can manage the pace of treatment, ensure privacy and

tailor content to their needs. Effective implementation of such services is vitally important in the context of the COVID-19 pandemic, with a number of services in Scotland having moved wholly or partly online in 2020.

The evidence supports the use of a range of interventions for problematic alcohol and drug use in children and younger people, but is less definitive about which type of treatment or service is better for specific population groups. Services that can provide a range of treatment modalities will be best placed to respond to the specific needs of the young person, and their family if relevant. Treatment planning should be tailored for each young person, taking into account co-existing disorders, developmental issues and their family and social environment. The evidence shows that services are best set up separately and specifically for young people (rather than integrated with adult services) to ensure a developmental and engagement-focussed approach. The implementation of effective treatments for young people in Scotland with alcohol and drug use disorders is critical, not only to alleviate suffering within a vulnerable sector of the population, but also as a means of altering trajectories of harmful alcohol and drug use that can persist into adulthood.

5. Conclusions

This report has presented the findings from a rapid review of the existing literature and evidence base pertaining to younger people experiencing harms from alcohol and drugs in Scotland. While Scotland's high levels of harms are driven primarily by those of older (although still young) age-groups, the data presented demonstrates that recent years have seen high (and, particularly in relation to drugs, increasing) harms from alcohol and drugs among younger people in Scotland. The evidence both from Scotland and from the wider UK and international literature allows for an understanding of the determinants which contribute to the development of problematic alcohol and drug use among younger people, and of approaches to treatment and recovery service provision which are effective for individuals of this age group. Importantly, this knowledge allows for a number of steps which should be taken in order to avoid the emergence of a cohort vulnerable to high levels of harms as they age. A number of recommendations for next steps, both in terms of policy and future research, are outlined below.

5.1 Recommendations

5.1.1 Next Steps

Given the emergence of concerning trends among younger people in relation to increasing harms from alcohol and drugs, coupled with the wealth of existing literature and evidence highlighting both the determinants of problematic alcohol and drug use among younger people and effective approaches to treatment and recovery, the implementation of policy to ameliorate these risks and improve both pathways into and quality of treatment and recovery should take priority over further research. A number of these recommendations are relevant to all ages, while others relate specifically to younger people.

Challenge the Determinants of Problem Alcohol and Drug Use

- **Policies should be rooted in tackling the structural determinants of problem alcohol and drug use** – Poverty and socioeconomic deprivation form the primary determinant of harms from alcohol and drug use, and cause a range of contextual and individual-level risk factors which increase the likelihood of developing problem alcohol and drug use and experiencing harms throughout the individual's life. The reduction of socioeconomic inequalities are therefore essential and must be the priority for policy. While a number of fiscal policy levers remain under Westminster control, a range of measures are available within Scotland, and it is paramount that all opportunities available are taken to do so. Such measures have been outlined elsewhere, and should include;
 - an economic strategy with the reduction in socioeconomic inequalities at its core;
 - the provision of incentives to employers in order to attract employers to areas with high youth unemployment;
 - progressive (wealth and asset, and income and corporate) taxation policies to reduce inequalities;

- policies to reduce inequalities in ownership of capital;
- the strengthening of the social security system to ensure that younger people receive necessary help, and;
- policies to address the costs of living (including the development of an ‘anti-poverty childcare system’, the reduction of the ‘poverty premium’ in goods and services; the implementation of a ‘living rent’, and; reducing transport costs.
- **Following recommendations made elsewhere, the Scottish Government should introduce a ‘poverty-proofing’ approach to all policies and major spending decisions**, as well as a ‘health in all policies’ approach to address issues relating to the social determinants of health and health inequalities in Scotland.
- **Strengthen the transition from school to further education and/or employment** – A range of measures have been evidenced¹¹⁸ to reduce the amount of individuals not in education, employment or training. These include;
 - the provision of early-intervention measures (including investment in quality early childhood education and care; identifying and targeting at-risk individuals; offering mentoring and one-to-one support; offering financial support to those from low-income households, and; introducing more vocational and technical education;
 - re-integration measures targeted at younger people currently or at-risk of becoming not in employment, education or training, including outreach services, intensive support (from trained advisers), financial support and tailored education, employment and training solutions;
 - tracking systems to identify at-risk individuals and to target these measures;
 - active labour market measures to encourage firms to hire younger employees, including offering wage and training subsidies, or tax and national insurance breaks/credits to employers;
 - improvement in the quality of jobs available to younger people (both through provision of the living wage and the provision of guaranteed working hours) in order to reduce the number of younger people not in employment, education or training (NEET).¹¹⁹
- **Develop training and employment opportunities to younger people in recovery from problematic alcohol and drug use** – Policies to encourage employers to take on younger people in recovery from problematic alcohol and drug use have been shown to promote the maintenance of abstinence.

¹¹⁸ S. Maguire (2013). What Measures Can Be Taken to Address the Specific Problem of Young People Who Are NEET?, in: *Intereconomics – Review of European Economic Policy*, Vol. 48(4): 196-201.

¹¹⁹ While employment law remains reserved, the Scottish Government has influence over public sector pay and the supply chain of the public sector.

Treatment and Recovery Services

Improve Access to Treatment and Recovery Services

- **Prioritise engagement with young people** – With younger people less likely than older age-groups to engage with drug and alcohol treatment services, work should be undertaken to increase engagement with services.
- **Improve awareness of pathways into treatment** – A lack of knowledge of available services forms a barrier to their uptake. Work should be undertaken to ensure that pathways into treatment and recovery services are well-known by young people.
- **Improve access to mental health services in schools** – A large proportion of schoolchildren feel that mental health services are not adequate at their school. Improving access to mental health services in schools and other universal settings is essential.

Improve Provision of Treatment and Recovery Services

- **Develop residential and community treatment and recovery services tailored towards the different drug-profile and developmental needs of younger groups** – The lack of treatment and recovery services addressing the needs of younger people was identified as an issue within the 2009 Audit Scotland report on alcohol and drug services in Scotland¹²⁰, and is a more pressing today given the transition towards a markedly different drug profile causing harms among younger people across the decade since. This should be prioritised as a lack of suitability of existing services has been identified as a barrier to uptake of services among younger people. Development of such services should include the development of both residential rehabilitation and community treatment and recovery services which cater for the specific needs of younger people, as well as ensuring existing services are well funded.
- **Encourage flexibility in (particularly age-related) admission criteria** – While tailoring services towards the needs of individuals of particular ages is desirable, excluding individuals who fall narrowly outside of the age-range (and who feel that they do not feel they fit elsewhere) is counterintuitive to the primary aim of engaging younger people in treatment and recovery from problematic alcohol and drug use. Where possible, admission criteria should be flexible in order to most effectively attract and retain younger people in treatment and recovery services.
- **Improve access to treatment for those with co-occurring mental health and substance use issues** – Existing reports suggest that many with co-morbidity are unable to attend mental health services due to substance use, and unable to attend substance use treatment and recovery services due to complex mental health conditions. Measures to improve access to this particularly vulnerable population of younger people should be prioritised.
- **Reduce waiting times for treatment and recovery services** – Waiting times for CAMHS and for adult mental health and alcohol and drug services should be reduced considerably, given the typically short windows of opportunity

¹²⁰ Audit Scotland (2009). Report: Drug and alcohol services in Scotland. Available at: <https://www.audit-scotland.gov.uk/report/drug-and-alcohol-services-in-scotland>

within which individuals are able to engage in the transition from problematic use of alcohol and drugs towards treatment and recovery.

- **Embed a human rights approach within all services** - Alcohol and drug-treatment services should have a rights-based and person-centred approach embedded in their service delivery. The needs of the younger person (and their personal choices regarding which services they feel they require) should be at the heart of service delivery. Work should be undertaken with professionals working with children and younger people to counter stigmatising attitudes towards those engaging in problematic alcohol and drug use, as this forms a substantial barrier to youth engagement.
- **Encourage the growth of recovery communities for younger people** – Existing recovery communities may not be suited to younger people’s specific needs. The Scottish Government should continue to fund those facilitating the development of recovery communities, and should particularly seek to fund the development of such groups for those of younger ages.
- **Develop safer injection facilities and supply drug-testing kits at points of use** – Safer-injection facilities should be available, particularly in areas where younger people are more likely to inject drugs. Particularly given the relatively large contribution of younger people to overall deaths from ecstasy, drug testing kits should be made readily available, including at venues where ecstasy-type drugs are likely to be taken.

Systematic and Regular Monitoring of the Harms Experienced by Younger People and their Access to Services

- **Systematic monitoring of need for alcohol and drug services** – The ratio of the number of people in need of treatment to the number of people receiving treatment is a vitally important measure of the effectiveness of alcohol and drug treatment.
- **Systematic monitoring of provision of alcohol and drug treatment services across Scotland** – Systematic monitoring of alcohol and drug treatment services – particularly Tier 3 and Tier 4 services – should be undertaken at ADP level.
- **Monitor and report on wider harms caused by alcohol and drugs among younger people** – ScotPHO’s analysis of alcohol-*attributable* hospital admissions and deaths demonstrated the far greater level of harms from alcohol experienced by younger people than is apparent from routine measures. Up-to-date monitoring and reporting of alcohol- and drug-attributable hospital admissions and deaths would provide a greater indication of the actual level of harm experienced among younger people.

Systematic Approach

- **Ensure that ADP and Community Planning Partnership agencies work effectively** – ‘Systems thinking’ should be adopted, with ADPs and agencies working closely with all individuals in communities to improve outcomes, particularly in disadvantaged communities where younger people are at risk of harms from alcohol and drug use.
- **An inclusive and collaborative approach with third-sector and private organisations** – With a large proportion of tier 3 and 4 services provided by

non-statutory providers (particularly third-sector providers), collaborative working and meaningful inclusion must be at the heart of local policy and service delivery.

- **Ensure proportionate funding across ADPs** – Currently, there is wide variation in funding of alcohol and drug-services across ADPs, including among those who have similar rates of drug-related harms. Work should be undertaken to ensure that funding is standardised and appropriate to levels of need (both in relation to deprivation profiles and existing alcohol- and drug-related harms).
- **Encourage systematic links between settings and agencies where younger people are present** – A focus should be placed on strengthening links between agencies and settings within which younger people vulnerable to problematic alcohol and drug use are present – including education, care, and community alcohol and drugs services – in order to provide appropriate and tailored support.
- **Monitor and provide proactive outreach during vulnerable transition periods** – Young people in periods within which they are vulnerable to transitioning towards problematic alcohol or drug use – those leaving school early and who are not transitioning to further education or employment, and those who are leaving care, for example – should be monitored, with proactive outreach and tailored support made readily available.

5.1.2 Future Research

The literature review and exploration of the Scottish data has also outlined a number of areas where our knowledge may be improved.

Improve monitoring of prevalence rates and harms

- **Consider wider harms in estimates of problem drug use** – Existing measures incorporating opioids and benzodiazepines should be maintained, but alongside an additional measure incorporating a wider range of drugs in recognition of the distinct profile of drugs causing harms among younger individuals.
- **Collect data on narrower age-categories for younger people** – Alongside the existing main categories, separating prevalence data into narrower ranges age-categories would increase the utility of data; particularly for younger people given that younger people go through a number of developmental stages within existing age-categories. This is particularly so for those aged 0-14 years, as including a number of years at which prevalence of alcohol and drug use is near non-existent among those aged 12-14 (at which initiation often begins) weakens the utility of the data, particularly in comparing prevalence rates with older age-groups.

Risk Factors

- **Undertake further research into ‘vulnerable periods’ at which younger people are at greater risk of transitioning towards problematic patterns**

of alcohol or drug use – While there is existing data on risk factors and vulnerable populations, comparatively little data identifies the transitional periods at which individuals are at most risk of developing problematic alcohol and/or drug use.

- **Research on the relationship between ACEs and problematic alcohol and drug use in Scotland among children and young people** – While work elsewhere in the UK has demonstrated the strength of association between ACEs and future problematic alcohol and drug use, existing data in Scotland is weak.

Treatment and recovery

- **Co-produce research with younger people with lived experience of alcohol and drug use and treatment to establish what works in treatment** – The insights of younger people, as well as their families, with experience of (or at risk of) problematic alcohol and/or drug use should be meaningfully incorporated into research in order to gain a greater understanding of the barriers and enablers in relation to engaging with and maintaining engagement with alcohol and/or drugs services.
- **Research into the effectiveness of alcohol and drug treatment and recovery services for younger people in Scotland** – Linked to this, research which explores what kinds of treatment and recovery services are most effective with different population groups (including those of different ages, genders, ethnic backgrounds, socioeconomic backgrounds, those with co-morbidities, etc.) would help to improve outcomes of such treatment.

Appendices

Appendix I – Detailed Description of Tiered Model of Alcohol and Drug Treatment Services

Alcohol and drug treatment services for those of all ages in Scotland are delivered through a tiered model of increasing intensity of intervention¹²¹. A brief description of these are outlined below.

- **Tier 1** interventions involve;
 - the provision of general information and advice;
 - screening and assessment, and;
 - referral to specialist alcohol or drug services if necessary.
 - Partnership of 'shared care' working with specialised alcohol or drug treatment interventions for those with problem use may also be undertaken within the context of their generic services.

Tier 1 services are provided by practitioners (including GPs, teachers and social workers) in the context of universal healthcare settings (including liver units, Accident and Emergency, pharmacies) or social care, education, or criminal justice settings (including probation, courts, prison reception) where the main focus is not drug treatment.

- **Tier 2** interventions include the provision of drug-related information and advice, triage assessment, referral to structured drug treatment, brief psychosocial interventions, harm reduction interventions (including needle exchange) and aftercare. More specifically, these services can include;
 - triage assessment and referral for structured alcohol and/or drug treatment;
 - interventions which attract and motivate those with problem use into local treatment systems, including engagement with priority groups;
 - interventions to reduce harm and risk due to blood-borne viruses and other infections for active drug users;
 - interventions to minimise the risk of overdose and diversion of prescribed drugs;
 - brief psychosocial interventions for alcohol and drug misuse;
 - brief interventions for specific target groups including high-risk and other priority groups;
 - support for clients seeking abstinence;
 - aftercare support for those who have left structured treatment, and;
 - outreach services to engage clients into treatment and re-engage people who have dropped out of treatment.

These tier 2 interventions will often be delivered in the same setting and by the same staff as tier 3 interventions. Other typical settings to increase access are through outreach, including home visits, general detached or street work, peripatetic work in general service, and primary care settings. Criminal justice

¹²¹ Smith, H. & Massaro-Mallinson, M. (2010). HEAT A11: Updated Drug and Alcohol Treatment Types. Available at: https://www.isdscotland.org/Health-Topics/Waiting-Times/Drugs-and-Alcohol/Docs/DATWT_TreatmentTypes_rev.pdf

and pharmacy settings are also important here in engaging individuals at risk and, for the latter, due to their unique role in pharmacy based needle exchange schemes and their role in the supervised consumption of prescribed drugs.

- **Tier 3** interventions centre on the provision of community-based specialised drug assessment and coordinated care-planned treatment and liaison with alcohol and/or drug specialists. More specifically, services here include;
 - comprehensive alcohol and/or drug misuse assessment;
 - care planning, co-ordination and review for all in structured treatment, often with regular key-working sessions as standard practice;
 - community care assessment and case management for those with problematic alcohol and drug use;
 - harm reduction activities as integral to care-planned treatment;
 - a range of prescribing interventions for problem drug use, in the context of a package of care and in line with 'the Clinical Guidelines'. These are updated according to the National Institute for Clinical Excellence (NICE) guidelines, and in line with other evidence-based clinical standards with specific interventions, including prescribing for stabilisation and oral opioid maintenance prescribing; community based detoxification; injectable maintenance prescribing, and a range of prescribing interventions to prevent relapse and ameliorate alcohol- and drug-related conditions;
 - a range of structured evidence-based psychosocial interventions to assist individuals to make changes in alcohol and drug using behaviour;
 - structured day programme and care-planned day care (e.g. interventions targeting specific groups);
 - liaison services for acute medical and psychiatric health services (e.g. pregnancy, mental health and hepatitis services);
 - liaison services for social care services (e.g. child protection and community care teams, housing, homelessness), and;
 - a range of the above interventions for drug-misusing offenders.

Tier 3 interventions are typically delivered in specialised alcohol and/or drug treatment services with their own premises in the community or in hospital settings. Other delivery may be undertaken by outreach (including work in generic services or other agencies or domiciliary or home visits). These may be provided along tier 2 interventions. Some of the tier 3 work in primary care settings (shared care schemes and GP-led prescribing services), as well as in pharmacies, but drug-specialist-led services are required within the local systems for the provision of care for severe or complex needs and to support primary care. Alcohol and drug-treatment interventions for offenders may also be delivered in prison settings, and community criminal-justice programmes can be delivered in contracted community drug-treatment services (statutory or third-sector).

- **Tier 4** includes the provision of residential specialised alcohol and/or drug treatment and rehabilitation services. These services are typically care

planned and care-coordinated to ensure continuity of care. Tier 4 interventions include;

- inpatient specialist drug and alcohol assessment, stabilisation, and detoxification/assisted withdrawal services (sometimes provided within residential rehabilitation services);
- a range of alcohol and drug residential rehabilitation services (typically provided by the third sector in Scotland);
- a range of supported accommodation services;
- residential alcohol and drug crisis intervention units, typically in larger urban areas;
- provision for special groups for which a need is identified (eg. for pregnant females, those with liver problems, those with severe and enduring mental illness) which may require joint initiatives between specialised drug services and other inpatient units, and;
- a range of the above for offenders with alcohol and drug use.

Inpatient tier 4 services are typically provided within specialist dedicated inpatient or residential units or wards. Provision may also be undertaken in general psychiatric wards for patients with co-morbid severe and enduring mental illness, but many such patients will benefit from a dedicated addiction specialist inpatient unit. Those with complex drug and other needs requiring inpatient interventions may require hospitalisation for their other needs (for pregnancy, liver problems and HIV-related problems, for example). Continuity of care is essential for preserving gains achieved in residential treatments. Therefore, there is a compelling argument for providing, for suitable patients, inpatient detoxification beds attached to residential rehabilitation units (if there are adequate medical supports). Other patients may need inpatient detoxification first in an addiction specialist inpatient unit (e.g. because of severity and complexity) but this still requires significant strengthening of the links with residential rehabilitation provision to ensure the seamless transition between the two.



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