ACMD

Advisory Council on the Misuse of Drugs

Profiles, Needs and Development of Prevention Interventions for Young People at Key Transition Points

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1. Introduction

1.1 Adolescence and the transition into adulthood are periods associated with increased experimentation with drugs[1] which brings heightened vulnerability to drug-related harms. Research has found that across the general population, most cases of drug use and related harm in adolescence and young adulthood typically follow a predictable developmental trajectory shaped by key life events and transitions. The initiation and escalation of drug use is driven by factors such as drug availability and accessibility, identity development, peer influence, and life/situational transitions (Schulenberg & Maggs, 2002; Steinberg, 2001). At the same time, biological, neuroscientific and behavioural research indicates that brain and behavioural development extend beyond adolescence and into early adulthood, which can affect decision making and propensity for risk taking (Mousley et al., 2025; Sawyer et al., 2018). This can mean that young people in this developmental phase are more susceptible to drug-related harm, and that harm can have long lasting adverse outcomes.

1.2 We presented a comprehensive overview of a whole-system approach to prevention, including definitions and concepts, in our 2025 publication, and the reader is referred to this (Advisory Council on the Misuse of Drugs, 2025). The impact and harms of adolescent drug use have been referred to in multiple ACMD drug classification reports, and more specifically in our prevention related publications (Advisory Council on the Misuse of Drugs, 2006, 2015, 2018, 2022, 2025). Earlier initiation, maintenance, and escalation of drug use have been associated with increased risk of a range of physical and social harms. The environmental and situational context of adolescent and young adult drug use may be different to older groups, and may also include harms related to the actions of others (e.g. exploitation, intra familial harm, peer harm).

1.3 As young people (aged 11 to 24 years old) enter young adulthood (aged 18 years and older), drug use peaks due to increased social and economic independence, reduced parental monitoring, and contexts such as educational or workplace environments (Arnett, 2000, 2023). Most drug use episodes are motivated by seeking novel

[1] Although the ACMD primarily provides advice to government in relation to the Misuse of Drugs Act 1971, and related legislation, the work of the Prevention Standing Committee also considers alcohol and other psychoactive drugs (e.g. nicotine, new psychoactive substances, and medicinal products). In this report we use the term ‘drugs’ to refer to all psychoactive drugs. Whilst there are shared drivers of use and harms across substance types, legal status and other factors such as accessibility, and cultural/social norms are also important, and so we draw distinctions between different substance categories where relevant.

experiences and socialising with peers in leisure spaces such as festivals, raves and nightlife settings (Lojszczyk et al., 2023). For a minority of young people, drug use might also be a consequence (and cause) of other life challenges such as mental ill health, adversity and trauma (Advisory Council on the Misuse of Drugs, 2018). At a population level, the transition into adult roles, such as stable employment, relationships, and parenthood, typically coincides with a decline in use (Arnett et al., 2014; Bachman et al., 2008). While most young people navigate these transitions into adult roles without significant harm, and this report does not frame drug use as inherently pathological, evidence consistently shows that risk of drug related harm across transitions is not evenly distributed across the population, and for some individuals this can mean greater exposure to drug-related harms (Advisory Council on the Misuse of Drugs, 2022).

1.4 The social, economic, and developmental contexts shaping these transitions have changed in recent years (Nuffield Foundation, 2025). Traditional markers of adulthood, such as completing education, entering stable employment, achieving financial independence, and forming long-term relationships, are occurring later, less consistently, or not at all for many young people. Considering broader understandings of the determinants of drug-related outcomes, these changes may be a source of inequity and may lead to patterning of harmful outcomes across different groups of young people. These shifts are also occurring against a backdrop of wider structural pressures faced by all young people, including rising poverty and inequality, housing insecurity, job market precarity, digitalisation of social life, and the cumulative impacts of major societal (and for young people, developmental) disruptions such as the COVID-19 pandemic and climate-related anxiety (Nuffield Foundation, 2025; UK Health Security Agency, 2025). These changes have implications for understanding drug use and harm, and the most appropriate prevention responses.

1.5 Drug-related risks during adolescence and young adulthood cannot be understood or addressed solely through individual-level factors or individual behaviour change. Structural and systemic determinants, such as poverty, housing policy, access to education and employment, availability of health and social care services, stigma, discrimination, and access to drugs, play an important role in shaping both trajectories and outcomes.

1.6 This report aims to present trajectory- and transition-focused perspectives to understand how risk and protection relating to drug use may emerge, intensify, or diminish across adolescence and young adulthood. Rather than assuming a single or universal pathway,

young people follow diverse trajectories shaped by individual, social, and structural factors. The report does not discount, but seeks to avoid an over-emphasis on individual resilience, and situates drug use and harm within the wider environments and social contexts that young people must navigate. Where populations or contexts are discussed, this is not to label ‘vulnerable groups’ as fixed categories, but to highlight how structural conditions and service arrangements can interact with developmental transitions to increase or reduce risk of drug related harms (ACMD, 2022).

1.7 Although our focus is adolescence and young adulthood (11 to 24 years of age), in accordance with the ACMD’s model of a whole system response to prevention (2025), the report reinforces the importance of viewing drug use through a developmental and life-course lens, rather than on fixed age thresholds. This allows consideration of the impact of early years experiences, including adversity, on adolescent and adult experiences.

1.8 The report aims to support prevention-oriented responses to drug-related harms among young people. Specifically, it examines:

- How changes in key developmental, social, and economic contexts may shape drug use risk in young people across adolescence and young adulthood.
- Transition points where prevention efforts may be particularly impactful.
- Structural, systemic, and environmental factors that exacerbate or mitigate risk.
- Gaps in current evidence, data, policy, and practice.

2. Drug Use in the UK

Summary

- There is no harmonised survey of drug use among young people across the four UK nations. School and young adult surveys differ in the ages covered, measures, reference periods and frequency, and Northern Ireland has no current data for young adults.
- Cannabis is the most frequently reported drug across all surveys and age groups. School-age use in England has declined since 2021, while signs of drug dependence among adults in England rose between 2014 and 2023/24, driven mainly by cannabis, with around one in ten 16 to 24-year-olds reporting at least one sign of dependence.
- Young adult surveys are reported in a single 16 to 24 age band, so the developmental window in which initiation and escalation of use are most likely, and the post-16 transition, are poorly characterised.
- School-based surveys under-represent the young people at greatest risk, including persistent absentees, excluded pupils, those in alternative provision, care experienced young people and those in contact with the criminal justice system. Several key transitions and subgroups are also not captured.
- Repeated cross-sectional designs cannot describe individual trajectories. UK birth cohorts and administrative data linkage, including linkage to treatment data, are an underused resource for understanding the development and outcomes of drug use.

2.1 For brevity, this report does not provide a review of recent UK drug use prevalence estimates. Table 1 provides a summary and comparison of key data across UK nations.

2.2 Estimating drug use prevalence among young people in the UK is complicated by the absence of a single, harmonised survey across the four nations. England's primary source for school-age estimates is the NHS Smoking, Drinking and Drug Use among Young People survey (SDD), a biennial survey of pupils in Years 7–11 (ages 11–15) that has run since 1982 (NHS Digital, 2024). Scotland's Scottish Schools Adolescent Lifestyle and Substance Use Survey (SALSUS) was discontinued in 2018, and replaced by the Health and Wellbeing Census Scotland which samples S2 and S4 pupils (approximately ages 13 and 15), but this has so far only been run in 2021/22 (Scottish Government, 2023). Wales launched the School Health Research Network (SHRN) Student Health and Wellbeing Survey in 2017, which has high coverage of maintained secondary schools, and surveys 11–16-year olds biennially (Public Health Wales, 2025). In Northern Ireland, the Young Persons' Behaviour and Attitudes Survey (YPBAS) is a school-based survey of Years 8–12 (ages 11–16) and is conducted approximately every three years (NISRA, 2026).

2.3 For those aged 16–24, national England and Wales estimates are taken from the Crime Survey for England and Wales (CSEW) which provides cross-sectional robust trend data (Office for National Statistics, 2025). Scotland's equivalent is the Scottish Crime and Justice Survey (SCJS), supplemented by the Scottish Health Survey (SHeS) (Scottish Government, 2026). Northern Ireland no longer has a dedicated population-level drug use prevalence survey for young adults following the end of the joint Ireland–Northern Ireland household survey series after 2014/15.

2.4 The English Adult Psychiatric Morbidity Survey 2023/24 (APMS) provides statistics on self-reported signs of drug dependence in the general population in England, which complement population prevalence figures (the survey also includes data on alcohol dependence, which are not summarised here) (NHS Digital, 2025). Sample sizes for 16–24 year olds are small, and the APMS team have urged caution when interpreting age-related trends. Overall, reports of one or more signs of drug dependence reported in the APMS rose from 3.8% of 16–64 year olds in 2014, to 6.7% in 2023/24, driven mainly by increases in cannabis dependence. Reports of signs of cannabis dependence nearly doubled, from 2.8% in 2014 to 5.4% in 2023/24, while past-year cannabis use rose only modestly (7.2% to 8.7%). Among 16–24 year olds, 10.1% reported signs of any drug dependence, and this was similar to the 25-34 year old age group (10.2%). In both age groups, cannabis was the most frequently reported drug of dependence (8.3%; 8.6%). Men and women aged 16–24 reported similar rates of signs of drug dependence (10.5% vs 9.4%), a change from earlier APMS waves, in which young men consistently reported the highest use and dependence. Men aged 25-34 were more than twice as likely as women to report signs of drug dependence (14.2%; 6.2%). It is unclear whether this represents convergence or a delayed onset of use among young men, with problematic use emerging later in the life course.

Table 1 Summary and comparison of UK drug use surveys of young people. Only data on controlled drugs are reported here.

Indicator	England	Scotland	Wales	Northern Ireland
School age				
Primary survey source	Smoking, Drinking and Drug Use (SDD) Survey *Latest: 2023, published October 2024*	Health and Wellbeing Census Scotland (HWB Census) *Latest: 2021/22, published February 2023*	SHRN Student Health and Wellbeing Survey *Published 2023*	Young Persons' Behaviour and Attitudes Survey (YPBAS) *Latest: 2022, published September 2023*
Age range / school years covered	Years 7–11 (ages 11–15)	S2 and S4 (ages 13 and 15)	Years 7–11 (ages 11–16)	Years 8–12 (ages 11–16)
Ever used any drug (%)	13% *Down from 18% in 2021*	9.6% (S4 pupils) *Decline from 21% in SALSUS 2018 — methodological difference; not directly comparable*	7% (ever used cannabis) *Pooled estimate 2013–2023*	4% *Stable since 2016*
Past-year drug use (%)	9%	Not directly reported at population level *Data limited to sub-group reporting ever use*	Not separately reported	Not separately reported
Past-month drug use (%)	5%	2% of S4 pupils *As proportion of all respondents reporting last-month use*	4% (cannabis, pooled 2013–2023)	Not reported at this level
Most frequently reported drug used	Cannabis (6.6% ever used; 0.8% 11-year-olds – 16.9% 15-year-olds)	Cannabis (95% of recent users reported past-year cannabis use)	Cannabis (~4% past month)	Cannabis (3% ever used; 9% of Year 12 pupils)
Other notable drug use	Class A: 2–4% (stable since 2010); ketamine 1.1%; nitrous oxide 2.5% *Volatile substances most common at younger ages;*	Cocaine 46%, ketamine 36%, benzodiazepines 24%, heroin 20% (past year, among recent users)	New psychoactive substances lifetime use: 7.3%	Cannabis most commonly offered drug; Class A not broken down

Indicator	England	Scotland	Wales	Northern Ireland
	cannabis at older ages	*These are proportions of recent users, not of all pupils*		
Gender pattern	12% boys, 12% girls (both fell from 17–19% in 2021), 30% other gender identity	Not reported by gender in HWB Census sub-sample	Not separately reported for drug use	Not reported by gender
Age gradient	Pronounced: near-negligible at age 11; ~19% of 15-year-old pupils report past-year use	S4 higher than S2; full age gradient not reported	Increases with year group	6% of Year 8 offered drugs, rising to 27% of Year 12
Trends	Declining	Apparent decline vs SALSUS 2018; not directly comparable	Cannabis use increased 2013–2019; 2023 broadly stable	Stable since 2016
Young adults aged 16–24				
Primary survey source	Crime Survey for England and Wales (CSEW); Adult Psychiatric Morbidity Survey (APMS)	Scottish Health Survey (SHeS) 2023; Scottish Crime and Justice Survey (SCJS) 2018/20	CSEW (England and Wales combined)	*No current national survey* *Most recent: joint Ireland/NI household survey, 2014/15*
Any past-year drug use (%)	15.1% (CSEW, year ending (YE) Mar 2025); 18.1% (APMS)	26% (SHeS 2023); 23.5% (SCJS 2018/20)	15.1% (CSEW, England and Wales combined)	*No current estimate available*
Cannabis past-year use (%)	12.5% (CSEW, YE Mar 2025); 17.9% (APMS)	21% (SHeS 2023)	CSEW England and Wales combined only	*Not available (current)*
Powder cocaine past-year use (%)	2.3% (CSEW, YE Mar 2025); 3.8% (APMS)	6% (SHeS 2023)	CSEW England and Wales combined only	*Not available (current)*
Ketamine past-year use (%)	2.0% (CSEW, YE Mar 2025); 4.3% (APMS) *Down from peak 3.8% in 2022/23*	3.6% (SCJS 2018/20)	CSEW England and Wales combined only	*Not available (current)*

Indicator	England	Scotland	Wales	Northern Ireland
Nitrous oxide past-year use (%)	1.3% (CSEW, YE Mar 2025) *Down from peak 7.6%;* 2.9% (APMS)	Not separately reported in recent SHeS data	CSEW England and Wales combined only	*Not available (current)*
Signs of drug dependence	APMS 2023/24: overall reports of signs of dependence steady at 11.8% (2014) to 10.1% (2023/24) among 16–24-year-olds, driven by cannabis	SHeS 2023: <0.5% of 16–24-year-olds self-report current drug problem	No Wales-specific estimate	*Not available (current)*
Gender pattern	Gender gap narrowing in 16–24 cohort vs older groups; women aged 16–24 have highest female prevalence (16.7%); men aged 25–34 highest male prevalence (26.9%)	SHeS 2023: highest female drug use in 16–24 (25%); highest male use in 25–34 (33%)	CSEW England and Wales combined only	*Not available (current)*
Trends	Gradual long-term decline in 16–24 use since 1997 peak; broadly stable 2022–2025; cannabis dependence rising	Higher prevalence than England and Wales across available data points; trend comparisons limited by survey changes	No Wales-specific trend data for 16–24	*Not trackable, no current survey*

2.5 Whilst providing a useful cross-sectional and historical perspective on drug use, there remain significant gaps in current data that weaken understanding of the development of drug use behaviours:

- UK school-based surveys cover different school years (NHS SDD ends at age 15; SHRN Wales at 16; YPBAS NI at 16; the Scottish HWB Census samples 13 and

15). (Young) adult population surveys (CSEW and APMS) start at age 16 but report data across a single 16–24 band, which means that the developmental window in which initiation, escalation and the transition from experimental to regular use are most likely to occur (e.g. across ages 15 to 19), and the post-16 transition into further and higher education, apprenticeship, work, or not in employment, education or training is poorly characterised. Within this age group where use estimates are highest, no UK datasets routinely report single year of age estimates, despite international evidence suggesting that risk rises sharply between the ages of 16–19, and peaking around 19–21.

- School-based surveys systematically exclude the highest risk groups. Persistent absentees, permanently excluded pupils, those in alternative provision, care experienced children and young people, those in contact with the criminal justice system, and other school-disengaged young people are groups with higher drug use prevalence (McCrystal et al., 2007), but current surveys rely on pupils being in school on the survey day. There is no UK equivalent of systematic sampling that some other countries use to capture out of school adolescents (e.g. the US National Survey on Drug Use and Health (prior to being paused in 2025)), so prevalence is under-estimated for school-age groups at elevated risk.
- To understand the effects of transitions better, including the formation of signs of harmful use and dependence, and the relationship between adolescent use and adult outcomes, longitudinal data are required. Although several birth cohort studies are available in the UK (e.g. Avon Longitudinal Study of Parents and Children (ALSPAC); Millennium Cohort Study), current national surveys are repeated cross-sectional samples, and so do not provide detailed data on drug use trajectories. They are thus unable to provide insights on important topics such as whether drug use profiles in cohorts of young people are escalating or declining, switching between drugs, or graduating from single to polydrug profiles.
- Several developmentally important transitions are absent from national statistics, including the primary to secondary school transition (although this is beginning to be captured by the SHRN primary expansion in Wales); the school to Further and Higher Education (FE/HE) transition; the live at home to leave home transition; the entry to work transition; and the parenthood/partnership transitions in mid-twenties that are associated with cessation/reduction of use. Subgroup transitions, including within care leavers, young people in contact with the criminal justice system, LGBTQ+ youth, ethnic minority subgroups, young people with health and

developmental needs, are usually too small in any single survey wave to support meaningful sub-group breakdowns, particularly at single ages.

- Trajectories are shaped by factors such as adverse childhood experiences, care experience, criminal justice contact, parental drug use, peer networks, neighbourhood drug market conditions (especially price), and co-occurring mental health symptoms (Broekhof et al., 2023; Rodriguez-Ruiz et al., 2023; Thornton et al., 2026). However, these are unevenly captured in current surveys. For example, Adverse Childhood Experiences (ACE) measurement is inconsistently included in official data series; peer network variables are usually a single item; and local drug market context (price, purity, availability) is provided in seizure/forensic data that are not linked to general population survey series. Including these variables may allow insight into mechanisms of the drug use trajectories.
- An underexploited resource in the UK is administrative data linkage. In Wales, pilot studies have linked SHRN responses to NHS, GP, education, and welfare records; ONS Longitudinal Study and Education Statistics linked datasets exist (e.g. the eChild study); and National Drug Treatment Monitoring System (NDTMS) capture data on people in contact with the treatment system, which can be linked to other government datasets. Linkage to drug use self-report at population level is fragmented and largely confined to individual research studies. The longitudinal Millennium Cohort Study, ALSPAC, and Born in Bradford cohorts are rich resources for the study of drug use, and all obtained consent for data linkage from participants and provide opportunity for analysis of long-term outcomes using administrative data. However, at present NDTMS data are not linked to these cohorts, which hinders understanding of precursors to treatment seeking and outcomes. Routine, consented linkage of survey self-reporting to Emergency Department attendances, mental health service contacts, education attainment/exclusion, criminal justice contact, and Department for Work and Pensions (DWP)/employment records would greatly aid understanding of drug use trajectories and outcomes. Linkage is a complex and resource-intensive process which may be beyond the reach of small studies, but if studies took the simple step of obtaining consent for linkage, and collected the necessary identifying data at recruitment, a larger project linking administrative data across multiple harmonised studies would form a valuable resource for understanding outcomes of drug use behaviours.

3. Conceptualisation of transitions and implications for prevention

Summary

- Accounts of the transition to adulthood have moved from traditional stage-based models anchored in fixed markers to life course and structural approaches that foreground inequality and precarity.
- Traditional markers of adulthood are now reached later, less consistently, or not at all. Rising mental health difficulties, the long-term effects of the COVID-19 pandemic, digital social life, the erosion of shared social spaces and economic pressures distinguish the experiences of the current generation from those of earlier cohorts.
- The opportunities brought by emerging adulthood partly explain the peak in drug use in the late teens and early twenties, but for many UK young people, transitions are marked by precarity rather than opportunity.
- Life course and socioecological models locate risk in the timing, sequencing and circumstances of transitions. The same transition may protect against or increase drug-related harm depending on the resources available, and risk is heightened when young people move into new settings before protective relationships have formed.
- The timing of prevention matters as much as its content. Support should be available at points of change, the effects of school-based education cannot be assumed to transfer to new settings, and individual-level interventions alone are likely to have limited reach among young people whose transitions are compressed, unsupported or constrained.

3.1 Much sociological and developmental research has characterised the transition from adolescence into adulthood. Frameworks have evolved and moved from stage-based models anchored in fixed sociodemographic events, through psychosocial accounts of prolonged identity exploration, to contemporary structural and intersectional approaches that foreground inequality, precarity, and the constraints imposed by institutional and economic contexts.

Traditional stage-based models

3.2 Earlier stage-based accounts of transitions into adulthood drew on sociological concepts of ‘status passage’ and ‘role theory’ (Glaser & Strauss, 1971). Transition was understood as a series of socially recognised, traditional markers (completing education, entering work, leaving home, marrying, and becoming a parent) that conferred adult social standing. These transitions were presumed to occur in a relatively fixed sequence, within a defined age window, and to be collectively recognised (including by

young adults) as markers of a completed passage. Normative transitions of this kind were embedded in and regulated by formal institutions. The education system structured leaving ages, employment law and labour markets shaped entry into work, and housing and benefits policies underpinned domestic independence. However, this orderly and sequential model was dependent on a particular configuration of the post-war job market, the availability of affordable housing, and normative gender relations that shaped UK life.

3.3 Classic transition models may still provide useful prevention heuristics. Notwithstanding their limitations, the identification of important transition points can provide a framework for organising prevention efforts (particularly universal approaches) and for identifying both protective factors and windows of heightened vulnerability (Advisory Council on the Misuse of Drugs, 2018, 2025). The greatest value lies in recognising that transition points represent a change in context that may alter risk and protective factors for drug use, and less in treating transition points as universally experienced or sequential.

The emerging adult framework

3.4 In contrast to the fixed external markers of stage-based accounts, Arnett's influential concept of 'emerging adulthood' proposed that the period from 18 to 25 years of age (extended to 29 by some researchers) constitutes a distinct developmental stage for young people (Arnett, 2000). This period is characterised by five features: i) identity exploration; ii) instability; iii) self-focus; iv) feeling 'in-between' (neither adolescent nor fully adult); and v) a sense of optimism and possibility. The concept drew on data suggesting deferral of traditional adult markers (delayed marriage, having children, and stable employment) as evidence that the life course had structurally changed, and Arnett argued that this extended 'exploratory phase' created a distinct developmental context for risk-taking. In accordance with this model, increased independence, reduced parental monitoring, identity experimentation, and peer context provide an explanatory mechanism for peaks in drug use prevalence reported in the late teens and early twenties. 'Role socialisation', the assumption of adult roles such as employment, partnership, and parenthood, subsequently exerts a moderating influence on drug use after young adulthood peaks (Staff et al., 2010).

3.5 The emerging adulthood framework has attracted some criticism (Côté & Bynner, 2008; Hendry & Kloep, 2010). It was developed primarily from US samples and so may not generalise to populations with different characteristics. For many groups of young

people in the UK, rather than providing opportunities for ‘exploration’, transitions are increasingly marked by precarity and increased risk (Nuffield Foundation, 2025). For example, care experienced young people may experience transitions that are abrupt and unsupported; young people from minority ethnic communities may experience transitions in ways that differ substantially from the experiences of the wider population; neurodivergent young people face distinct barriers in education and employment transitions; and young people in areas of socioeconomic deprivation face constrained ‘choices’ and opportunities in their transitions. The framework has also been criticised for individualising what are often structurally produced conditions, treating any delays in adulthood as a feature of psychological or social development rather than being influenced by external factors such as housing costs, job market changes, and public policy. It also provides limited insight on the experiences of those whose transitions are compressed or disrupted (MacDonald & Marsh, 2005).

3.6 Influenced by Arnett’s model, the Nuffield Foundation’s *Grown Up: rethinking journeys to adulthood* programme recently reviewed the relevance of stage-based markers that have been used by bodies such as the ONS to quantify transition (Nuffield Foundation, 2025). They concluded that these markers are inadequate as a framework for understanding today's young people. Young people are reaching traditional markers later, even compared to a few years ago (e.g. the age that more than half of people did not live with their parents increased from 21 years in 2011 to 24 years in 2021 (Office for National Statistics, 2024)), and in some cases not at all. Four contextual features distinguished young people’s journeys from those of earlier cohorts:

- They are the first generation to be entirely born in the digital age, with 98% of 16–24-year-olds owning a smartphone.
- Mental health difficulties have risen substantially, with the proportion of 17–19-year-olds with a probable mental disorder more than doubling between 2017 and 2023 to over 1 in 7.
- The cohort was aged between 10 and 20 years during the COVID-19 pandemic, with associated disruptions to in-person interactions, education, social development, and mental health.
- This has been complicated and prolonged by intersecting challenges including the rising cost of living, increasing debt, insecure and unaffordable housing, rising unemployment rates, and the increasing effects of (and future worries about) climate change.

3.7 Increases in mental health problems may reflect a wider erosion of the social infrastructure that supports adolescent development and confers resilience. This process has been described by McCrory and Chokhani (2025) as 'social thinning'. In relation to transitions, important adolescent developmental stages such as identity formation, social integration, and the cultivation of autonomy depend not only on internal capacities but on access to diverse social environments and to relationships of varying depth and duration. Where these environments are available and supportive, young people can develop the social competencies that underpin resilience. Where they fragment, developmental vulnerabilities that may lead to drug use can accumulate. The loss of shared and free-to-access spaces such as youth centres and recreational areas, and cultural shifts towards risk-averse parenting and intensified academic pressure have contributed to social thinning. Digital platforms can provide social connection and community, particularly for young people who are marginalised offline, and online interactions with known peers can extend and deepen existing relationships. However, most adolescents encounter digital life on platforms that were designed for engagement and monetisation rather than wellbeing, and so are poorly suited for the support of healthy development of social relationships that adolescence requires. Those young people who have experienced childhood adversity or trauma face a 'double disadvantage'. They encounter greater barriers to offline social participation and may also be more susceptible to the negative effects of social media use.

3.8 Although the Nuffield Foundation highlighted that many young adults continue to aspire to traditional socio-demographic markers, with the majority wanting to buy a property, achieve full-time employment and get married/enter a civil partnership, the relevance, desirability, attainability, reliability and sufficiency of these markers are questioned (Guerrero Puerta, 2023; Nuffield Foundation, 2025; Wright & von Stumm, 2025). Alternative or supplementary markers that may better capture young contemporary lives have been proposed, including cohabitation rather than legal partnerships; progressing from not in education, employment or training (NEET) status; the quality of employment, rather than employment status per se; financial independence; and digital markers such as first social media accounts (Nuffield Foundation, 2025).

Life course perspectives

3.9 Life course perspectives offer a more structurally attentive account of transitions than the emerging adulthood and stage-based frameworks (Elder & Shanahan, 2006). They

emphasise that individual biographies (and related health and social outcomes) are shaped by historical and social contexts, and that transitions are dependent on social relationships, so that, for example, a parent's mental health, a sibling's drug use, or experiences of migration, affect an individual's own trajectory (the ‘linked lives’ principle). Life course perspectives propose four important principles that are relevant in discussions of drug use:

i) life span development (development is a lifelong process);
ii) agency (individuals construct their lives within the constraints and opportunities available to them);
iii) time and place (lives are embedded in specific historical and geographic contexts); and
iv) the linked lives principle.

3.10 In a review of life course epidemiology and public health, Wagner and colleagues (2024) identified four models that are relevant to understanding drug use (Figure 1 below). The ‘sensitive period’ model holds that certain phases of the life course, commonly in early life, but also including major life transitions, amplify the effect of a given exposure relative to its effect at other times. The consequences of an exposure during a sensitive period may be greater but potentially recoverable, whereas exposure during a critical period may produce more permanent effects. The ‘accumulation model’ focuses on the duration and clustering of exposures rather than their timing, arguing that risk accumulates across the life course in a dose-response relationship, and it is the weight of compounding disadvantage, rather than any single event, that drives later outcomes. The ‘pathway model’ suggests that each exposure increases the probability of subsequent exposure, such that early adversity leads to an escalation of risk. Finally, the ‘social mobility’ model focuses specifically on the consequences of the direction of socioeconomic change across the life course, distinguishing between upward, downward, and stable trajectories. Downward mobility carries distinct health and social risks that are not reducible to the characteristics of either the origin or destination social position (Wagner et al., 2024).

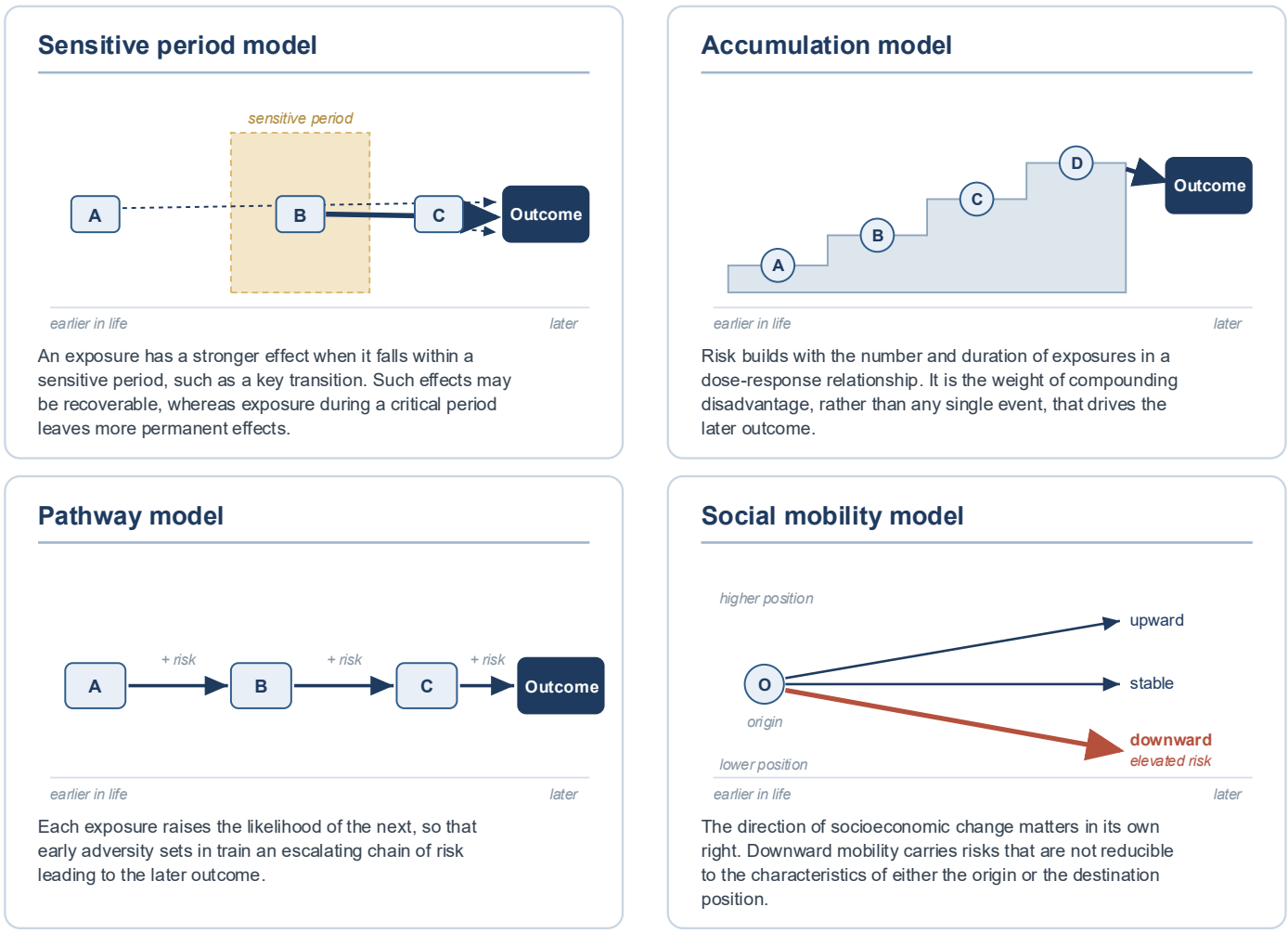


Figure 1 Life course models of exposure and drug use risk (adapted from Wagner et al., 2024). A to D denotes exposures at successive points in the life course. Arrows show putative causal effects, with heavier or solid arrows indicating stronger effects and dotted arrows indicating weaker effects.

3.11 These models help to direct attention to causes of drug use, including the social conditions that systematically expose groups to multiple, and sequentially linked risks. In this framing, socioeconomic disadvantage is not only a correlate of drug use risk but a fundamental cause that shapes access to protective resources (knowledge, economic security, stable housing, and supportive social connections) across the life course. As presented in the ACMD's 2025 report on a whole-system approach to prevention (Advisory Council on the Misuse of Drugs, 2025), prevention frameworks that target only proximal individual-level risk factors, without attending to the social conditions that increase exposure to these factors, are therefore likely to have limited reach among the most disadvantaged.

3.12 In relation to drug use, life course perspectives direct attention to the timing and sequencing of transitions as determinants of risk, rather than focusing on any single event. For example, early school leaving or early contact with the criminal justice system are not isolated events but are turning points that alter the probabilities of subsequent outcomes (Advisory Council on the Misuse of Drugs, 2018). The same transition (e.g. leaving home) can be a risk factor or a protective factor depending on the circumstances under which it occurs and the resources available. Leaving home into safe, stable housing with supportive relationships is qualitatively different from leaving local authority care into unsupported temporary accommodation. The sensitive period model suggests that transitions represent moments when social environments are reorganised, protective relationships are disrupted, and new exposures are encountered, making them periods of heightened susceptibility to risk.

3.13 As discussed in previous ACMD prevention reports (Advisory Council on the Misuse of Drugs, 2015, 2018, 2022, 2025), socioecological models offer a complementary framework that situates the developing individual within nested systems of influence: the microsystem (family, peer group, school, workplace), mesosystem (interactions between microsystems), exosystem (broader social institutions), macrosystem (cultural and policy context), and chronosystem (the temporal dimension, including historical change and individual, group and organisational developmental trajectories). This model is useful for understanding drug use because it frames risk and protection as properties of contexts and relationships, not solely of individuals, and it directs attention to the mesosystem and the ways in which transitions move young people between microsystems (e.g. from school to college, from family home to student accommodation, from education into work), creating disruptions in established support networks and exposures to new contexts.

3.14 Applied to drug use, the socioecological model suggests that transitions can be risky in part because they involve a change in microsystem before the protective relationships within the new context have been established. A young person who leaves school for university, for example, loses the established peer group, family proximity, and institutional routines of school, and enters a new environment in which new social norms and contexts, drug availability, and peer influences prevail. This also applies to other important transition points such as leaving home, entering employment, or leaving care.

Implications for prevention

3.15 An important implication of these frameworks is that the timing of prevention action matters as much as its content. Support should be available at the point of change, and not delivered in advance and effects assumed to persist. This is because protective skills, knowledge and/or attitudes formed in one environment, particularly through one-off activities, cannot reliably be assumed to transfer into another. This suggests that prevention action could be usefully designed around relevant developmental and transition points rather than fixed ages, and that contextually appropriate interventions at entry into new settings may have value.

3.16 As discussed in our 2025 report, if the conditions under which young people encounter drugs (e.g. housing precarity, economic insecurity, unsupported transitions, concentrated disadvantage) are drivers of risk, then interventions that address only individual factors are likely to have limited and short-lived impact (Advisory Council on the Misuse of Drugs, 2025). There is no single normative pathway through adolescence and early adulthood, and so treating the experiences of the majority as a template for prevention fails to capture the experiences of those on other trajectories. The young people for whom transition-related risk is most acute are those whose transitions are most compressed, unsupported, and constrained (e.g. care leavers; those leaving school without qualifications; those looking for education, employment or training; those in temporary or insecure housing; those in contact with the criminal justice system). For these groups, the conditions that create vulnerability to drug-related harms are not amenable to modification through knowledge or skill acquisition alone.

3.17 Educational settings are some of the most important contextual determinants of drug use among adolescents, and mechanisms operate through peer norms, staff relationships, and institutional climate (Thornton et al., 2026). This has significant implications for how education settings conceptualise their role in prevention. A school with strong staff-student relationships, a supportive climate, and effective pastoral structures may produce greater prevention benefit than the same school delivering a structured drug education programme in an otherwise unsupportive environment. Furthermore, most school-based prevention programmes are delivered within stable institutional contexts and on the assumption that their effects will transfer into new environments. The socioecological model challenges this, and a young person who receives drug education in Year 11 and then moves to a sixth-form college, university, or the workplace at 16 or 18 years old enters a qualitatively different social environment

with different peer norms, different drug availability, and different supervisory structures which may not have been addressed in the Year 11 drug education.

4. Structural and Systemic Determinants

Summary

- Structural disadvantage tends to cluster and accumulate across transitions, so that drug use trajectories emerge from exposures across the life course rather than from single precipitating events. These conditions can constrain the opportunities that young people have to make healthier and safer choices.
- Young people have limited influence over the decisions that shape their lives. Prevention should be designed with young people, including those who use drugs and those who are otherwise marginalised, although the legal force of children's participation rights varies across the four nations.
- The transition to adulthood involves a shift from a protective, welfare-oriented interpretation of drug use to one of personal culpability. This shift occurs earlier for minoritised young people through adultification bias and is patterned by socioeconomics and place.
- Poverty operates as a chronic condition across childhood, adolescence and young adulthood, shaping drug-related outcomes through social stratification, differential exposure, differential vulnerability and differential consequences.
- Digital platforms have altered the cultural and social dimensions of drug normalisation. Algorithmic curation can produce the appearance of peer acceptance independent of offline networks, and exposure to drug advertising on social media has been associated with lower perceived risk and with purchasing drugs online.

4.1 Structural disadvantages rarely occur in isolation; instead, they tend to cluster and accumulate across key developmental and institutional transitions, such as moving between schools, leaving care, entering the job market or encountering the criminal justice system (Bramley et al., 2015; DiPrete & Eirich, 2006; Webster et al., 2004). These transitions often represent critical junctures where inequalities can either be mitigated or intensified. In accordance with the life course models discussed in Section 3, for many young people, particularly those already positioned at the margins, each transition can amplify existing vulnerabilities rather than reset opportunities, producing compounding effects over time (Webster et al., 2004). As a result, drug use trajectories are not simply the outcome of singular life events but emerge from layered exposures to disadvantages that unfold across the life course.

4.2 Transition-associated risk is unevenly distributed, and is patterned by social position and shaped by structural conditions such as poverty, housing instability, inequalities and limited access to support services (McGovern et al., 2020). Certain groups of young people are more likely to encounter repeated, prolonged, or overlapping stressors that

are produced by these structural arrangements. For example, experiences of educational exclusion may intersect with precarious housing or involvement in care, creating reinforcing cycles of instability. These patterned inequalities mean that some harmful patterns of drug use might be better understood as a socially structured response to chronic stress, constrained opportunity, and limited pathways to stability.

4.3 Understanding drug use requires moving beyond approaches that isolate single risk factors or focus narrowly on individual behaviours. Instead, it calls for an examination of how multiple systems, including education, welfare, healthcare, housing, and criminal justice, interact over time to shape lived experiences. These systems do not operate independently; their policies, practices, and thresholds of access can align in ways that either support or further disadvantage young people. A focus on how systems and services interact (or fail to) can highlight how institutional fragmentation or gaps in provision can leave young people without consistent or meaningful support during periods of transition.

4.4 Importantly, structural barriers can significantly limit young people's capacity to exercise agency. While resilience and personal choice are often emphasised in narratives about drug use, such framings can obscure the constraints imposed by broader socio-political contexts (Burkhart & von Heyden, 2026). These restrictions are also structural determinants, shaping not only the options available to them but also their ability to respond to adversity. Recognising this helps to shift analysis away from individualised blame towards a more nuanced understanding of how power, inequality, and system-level processes shape drug use trajectories.

Participation of young people in decision making

4.5 Young people typically have limited influence over the institutional decisions, resource allocations and policy choices that shape their lives. Prevention should therefore be designed with young people rather than for them, and the groups most affected, including those who use drugs already and those who are otherwise marginalised, should be represented in its design and delivery (Duke et al., 2021; Duke et al., 2023; Duke & Welch, 2026). However, the nature and opportunities for participation in these activities can vary depending upon developmental stage.

4.6 Article 12 of the United Nations Convention on the Rights of the Child (UNCRC) established the right of children to express their views freely in all matters affecting them

and to have those views given due weight (United Nations, 1989). Although the UK has signed and ratified the UNCRC, the legal force of this right varies across the nations. It is not incorporated into law in England and Northern Ireland. Scotland has directly incorporated the Convention into domestic law through the United Nations Convention on the Rights of the Child (Incorporation) (Scotland) Act 2024, which requires public authorities to act compatibly with Convention rights. Wales places a duty on Welsh Ministers to have due regard to the Convention under the Rights of Children and Young Persons (Wales) Measure 2011 when developing or reviewing policy.

4.7 The United Nations Office on Drugs and Crime (UNODC) Handbook on Youth Participation in Drug Prevention Work sets out principles for involving young people at every level of the prevention system (United Nations Office on Drugs and Crime, 2019). These include a transparent and justified sharing of power between young people and adults; the allocation of sufficient time and resources; deliberate work to build the readiness of adults and organisations to engage; and a strengths-based rather than deficit-based stance, which matters particularly when working with marginalised or higher-risk young people. The wider UNODC Listen First initiative (see https://www.unodc.org/unodc/en/listen-first/) and its peer-led Friends in Focus (https://www.unodc.org/unodc/en/prevention/youth-initiative/friends-in-focus.html) programme emphasises that young people should be understood as contributors to prevention and not solely as its recipients.

4.8 Youth RISE, an international youth-led network working on harm reduction and drug policy, involves young people who use drugs, a group routinely absent from the policies that affect them most directly. Its resources include ethical guidelines for research and advocacy with young people who use drugs and a youth engagement scorecard for assessing the depth of involvement in youth-focused projects (Youth RISE, 2024, 2025). Engaging young people with lived and current experience of drug use can raise specific ethical and safeguarding considerations, including confidentiality, the legal vulnerability that attends disclosure of criminalised activity, and the risk of tokenistic consultation. However, these are identified as matters to be addressed through careful practice rather than treated as reasons for exclusion from consultations, and relate to participative principles within transitional safeguarding (see Section 6), under which young people help to design their own support (Holmes & Smale, 2018).

Stigma, transitions, and responses to drug use

4.9 Stigma operates at several levels: public stigma, comprising the stereotypes and prejudices held within a population; self-stigma, the internalisation of those attitudes by the person to whom they are applied; associative stigma, prejudice and discrimination experienced by individuals closely related to those with a stigmatised condition or behaviour; and structural stigma, the embedding of disadvantage within laws, institutional rules and routine practice (Link & Phelan, 2001). Drug-related stigma is among the most powerful and least challenged forms of social stigma in the UK. People affected by drug use are widely regarded as both blameworthy and dangerous, and are consequently subject to discrimination and exclusion across employment, housing and support systems (Lloyd, 2013; Sumnall et al., 2021; UK Drug Policy Commission, 2010). Higher levels of stigma are associated with negative outcomes such as public preference for punitive rather than supportive responses to drug use, and poorer quality of care.

4.10 The extent of experienced stigmatisation is not uniform but is governed by factors such as the perceived 'dangerousness' of the person and the degree to which they are held responsible for their behaviour or condition (Lloyd, 2013). Responsibility is linked to individual characteristics such as age and gender, and younger people are perceived to have less control over drug use (Sumnall et al., 2023). Drug use by young people, and in particular more harmful patterns of use, is predominantly interpreted through a frame of welfare and protection, with young people positioned as vulnerable and potentially exploited. Drug use by adults is more typically interpreted through a frame of personal culpability, in which the individual is positioned as responsible for their choices and, where they come into contact with the criminal justice system, as an offender. Younger people are therefore characterised as being 'at risk' and in need of protection, whereas adults who use drugs are more readily construed as 'a risk', and a source of danger to others. The transition into adulthood therefore involves a change not only in a young person's social and economic circumstances but in their moral and institutional status, as the protective interpretation of the causes of drug use is withdrawn, and a more stigmatising and punitive interpretation predominates.

4.11 The protective frame that is generally applied to young people is not extended equally. As discussed further in Section 6, adultification bias, by which minoritised children are perceived as older, less innocent and more culpable than their peers, means that the vulnerability interpretation of drug use is withdrawn earlier and less

completely for Black and other minoritised young people, and that the punitive interpretation is applied sooner (Alliance for Youth Justice, 2023; Davis, 2022). Class and place operate similarly and the drug use of a relatively advantaged young person may be interpreted as a feature of growing up, as part of identity making and normative risk taking, whereas similar use by a young person from a deprived area, or in contact with state systems and services, is more likely to be interpreted as evidence of disorder or criminality. Similarly, stereotypes and misperceptions about campus life may afford greater tolerance towards student drug use compared with use by non-attending peers. A young person whose drug use becomes more frequent or more visible may move from a relatively 'tolerated' category of use into a heavily stigmatised one, and at an age point when protective framings are being withdrawn.

4.12 The consequences of stigma are shaped by the developmental character of the transition period. Adolescence and young adulthood are defined in part by identity formation and by heightened sensitivity to social standing and peer evaluation, which can make the internalisation of a stigmatised identity especially harmful at this stage. Self-stigma can erode self-efficacy and the willingness to pursue goals such as treatment and healthcare contact, education and employment (Corrigan et al., 2009; Schomerus et al., 2011). Young people who experience discrimination during the transition to adulthood have been found to be at elevated risk of subsequent drug use and related adverse outcomes (Lei et al., 2021). Reducing stigma should therefore be considered an important aim of prevention activity.

4.13 Stigma attached to some drug use identities may also have implications for the perceived relevance of prevention activity amongst target groups, because it may lead to prototyping of people with 'drug problems' as a distinct and devalued social category rather than as one point on a continuum of use (Morris et al., 2020). Where prevention messaging is anchored in this dependency frame, young people (and policy makers, funders, and other stakeholders) may conclude that such activity is not relevant to them. By distancing themselves from stigmatised identities and use behaviours, young people may reject support and prevention activities that might otherwise be helpful.

Poverty as a chronic structural condition

4.14 Poverty operates across childhood, adolescence, and young adulthood, shaping transitions rather than acting as a one-off adverse event. Whilst poverty at any time during childhood and adolescence has been found to be associated with a higher risk of

drug use in young adulthood, economic instability during childhood or adolescence is particularly detrimental (Manhica et al., 2021). These inequalities in health are determined by four mechanisms which are unequally differentiated across society: social stratification; risk exposure; vulnerability; and severity of consequences (Diderichsen et al., 2001).

4.15 Social stratification refers to a person's social standing and interaction with their social context. Individuals in the least privileged social positions have access to lower levels of valued resources in society such as power, wealth and property. They typically experience clustering of disadvantage, which impacts upon their life chances. This social context links to outcomes through the other mechanisms. For example, adolescents living in socioeconomic deprivation may be exposed to higher risks due to living in neighbourhoods where availability of drugs may be higher and exposure to drug use and related activities may be more frequent. Adolescents living in poverty may be more vulnerable to continued and/or harmful drug use due to accumulative risk factors or more susceptible to harm due to the absence of developmental protective factors (such as involvement in education or employment). Key transitions (e.g. leaving school, entering precarious work, welfare transitions, leaving care) can intensify financial strain experienced by families and uncertainty within adolescence, increasing vulnerability to drug use as a way of coping, for income generation or to enhance feelings of social inclusion.

Changes in access to drug markets, and new mechanisms in drug normalisation

4.16 Availability and access to drugs is shaped by broader economic, technological, and policy contexts. Shifts in drug production, pricing, and supply disproportionately affect young people. The ACMD is currently undertaking a review on Internet Facilitated Drug Markets, which will examine the access and availability of drugs online, and includes recommendations on prevention.

4.17 Digital platforms and social media have altered many young people's exposure to different drugs and drug use, and the representation of these. The influential normalisation theory suggests that drug use has become accommodated within the everyday lives of many young people (Aldridge et al., 2011; Parker et al., 1998). The theory describes several dimensions of this process, two of which the digital environment has directly altered. The first is 'cultural accommodation' which was

originally assessed in part through the presence of drug references in traditional mass media such as film, television, and recorded music. In a recent study by Fuller and colleagues (2025), 60% of 13-18 year olds reported having seen drug-related content on social media, often through humorous and meme-based material and depictions of others using. This content is produced by users rather than by editorially governed broadcasters, distributed at far greater volume, and subject to little of the gatekeeping and regulation that shapes the representation of drug use in traditional media.

4.18 Content is produced within widely varying legal, political and cultural regimes and largely consumed without regard to national borders. Media representations of drugs originating in jurisdictions with less restrictive frameworks, such as those that have legalised non-medical cannabis sales, circulate freely to UK audiences and may blur legal and normative distinctions that previously structured the local risk environment (Fuller et al., 2025). Globally distributed musical genres carry drug references to mass youth audiences in a manner continuous with, but greatly amplified beyond the cultural accommodation that Parker and colleagues originally described in relation to recorded music (Luo et al., 2024; Parker et al., 1998).

4.19 Drug references conveyed by social media influencers and similar figures, with whom young people sustain a sense of personal familiarity, may carry greater normative weight than references in other forms of entertainment media (e.g. films, TV), because the source is experienced as known and trusted (Childers et al., 2019; Harris et al., 2021). This has implications for prevention approaches aimed at addressing social norms (see also Section 5.29). Influencer promotion, and social material that functions simultaneously as entertainment and as de facto ‘marketing’ of drugs may erode boundaries between content and advertising (Cox & Paoli, 2023; Gell et al., 2026; Rutherford et al., 2023; Vassey et al., 2024).

4.20 The second relevant dimension of normalisation is ‘social accommodation’. This originally referred to offline peer cultures and was assessed through the tolerance and incorporation of drug use among young people’s offline social contacts. In contrast, contemporary digital platforms can generate the appearance of social accommodation without being grounded in a young person’s own offline social world. Algorithmic curation can present a young person with a stream of content in which drug use appears prevalent and unremarkable, irrespective of whether use is in fact common within immediate offline social networks. Social accommodation may therefore be acquired

from a curated and personalised content feed rather than from the peer group, the neighbourhood, or the school.

4.21 The normalisation thesis has been qualified through the concept of ‘differentiated normalisation’, according to which normalisation operates unevenly across drugs, social groups, and settings rather than as a uniform cultural shift (Measham & Shiner, 2009; Pennay & Measham, 2016). Algorithmic curation is itself a mechanism of differentiation. Recommender systems (i.e. recommended accounts to follow and passive exposure to content) do not produce a single shared culture of accommodation; they generate segmented and individualised content environments in which normalisation may be intense within particular feeds and effectively absent in others.

4.22 Increased opportunities to purchase drugs, that might otherwise have been associated with social shifts during transitions between stages and settings, are also facilitated by digital media, and contribute to social accommodation. Fuller and colleagues’ study also suggested that 29% of respondents had seen illicit drug advertisements, of which 83% reported that the advertisements had appeared on their social media feed (Fuller et al., 2025). Exposure to illicit drug advertisements on social media was also associated with a decreased perception of the risks associated with drug use, and an increased likelihood of purchasing drugs through social media platforms.

5. Key Populations and Contexts in Transition

Summary

- This section examines selected populations and settings in which transitions are atypical in timing or support, exposure to drug-related risk is elevated, and there is an identifiable point of policy or practice leverage. The section is illustrative rather than exhaustive.
- Care experienced young people report earlier and more frequent drug use than their peers, and the abrupt loss of support on leaving care is a point of particular risk. Exposure to adversity and persistent poverty shows a cumulative relationship with later drug use.
- For neurodivergent young people and those with mental health difficulties, drug use may function as a way of coping with distress, sensory overwhelm, masking or social exclusion. Long waits and high thresholds for support can allow difficulties to escalate.
- Educational transitions are important but poorly evidenced. There are no data on drug use in further education colleges, which are not required to deliver drug education, and no nationally representative survey of student drug use. Suspensions, permanent exclusions and severe absence have increased, removing protective school contexts for young people who are at elevated risk.
- Higher education responses should be welfare-led and embedded within existing wellbeing services, with support timed to arrival, induction and graduation.

5.1 This section considers a selection of populations and contexts that illustrate how transitions can increase risk of drug-related harm. It is not intended to be exhaustive, but foci were identified by the Prevention Standing Committee members as having atypical transitions with respect to timing or in support available; that there was evidence of elevated exposure to drug-related risk, or a structural mechanism through which such exposure is generated; and that there is an identifiable point of policy or practice leverage. Omission from this section should not be interpreted as an assessment that other groups or settings are a lower priority for prevention work.

Care experienced young people and care leavers

5.2 ‘Care experienced’ refers to anyone who has been or currently is in the care of the local authority (including at home, kinship care, foster care, residential and secure care, and adoption). ‘Looked after’ is typically used to refer to those currently in care, while ‘care leaver’ refers to someone aged 16-25 years who has been in care during their earlier life. Children and young people become looked after for various reasons, including abuse,

neglect, and parental drug use (National Institute for Health and Care Excellence, 2021). Many have also experienced traumatic upbringings, and the loss and separation experienced as a result of being placed into care can also contribute to their trauma (Greeson et al., 2011). These factors can influence the likelihood of care experienced young people using drugs (Blake et al., 2018). There is evidence that they may use drugs as a way of coping with issues like inconsistent parenting, domestic violence, and physical abuse, or as a way of seeking attention from peers, enhancing social activities, and enabling social contact (Yampolskaya et al., 2019).

5.3 Care experienced young people report higher rates of drug use than the general population. These young people are also at increased risk of developing drug use problems and report initiation of drug use at an earlier age than the general population (Alderson et al., 2019; Alderson et al., 2020; Beal et al., 2023; Heradstveit et al., 2020; Simkiss, 2012). There is evidence from surveys in England and Scotland that those in care report higher rates of drug use, with those in residential care reporting higher rates than those in foster care (Meltzer et al., 2003; Meltzer & Lader, 2005; Vincent & Jopling, 2018). Although there are not comparable figures in the general population, in England, 3% of care experienced young people were identified as having a drug use problem in 2024/25, of which only 39% were receiving formal support. Higher rates of drug use may be due to a range of factors including ACEs and trauma (Hoffmann & Hoffmann, 2025; Turney & Wildeman, 2017); mental health problems (Varnish et al., 2025); inconsistent attachments (Bederian-Gardner et al., 2018); social and environmental factors including poverty and social disadvantage (Turney & Wildeman, 2017); peer influences (Kim et al., 2017); and particular challenges during transitions out of care as a result of the sudden loss of support (Courtney & Dworsky, 2006). They are also more likely to have personal experience of the criminal justice system (Baidawi et al., 2025).

5.4 Systematic reviews have also examined factors that might increase the risk of drug use, such as mental health disorders. Although estimates vary widely between studies (ranging from 1% to 82 %), rates of mental health problems in care experienced young people are considered to be higher than in the general population (Cummings & Shelton, 2024).

5.5 A study by Dixon (2008) examined the health and wellbeing of 106 young people making the transition from care to independent adulthood in seven local authorities in England, most of whom were aged 16-18 years. Using a combined measure of drug use, 18% of young people reportedly had problems with alcohol or other drugs at baseline, and 32%

at follow up 12 months later. Fourteen percent of the sample was considered to have moderate to severe problems at baseline and 21% at follow up. Those with drug use problems also had poorer mental wellbeing. Another study in the US reported higher rates of drug use among those who had left foster care compared to those currently in care and concluded that greater preparation for independence was associated with lower rates of drug use (Greeno et al., 2019).

5.6 There is evidence that care-specific features (age of entry into care and exit), good education, and employment and housing quality are associated with successful transitions from care to independent living (Häggman-Laitila et al., 2019). However, a lower proportion of care experienced young people are in adult employment than those who are not care experienced (National Centre for Social Research, 2025). Care leavers are three times more likely to not be in education, employment, or training, and after leaving school, 25% of care experienced individuals spend at least eight years never having been employed. These outcomes are influenced by system instability and housing challenges, and those placed in unregulated or semi-independent accommodation experience even higher rates of unemployment. There is limited evidence regarding drug use among these young people during these transition periods.

Young people experiencing early adversity and/or ongoing poverty

5.7 Adverse childhood experiences such as abuse, neglect, parental drug use, poverty, and household dysfunction play a profound role in shaping trajectories of drug use, as young people transition from adolescence into adulthood (Felitti et al., 1998; Hughes et al., 2017). Evidence consistently demonstrates a cumulative, dose-response relationship, whereby increasing exposure to adversity is associated with progressively higher risks of drug use. For example, young people with higher ACE scores show significantly elevated odds of alcohol, cannabis, and other drug use (Azagba et al., 2025), while the presence of four or more ACEs has been linked to substantially increased risks of problematic drug use in adulthood (Hughes et al., 2017). Longitudinal studies further show that childhood adversity exerts both direct and indirect effects, increasing drug use through pathways including early initiation, poor emotional regulation, and mental health difficulties such as anxiety and depression (Adjei et al., 2024; Mongan et al., 2025). These findings align with developmental and life-course frameworks, which emphasise how early adversity disrupts attachment processes and stress regulation, creating enduring risk vulnerabilities, including drug use (Sebalo et al., 2023).

5.8 Importantly, the transition to young adulthood represents a critical consolidation phase in which earlier vulnerabilities interact with broader structural and relational contexts. Young people exposed to persistent poverty and family adversity are more likely to develop drug use disorders in adulthood, with large cohort studies demonstrating significantly elevated risks among those experiencing sustained economic disadvantage (Adjei et al., 2022; Manhica et al., 2022; McGovern et al., 2023). These risks are further amplified through intergenerational and relational processes, including parental drug use, mental ill-health, family instability, and associated shame and stigma, which shape both the young person's behaviour and the emotional environment within which they develop (McGovern et al., 2023; McGovern et al., 2020; Muir et al., 2023; Rodriguez-Ruiz et al., 2025).

Neurodivergent young people

5.9 Neurodivergent young people, including those who are autistic or who have Attention Deficit Hyperactivity Disorder (ADHD), are at increased risk of drug use due to a complex interplay of psychological, social, and environmental factors. One key contributor is the high prevalence of co-occurring mental health difficulties within this population. Estimates suggest that around 70% of neurodivergent (ND) young people have a co-occurring mental health condition (Simonoff et al., 2008), and they are up to 28 times more likely to experience suicidal thoughts or behaviours (Cusack et al., 2016). These emotional vulnerabilities can increase the likelihood of drug use as a way of coping with distress, regulating mood, or escaping overwhelming emotions.

5.10 Many neurodivergent young people find educational environments particularly challenging, as they are generally designed for neurotypical students. As a result, neurodivergent young people often experience difficulties with unpredictable routines, and insufficiently adapted or sensorily overwhelming environments, particularly during transitions such as moving to secondary school (Lukito et al., 2025). Additional challenge and risk would be associated with other transitional points for these reasons. A lack of neuroaffirmative approaches and limited staff understanding can leave neurodivergent young people feeling unsafe, dysregulated, or unable to cope in school (Ashworth et al., 2025). In the absence of appropriate support, drugs may become an alternative coping strategy to manage stress and sensory overwhelm.

5.11 Many neurodivergent young people adopt masking or camouflaging behaviours, whereby they consciously or unconsciously suppress or adapt their natural behaviours to

conform to social norms and be more accepted in society, which can be more pronounced when transitioning between social environments, structures and contexts. However, the sustained effort of masking can lead to exhaustion and burnout (Raymaker et al., 2020), which, in turn, can increase the appeal of drugs as a means to relax, disengage, or manage the associated stress (Weir et al., 2021). Furthermore, drugs such as alcohol may also be used strategically within social contexts as part of attempts to 'fit in' or engage in 'normal' adolescent behaviours, while also lowering inhibitions and temporarily easing social interactions that might otherwise feel difficult or anxiety-provoking (Rengit et al., 2016).

5.12 Neurodivergent young people who remain undiagnosed, or who are diagnosed later (primarily females), may struggle to understand why they feel different or find social situations challenging. This lack of self-understanding can lead to feelings of shame, low self-esteem, and isolation (Leedham et al., 2020). Similarly, neurodivergent young people are more likely to experience loneliness, social isolation, difficulties forming and maintaining friendships, and bullying (Holmes et al., 2024). These adverse experiences can contribute to emotional distress, a sense of exclusion, and a lack of belonging, all of which are known risk factors for drug use. Drugs may be used as a form of self-medication to cope with these feelings, reduce anxiety, or to facilitate social inclusion (Holmes et al., 2024).

5.13 Cognitive differences in executive functioning can increase vulnerability. Differences in impulse control, planning, and assessing long-term consequences may make it harder for neurodivergent young people to resist drug use or fully consider its risks (Pozo-Rodriguez et al., 2026). Some individuals may also use drugs to reduce sensory overload, or alternatively to provide sensory stimulation in sensory-seeking individuals (Weir et al., 2021). Combined with limited access to appropriate and accessible mental health support, this creates a context in which drug use can emerge as a coping mechanism.

Further education

5.14 In England, it is a legal requirement to continue in education or training until the age of 18, and although some young people will continue into sixth form at their own school, some will leave after Year 11 and move on to another school sixth form, or to further education (FE) or sixth form colleges. For the many schools that do not have sixth forms, FE or sixth form colleges are the primary options at age 16. Overall, 2,150,791 of 16-18 year olds in England were in education, apprenticeships or wider training in 2025

(Department for Education, 2026b), with 28% of 16-18 year olds continuing their education in schools and 33% attending FE or sixth form colleges (Association of Colleges, 2026).

5.15 This creates an additional transition point for many young people. Year group cohorts in FE and sixth form colleges are typically much larger than those in schools, and bring together young people from different schools, across often a relatively wide area, introducing socialisation with a greater number and range of peers. Although some young people will move on with existing friendships, the move is a significant transition into an unfamiliar environment, with different expectations for behaviour, and different social norms, including relating to substance related behaviours.

5.16 Young people accessing education through colleges are typically from more disadvantaged backgrounds: 23% of 16-18 year olds in college claimed free school meals at age 15 compared to 13% in maintained school and academy and sixth forms. Colleges often also provide education for students with special educational needs and disabilities. Almost one quarter (23%) of students have a learning difficulty and/or disability (Association of Colleges, 2026) compared to 14.8% in mainstream secondary schools in 2024/25 (Department for Education, 2026e).

5.17 There are no data on drug use in FE and sixth form colleges in the UK, which prevents meaningful insights. However, a 2024 survey conducted by UNISON of college support staff found that seven in ten (70%) reported drug use among students was a ‘problem’ in their college, three in ten (31%) had had to respond to students who brought drugs into college, and two fifths (40%) had interactions with students who were suspected to be under the influence of drugs (UNISON, 2024).

5.18 It has been a statutory requirement in England since 2020 to deliver drug education to 16-18 year olds as part of the Relationships, Sex and Health Education (RSHE) curriculum, but this only applies to school sixth forms, not to sixth form or FE colleges. Similarly, unlike compulsory age schooling, there is no specific statutory requirement for sixth form or Further Education colleges in Wales, Scotland or Northern Ireland to deliver drug and alcohol education. In Wales, post-16 provision is characterised by local curriculum arrangements and institutional autonomy. In Scotland, colleges operate outside the Curriculum for Excellence school curriculum framework. In Northern Ireland, statutory drug education requirements apply to compulsory schooling and do not extend to FE colleges or post-16 provision. Consequently, the provision of substance use

education within these settings in all UK nations is largely dependent on institutional priorities, local arrangements and individual curriculum or student wellbeing programmes. Age-appropriate, evidence-based drug education and other prevention interventions can be integrated into programmes of learning and overall welfare provision, and planned to support students through transitional vulnerabilities both at the start of their college experience, as well as their transition beyond college into higher education, further training or work.

Higher education

5.19 In 2024/25 there were 2,863,180 students enrolled in UK higher education (HE) institutions (Higher Education Statistics Agency, 2026). The HE entry rate among UK 18-year-olds was 36.3% in 2024/25, ranging from 18% (Bridgwater, Somerset) to 71% (Wimbledon, London).

5.20 In England, there is similar HE enrolment across deprivation quintiles, but there is a clear deprivation gradient in the other countries of the UK, with those living in the least deprived quintiles more likely to enrol. For all students, where structural disadvantage is carried into higher education, it is borne by particular groups, including those who are care experienced, estranged and first-in-family students.

5.21 For many young people, the move to HE is the most significant life transition they will have faced in their lives. It typically involves leaving the family home, the loss of established family proximity and monitoring, disruption of school-based peer networks, and entry into an unfamiliar environment with its own social norms, routines and patterns of drug availability, often before protective relationships in the new setting have had time to form. The higher education period also contains several sub-transitions (see Table 2 below).

5.22 In accordance with the models presented in Section 3, the pre-arrival and induction window (i.e. the ‘Freshers’ period), the first-year settling-in phase, and the eventual exit into employment or further study mark significant changes in context which might affect propensity for drug use. A weakness of current practice is that prevention efforts are effectively reset at the end of statutory education, so that the period of greatest contextual change is the period of least support. Continuity of support across this boundary, coordinated where possible with prior school-based provision, would align the timing of prevention activity with the structure of the transition itself rather than with academic

calendars. Similarly, graduation may be protective for some but destabilising for others. The move from a structured institutional environment into less structured and less supported settings, including unemployment or precarious work, removes one source of stability that may elevate drug-related risk. Table 2 provides a summary of the key transition points in higher education.

Table 2 Key transition points across higher education

Transition	Description
Transition and social disruption	The loss of established support at the point of arrival, and the concentration of risk in the induction window before new protective ties have formed
Peer norms and misperceptions about student 'drug cultures'	Cultural stereotypes about students and the alcohol-centred economy of many campuses, lead to overestimation of peer use and acceptability of use
Reduced structure and supervision	Unstructured time, self-directed study, and for most undergraduates a first sustained period of living independently
Availability and access	Friends and social contacts, rather than commercial sellers, are the main source of drugs, which lowers both perceived risk and access barriers
Academic pressure and cognitive enhancement	Assessment cycles linked to drug use to 'cope' with non-clinical symptomology and stress relief
Mental health and self-medication	Associations with anxiety, depression, stress and insomnia, and self-medication motives, that may be more pronounced among neurodivergent students
Financial and cost-of-living pressures	Relevant both as a stressor and as a constraint on the resources available for drug purchases and use
Differential vulnerability within the student body	Care experienced and estranged students without a family home to return to, international students, and LGBTQ+ students, may have different experiences of university to the majority of students, including greater social isolation and drug use patterns that differ from the wider student body

5.23 There is no nationally representative survey of student drug use in the UK, nor in any of the constituent countries. Whilst the CSEW is an age-matched general-population survey that covers England and Wales (see Section 2), as a household survey it underrepresents those living in temporary student accommodation.

5.24 A scoping review of research on student drug use in the UK and Ireland undertaken by Boden and Day (2023) identified 54 relevant studies. However, the authors concluded that no coherent body of research exists in this area. Although individual studies suggested that reported prevalence had risen over time (in contrast to CSEW data), studies were methodologically weak. Most were cross-sectional, frequently sampled a single university or department, varied widely in their recall period and measures used, and rarely distinguished patterns of use. The review also identified substantial evidence gaps. Little research had been undertaken on vulnerable groups such as LGBTQ+ or ethnic minority students and those with co-occurring mental health problems. Few studies had examined educational outcomes and harms such as attainment or course completion, and there was an almost complete absence of published prevention or harm-reduction interventions.

5.25 Although the ideal response to a lack of data on student drug use would be sustained investment in a new nationally representative survey, considering current funding challenges affecting delivery of existing surveys, a more realistic proposal is the coordination and harmonisation of methodologies across existing data collection activities, so that institutional and sector approaches better converge.

5.26 The *Students, Alcohol and Drugs Survey* is an annual survey conducted by the Students Organising for Sustainability (SOS-UK) charity. It has a large but self-selecting sample (n = 10,561 in 2025/26), recruited largely through the National Union of Students (NUS). In 2025/26, the survey reported that 19% of respondents currently reported drug use at any frequency (primarily cannabis). A quarter (25%) had used drugs at some point while at university, and 2% reported daily or near-daily use (SOS-UK, 2026). Most respondents (71%) reported that they used drugs for ‘recreation’, while 21% used drugs to enhance their social interactions. Sixteen percent reported using drugs to help deal with stress, 14% ‘to escape reality’, and 11% to ‘self-medicate’ an existing mental health problem. Using drugs to improve performance (academic, athletic/sports or paid work) was uncommon (1% - 2% reported using for these purposes). The survey also highlighted overestimation of student drug use. Three quarters (76%) of respondents thought that more than 21% of students reported use (the reference category included in the survey

that was closest to the actual survey estimate). One fifth agreed with the statement that taking drugs was ‘part of university culture’.

5.27 We are not aware of any prevention programmes that are currently being delivered on UK campuses. Universities UK, a sector representative organisation, reports that around one in five students who had used drugs in the previous year had ever sought support from their institution (Universities UK, 2024). Among those who did, 46% identified the institution’s drug policy as a barrier and 37% cited fear of the consequences of coming forward. The 2025/26 SOS-UK survey further indicated that around a third of students did not know whether their institution had a drug policy at all. There can also be uncertainty among students about whether the institutional approach to drug use would be supportive or punitive, often due to inconsistencies or conflicts between different branches of the university (Duke et al., 2025).

5.28 In accordance with the ACMD’s 2025 prevention report, universities should be positioned as one setting within the wider local community, and not a separate institution. Accordingly, this means that universities should seek to identify appropriate partnerships and signposting pathways with local services to help develop and deliver drug-related support for students.

5.29 SOS-UK data suggest that UK students overestimate the prevalence and acceptability of drug use among their peers, and a wider body of research suggests that behaviour is partly influenced by perceptions of what others do and of what they approve of (Lahiri et al., 2025; SOS-UK, 2026). Correcting these misperceptions, typically by communicating accurate prevalence and attitudinal data, is intended to reduce the perceived social pressure to use (social norms approaches) (Berkowitz, 2005). However, the evidence base for social norms interventions is mixed, and effects are inconsistent across settings and drugs (Lemmel & Morina, 2024). Of note, the algorithmically driven amplification of young people’s perceptions of the prevalence and intensity of drug use among their peers is now established well before the higher education transition, when social norms interventions have typically been implemented. Social-norms work is therefore better positioned as one component of a broader strategy than as a stand-alone intervention, and its local effects should be evaluated rather than assumed.

5.30 Alongside prevention activities, support is needed at the point of drug use itself. This includes welfare-led arrangements at campus events, such as trained welfare staff, accessible water and rest spaces, and clear routes to medical assistance; drug checking

and amnesty provision; and non-punitive disclosure routes that allow students to seek help without triggering disciplinary processes. However, the legal constraints on drug checking are acknowledged, and institutions should not act beyond the current legal framework.

5.31 Provision should not be confined to responses to drug use but should extend to the social environment that surrounds it. There is clear student demand for lower-risk and alcohol-free social options, and such provision is relevant to the substantial minority of students who do not drink at all, whether for religious, cultural, health, or personal reasons. Investment in attractive non-drinking provision, designed with rather than for students, broadens participation and reduces the structural pressure toward alcohol use as the default mode of student belonging.

5.32 Drug use rarely presents in isolation and is frequently a marker of wider difficulty, so prevention and support should be embedded within existing wellbeing services and personal-tutor systems rather than a separate function. Embedding offers two advantages: it normalises disclosure within relationships students already hold, and it situates drug use within a broader account of student welfare. This general provision should be complemented by targeted and adequately resourced pathways for the higher-risk groups identified elsewhere in this report, since universal embedding without specific routes for those at greatest risk tends to better serve the already advantaged.

Young people not in mainstream education

5.33 Some young people's experience of education can disrupt expected patterns and trajectories of transition, in particular severe pupil absenteeism and school exclusion, increasing vulnerability and reducing opportunities to intervene.

5.34 Latest Department for Education data (Spring term 2024/25) report that 312,562 pupils in England had received a temporary suspension (an increase from 295,559 in 2023/24) and 3,320 had been permanently excluded (an increase from 3,107 in 2023/24) (Department for Education, 2026c). In the academic year 2024/25 176,000 (2.39%) of pupils were severely absent (i.e. missing half or more of their school time), a figure that has nearly tripled post-pandemic (Department for Education, 2026d). Over 1.34 million children (18.14%) were persistently absent (i.e. missing 10% or more of school time). In 2018/19, prior to the pandemic, the persistent absence rate was 10.86%.

5.35 The number of permanent exclusions attributable to alcohol and other drug-related incidents rose from 452 in 2021/22 to 742 in 2023/24, representing a 64% increase over that period. The partial 2024/25 data (autumn and spring terms) show 447 permanent exclusions, suggesting a further increase is likely. As a proportion of all permanent exclusions, the attributable share has also risen, ranging from approximately 4.5% to 5.8% across comparable terms. The number of alcohol and other drug-related suspensions has also risen, from around 22,700 in 2021/22 to approximately 24,500 in 2023/24, but the share of all suspensions has declined (3.36% to 2.19%). The declining share reflects suspensions related to persistent disruptive behaviour.

5.36 Both school exclusion and severe absenteeism are associated with vulnerabilities which may also affect the level of additional risk experienced by young people as they move into adulthood. Children with special educational needs or disabilities (SEND) and those eligible for free school meals (FSM) are disproportionately represented in school exclusion data (Graham et al., 2019). Pupils receiving FSM are 3.5 times more likely to be severely absent than their peers, while those with an Education, Health and Care Plan (EHCP) are 5.6 times more likely (Department for Education, 2026d).

5.37 Many of these young people will experience formal education as constant transition. Extended periods of disengagement, and factors such as unstable social connections, the loss of normative influences associated with educational settings, and lower school attainment, can all heighten vulnerability to drug-related harms. At the same time, protective factors such as school connectedness, and opportunities to access drug education and signposting to support services are lost. School exclusion may lead to isolation, and drug use can function as a maladaptive coping strategy for managing stress, escaping problems, or regulating negative emotions (O'Dea et al., 2014; Okey et al., 2022). Alternative provision can provide a stable, secure setting for some of those excluded from school (102,996 students in England aged 11 to 19 in 2024/25) (Bridges, 2026). However, nearly two thirds (63.9%) of those who completed educational Key Stage 4 in alternative provision were not classed as being in sustained education, apprenticeship or employment after five years, compared to 19.5% of those in mainstream schools (Bridges, 2026).

5.38 A recent meta-analysis reviewed 25 studies examining drug use in young people not in education, employment or training (Eyraud et al., 2026). Overall, these young people were found to have significantly higher rates of both tobacco use (OR = 1.92, 95% CI = 1.46–2.53) and current cannabis use (OR = 2.14, 95% CI = 1.68–2.71) compared with

their peers. In relation to educational status, cannabis use was significantly higher relative to students in education (OR = 1.81, 95% CI = 1.34–2.44). Although no studies had specifically examined groups not in contact with education, higher prevalence of cannabis use disorders was found in young people broadly classed as not in education, employment or training (31.93%) compared with their peers (12.12%). However, as this estimate was based on only three studies, the difference did not reach statistical significance, and caution is warranted in interpretation.

5.39 An increasing number of pupils are educated at home, and may therefore also have a different experience of anticipated transition into adulthood, although no UK research has examined whether this has any impact on drug use. On the census day in autumn 2025 there were 126,000 children in elective home education (EHE), up from 111,700 the previous autumn, of which 88,400 were secondary students (Department for Education, 2026a).

Intersection with mental health difficulties

5.40 Mental health difficulties and drug use typically begin within the same developmental window, and both are shaped by the transitions that structure it. Global meta-analytic evidence indicates that the peak age at onset for any mental disorder is 14.5 years, with 48.4% of first onsets occurring before age 18 and 62.5% before age 25; the corresponding peak for substance use disorders is later, at 19.5 years (Solmi et al., 2022). In addition to important biopsychosocial factors, the two outcomes are produced in part by common conditions, including adversity, poverty, discrimination, and insecure housing and education. Transitions during key developmental periods, such as moving to secondary school, college, or university, can heighten risk (Bagnall et al., 2025; Cage et al., 2021). These periods are often associated with significant change, including disruption to support networks, increased independence, financial pressures, and a stronger desire to belong. They are also often coupled with increased exposure to social situations where drugs are present and available. Taken together, this can make drug use more appealing or accessible, particularly for those who are already experiencing mental health difficulties (Kirst et al., 2014).

5.41 An important driver of drug use among young people experiencing mental health difficulties is ‘self-medication’, or using drugs as a means of coping with distress (National Institute on Drug Abuse, 2020). Young people may use drugs to ‘switch off’ intrusive or negative thoughts, to cope with painful emotions, or to counteract symptoms such as low

mood, anxiety, or agitation (Chorlton & Smith, 2016). Drugs can be used as an emotion regulation strategy, offering temporary relief from overwhelming feelings, or to help manage challenging situations, for example reducing anxiety in social settings (Shadur & Lejuez, 2015). The relationship can be bi-directional with drug use causing or worsening mental health symptoms. Nearly half of those aged under 18 years (48%) who started specialist substance use treatment in England in 2024/25 reported needing mental health treatment (Office for Health Improvement and Disparities, 2025). Furthermore, 24% of girls and 30% of boys reported a mental health treatment need but either were not receiving treatment or refused treatment.

5.42 A lack of understanding about their own emotional experiences can further contribute to vulnerability in young people. Those young people with emerging or undiagnosed mental health difficulties may feel confused about why their mood or behaviour differs from peers, leading to distress, frustration, or a sense of being ‘different’ (Grob et al., 2020). Indeed, young people with mental health difficulties are also more likely to experience loneliness, social isolation, and difficulties maintaining relationships (Hards et al., 2022). In this context, drugs may be used both to manage these internal experiences and to support efforts to fit in socially (Chorlton & Smith, 2016). Given adolescence is also a developmental period often associated with declining self-esteem, this can intensify these feelings and increase susceptibility to peer influence and external coping mechanisms such as drug use (Masselink et al., 2018).

5.43 Systemic barriers to support further compound vulnerabilities for young people experiencing mental health difficulties (see Section 6). Long waiting times and high thresholds for accessing Child and Adolescent Mental Health Services (CAMHS) result in a ‘wait-to-fail’ model, and there are inequalities in service access among certain marginalised groups; this ultimately means that many young people do not receive timely or appropriate help, allowing difficulties to escalate (England & Mughal, 2019; Humphrey & Wigelsworth, 2016). Similarly, schools may lack the resources, training, or capacity to identify and support young people experiencing mental health difficulties effectively, leading to unmet needs and worsening symptoms (Soneson et al., 2020). In the absence of accessible and effective support, drugs may become an alternative way of coping with distress.

Trans young people and intersecting developmental, social and service transitions

5.44 While each individual's transition trajectory will vary due to individual, social, service and structural factors, trans and gender diverse young people and emerging adults aged 18-25 or even older may experience 'atemporal adolescence' or 'second puberty' depending on when, how and where they are able to actualise and express their gender identity (Ansara, 2015; Bailey, 2012; Pearce, 2018).

5.45 Social transition for trans and gender diverse young people is complex and not consistently defined in existing literature or behaviours: different social settings may be more or less socially accepting or physically or psychologically safe for young trans or gender diverse people and this may delay or support social and other transitions (Conabere et al., 2026). Socially accepting, physically and psychologically safer spaces for LGBTQ+ people may also be disproportionately co-located with licensed premises (Hillyard, 2024).

5.46 Trans and gender diverse young people's disproportionately higher experiences of violence, discrimination and stigma, including from state actors, can lead to 'minority stress' (Boyle et al., 2017; Meyer, 2003) which correlates with poor health outcomes, social exclusion and increasing risk factors in relation to drug harms.

5.47 Young trans and gender diverse people who are Black or are members of other minority ethnic groups also experience adultification bias when seeking to access support services (see Section 6.6). Institutional and interpersonal prejudice and discrimination may attribute adult standards to them, ignoring vulnerabilities or needs to the point where their legal rights to support and care are denied (Burton, 2007).

5.48 Trans and gender diverse people also face increasing barriers to accessing services: waiting times for gender-affirming care vary and may be in excess of seven years, exacerbating dysphoria and psychological distress (Department of Health and Social Care, 2025). Private medical alternatives are expensive and unaffordable to the most vulnerable young trans and gender diverse people seeking support with transitions, a situation that will replicate existing barriers to positive transitions.

5.49 While the transition to university could present an opportunity for trans young people to develop confidence in their identity in a fresh social environment, a study in UK

universities found trans young people experienced feelings of marginalisation and disenfranchisement caused by various factors, including insufficient gender-neutral facilities on campus, a lack of trans representation in the curriculum, obstacles accessing mental health support services, and administrative challenges changing names/genders on HEI systems (Regan, 2023).

6. Service Transitions

Summary

- The move from children's to adult services typically occurs at or near the 18th birthday, and this can be irrespective of need or readiness. This age coincides with leaving care, education or the youth justice system.
- Provision of drug support for 18 to 25-year-olds varies between local areas, and adult treatment services may not be suited to the needs and drug use profiles of young adults.
- Transitions from child and adolescent to adult mental health services are often poorly planned. Many young people with continuing needs are not referred on, and managed transition models have produced only modest improvements because gaps in provision are sustained by service structure and capacity.
- In the criminal justice system, support falls away at 18 as the orientation shifts from welfare to risk management, and adultification bias accelerates the withdrawal of protection from minoritised young people.
- Transitional safeguarding offers a whole-system approach that is developmentally informed, contextual, relational, attentive to equity and participative, and that prioritises continuity of relationships over age-based eligibility rules.

6.1 The transitions examined elsewhere in this report concern changes in young people's social and economic circumstances. Although not the primary focus of the report, this section addresses administrative and service level transitions as young people move between children's and young people's (CYP) services to adult services.

6.2 The National Institute for Health and Care Excellence (NICE) guideline NG43 sets out expectations for a planned, person-centred transition supported by a named worker, beginning early and actively involving adult health and social care services, for young people up to the age of 25 (National Institute for Health and Care Excellence, 2016). In most English services, service transitions fall at or close to the 18th birthday, but the difference between chronological age, and needs and readiness, makes this transition a potential driver of risk. Established relationships, routines and points of contact are withdrawn before equivalents in the adult system are in place. Some young people crossing service age boundaries are simultaneously leaving care, the youth justice system, or education, which means that their transitions are accelerated.

6.3 In relation to drug use, support for young people varies across the local areas. In some areas, it extends to age 25, while in others, it covers those up to 19. However, most young adults aged 18-25 are supported by adult drug services or only seen within CYP

services as part of temporary transitional arrangements to adult services. Young adults are a diverse group with distinct drug use profiles and adult services are often inappropriate in meeting their needs (Duke & Welch, 2026).

6.4 The transition from child and adolescent mental health services (CAMHS) to Adult Mental Health Services (AMHS) is an important point of transition. This is often poorly planned and executed, and can result in poor experiences for young people and their carers (Adanijo & Bird, 2026; Broad et al., 2017; Rowland et al., 2026). Transfers have been historically undermined by poor information exchange and by differing eligibility thresholds between the two systems. There is a high risk of discontinuity of care, and young people may 'fall through the gap' between CAMHS and AMHS, subsequently only re-presenting to mental health services in crisis (Tuomainen et al., 2020). The TRACK study found that around a third of young people who left CAMHS and had continuing needs were not referred on to adult services, with those experiencing neurodevelopmental, emotional or emerging personality difficulties most likely to fall through the gap (Singh et al., 2010).

6.5 Managed transition programmes are structured interventions designed to improve the handover of young people from CAMHS to AMHS (Singh et al., 2023). They support clinical decisions about who should move to AMHS, who can be safely discharged, and who should be directed to community-based provision. The MILESTONE model combined training for CAMHS clinicians, systematic identification of young people approaching the service boundary, a standardised assessment of transition readiness and appropriateness, and the structured sharing of information between CAMHS and adult services. One pan-European randomised controlled trial (RCT) of the model showed that it produced small improvements in mental health outcomes and addressed several of the process failures young people consistently report, namely lack of preparation, discontinuity, and limited involvement (Singh et al., 2023). However, procedural intervention alone did not resolve this transition problem, and 'cliff edges' were sustained by service architecture and capacity.

6.6 The transition is even more pronounced in the criminal justice sector. Support falls away at age 18, and the orientation of the system shifts from welfare-informed youth justice toward the enforcement and risk-management ethos of the adult estate (Alliance for Youth Justice, 2023; Phillips et al., 2026). An Alliance for Youth Justice review (2023) found that the vulnerabilities common in this population, including care experience, neurodiversity, exploitation and mental health need, compounded the effect of the

transition, and that racially minoritised young people, girls and young women, and care experienced and neurodivergent young people experienced particularly destabilising transitions. The report also identified adultification bias, by which minoritised young people were deemed more culpable and less vulnerable, as a mechanism that accelerated the withdrawal of protective support (see also Davis (2022) for an overview). A scoping study for HM Inspectorate of Probation framed the same problem as an ‘administrative cliff edge’ at age 18 and documented the disconnect between the safeguarding orientation of youth justice services and the risk-management orientation of probation (HM Inspectorate of Probation, 2025).

6.7 The concept of transitional safeguarding, presents a whole-system approach to safeguarding adolescents and young adults across developmental stages, drawing upon learning from both children’s and adult safeguarding practice (Holmes & Smale, 2018). A transitional safeguarding approach is developmentally informed, based on evidence that maturation continues into the mid-twenties; contextual or ecological, attending to harms arising beyond the family, including peer networks and criminal exploitation such as county lines; transitional or developmental, recognising young adulthood as a distinct stage rather than a junior form of adulthood; relational, prioritising continuity of the relationship with a practitioner over the eligibility rules of a particular service; attentive to equity, equalities, diversity and inclusion, addressing how adultification affects minoritised young people specifically; and participative, ensuring that young people help design their own support and safety planning rather than having it imposed.

7. Policy, Practice and Research Recommendations

Recommendation 1: Prioritise transitions and life-course framing in the drug prevention components of local and national action

Local and national drug prevention activity and strategy should explicitly recognise developmental transitions as priority points for both universal and targeted prevention. Prevention commitments should be organised around all points of change in young people's social context (e.g. the move from primary to secondary school; the post-16 transition into further education, higher education, apprenticeship, employment or a period not in education, employment or training; leaving the family home; leaving care; and the move between children's and adult services) rather than around fixed age thresholds or one-off delivery. This would align prevention activity with the periods of heightened risk identified in the current report and with the whole-system approach set out in the ACMD's 2025 prevention report.

Lead(s): Joint Combating Drugs Unit and Home Office, working with the Department for Education, the Department of Health and Social Care (DHSC), and the devolved administrations.

Measure of outcome: Transition points are identified as prevention priorities in the successor drug strategy and its delivery plan, and in the corresponding devolved prevention frameworks.

Recommendation 2: Embed transitional safeguarding across the children-to-adult service boundary

Government and local partnerships should include a transitional safeguarding approach for young people moving between children's and adult services as part of drug prevention activity. Support should be planned around developmental readiness with continuity of a trusted relationship maintained across the boundary and protective support not withdrawn before equivalent adult provision is in place. This applies across drug services, mental health, and criminal justice. Particular attention should be given to the compounding of risk, where a service transition coincides with leaving care, leaving the youth justice system, or leaving education, and to the effect of adultification bias on minoritised young people.

Lead(s): DHSC and Department for Education; locally, integrated care boards, local authorities, youth justice and probation services, and Combating Drugs Partnerships. Devolved equivalents in Scotland, Wales and Northern Ireland.
Measure of outcome: Local protocols provide for needs-based, relationally continuous transitions to age 25 where appropriate, with a measurable reduction in the proportion of young people who have continuing needs but are discharged without onward referral.

Recommendation 3: Commission drug-related support tailored to young adults (aged 18 to 25)

Commissioners should secure provision designed for the distinct needs and drug use profiles of young adults aged 18-25, rather than defaulting either to children's services or to adult treatment services. Such provision should accommodate the accelerated and unsupported transitions experienced by care leavers, young people in contact with the criminal justice system, and those leaving education, and should be reachable through outreach as well as referral.
Lead(s): DHSC/OHID and local authority commissioners in England; devolved commissioning bodies elsewhere.
Measure of outcome: Young adult-oriented treatment and outreach pathways are available in local areas, with evidence of access and retention among 18 to 25-year-olds.

Recommendation 4: Situate prevention within a whole-school approach and align it with the post-16 transition

Prevention activity should be continuous across the boundary between statutory education and post-16 settings, so that the period of greatest contextual change is not also the period of least support. Curriculum-based drug education should sit within a whole-school approach that strengthens school connectedness, staff-student relationships and pastoral support. Provision should account explicitly for young people not in mainstream education, who are less well reached by school-based approaches yet are at elevated risk.
Lead(s): Department for Education and the devolved education departments; schools, further education colleges, and alternative provision settings.
Measure of outcome: Continuity arrangements operate between schools and post-16 settings, and prevention is situated within whole-school health and wellbeing frameworks.

Recommendation 5: Reorient higher education responses to drug use to focus on student health, wellbeing, and welfare

Higher education providers should offer a supportive whole-institution response to substance use, including preventative action, and welfare-led models of harm reduction, consistent with Universities UK (2024) guidance. This should include non-punitive disclosure routes; embedding of substance use support within wellbeing and personal tutor systems; provision timed to the pre-arrival and induction period, and seasonality such as summer and winter breaks; and the transition at graduation.

Lead(s): Higher education providers, in partnership with Combating Drugs Partnerships (and equivalents in devolved administrations), and locally commissioned drug services.

Measure of outcome: Sector adoption of welfare-led drug policies.

Recommendation 6: Improve the availability of accessible early intervention services for young people

In the UK, young people's mental health can worsen if they are on a long waiting list for support or are turned away from non-specialist services due to high thresholds of need. This is exacerbated for neurodivergent young people, who often find early intervention services inaccessible, or not appropriately adapted to meet their needs. Given the relationship between poor mental health and drug use, improving the availability of accessible services would help to reduce the likelihood of later drug use among this population. Early intervention services should be more readily available for children and young people when they first need support, within both education and healthcare settings, with accessible and effective services available for neurodivergent young people.

Lead(s): Department for Education; Department for Health and Social Care; NHS Trusts (and equivalents in devolved administrations); education providers; research funders.

Measure of outcome: Reduced waiting times for mental health services, increased provision of early intervention in both schools and healthcare settings, further research into effective support/adaptations for neurodivergent young people, tailored support offered to neurodivergent young people across services.

Recommendation 7: Harmonise substance use survey methods across the four nations, including for students in further/higher education

The four nations' school and young adult surveys should converge, as far as is practical, on common items, definitions, age bands and reference periods, to improve comparability across the UK and over time. Harmonisation should extend to recommendations for institutional and sector data collection that already exists for the young adult population (e.g. university students).

Lead(s): A coordinating role for the Joint Combating Drugs Unit, working with the Office for National Statistics, the devolved statistical and public health bodies, and national survey leads (including NHS England, Public Health Scotland, the School Health Research Network in Wales, and the Northern Ireland Department of Health).

Measure of outcome: An agreed minimum common dataset.

Recommendation 8: Strengthen coverage of out-of-school and otherwise excluded young people in survey research

School-based surveys rely on pupils being present on the survey day, and systematically under-represent groups at elevated risk, including persistent and severe absentees, permanently excluded pupils, those in alternative provision, looked-after children, and those in custody. Research and survey design should incorporate methods to reach these populations, so that prevalence among higher risk groups is not under-estimated.

Lead(s): Research funders and survey commissioners; the Department for Education and equivalent departments in the devolved administrations, in respect of linkage to exclusion and absence data; researchers undertaking surveys.

Measure of outcome: Commissioned work, or changes to survey design, that generate prevalence estimates for out-of-school and excluded young people.

Recommendation 9: Build longitudinal research capacity through cohorts and data linkage

Understanding trajectories and outcomes of drug use requires better longitudinal data. Meaningful substance use measurement should be embedded within existing UK longitudinal cohorts. At a minimum, this measurement should capture health-relevant data including use, age of onset and recency and frequency of use. In parallel, routine and

consented linkage of survey self-report to health records (including accident and emergency and mental health contacts), education attainment and exclusion, criminal justice contact, and employment and welfare records should be developed. Standard guidance should be produced for smaller studies on embedding the provision for linkage at recruitment and data collection, to enable linkage of data for future analyses. The National Drug Treatment Monitoring System should be made more readily available for research linkage beyond government data, ensuring that linkage to individual data via longitudinal cohorts is prioritised.

Lead(s): UK Research and Innovation and the National Institute for Health and Care Research (cohort investment); DHSC/OHID and the National Drug Treatment Monitoring System; the Office for National Statistics (Longitudinal Study and linked administrative data), with appropriate information governance.

Measure of outcome: Substance use measures are included in one or more existing cohorts, and an established route exists for consented linkage of self-report data to administrative records, including availability of the National Drug Treatment Monitoring System for research. Equivalent organisations in devolved administrations should lead the work in those nations.

Annexes

Annex A: UK Four-Nations Context

The UK does not have a unified statutory definition of 'adolescents' or 'young people'. Instead, age thresholds and definitions vary across the four nations, and across sectors such as health, education, and social care. As a result, exposure to drug use prevention activities may diverge across the four nations. This underscores the need for policies and interventions that are sensitive to the unique contexts and developmental trajectories present in each part of the UK.

In England, school-based drug prevention interventions are primarily targeted at those aged 11 to 16, with health and social care services potentially extending individualised support up to ages 18 or 25, depending on individual circumstances. Whilst in Wales age ranges are not defined in statute, drug prevention is delivered through youth services that may reach young people up to 25 years in policy. Similarly, in Scotland, drug prevention policies are frequently aligned with youth services covering the 11 to 25 age group, though statutory definitions remain focused on those under 18. In Northern Ireland, strategies are implemented through both schools and youth services, with practical reach extending up to age 25. These variations reflect a common commitment to supporting young people but also highlight differences in statutory frameworks, service delivery models, and the age groups targeted, which can influence the reach and effectiveness of interventions across the four nations.

a) Statutory Definitions

There is no single statutory definition of a 'child' across the UK. In England, the Children Act 1989 defines a child as anyone under the age of 18[2]. This definition is echoed in Wales, where the same Act applies, and is further supported by the Children and Young Persons Act 1933, which distinguishes between a 'child' (under 14) and a 'young person' (aged 14–17)[3]. The General Medical Council's guidance also applies to all individuals under 18 in both nations[4]. Wales, however, overlays additional duties for children and adults through the Social Services and Well-being (Wales) Act 2014, without redefining the age threshold.

In Scotland, the Children and Young People (Scotland) Act 2014 similarly defines a child as someone under 18, maintaining statutory alignment with England and Wales. However, a

[2] Children Act 1989, s.105: 'child' means a person under the age of eighteen.
[3] Children and Young Persons Act 1933, s.107: 'child' means under 14; 'young person' means 14–17.
[4] General Medical Council (GMC), 0-18 years: guidance for all doctors (2020).

notable difference arises with the Age of Legal Capacity (Scotland) Act 1991, which grants full legal capacity at age 16, introducing a divergence in the practical application of childhood and adulthood[5].

Northern Ireland follows the Children (Northern Ireland) Order 1995, which also sets the threshold for childhood at under 18.

b) Education Age Thresholds

As described in the main report, the educational environment plays an important role in shaping young people's experiences and outcomes. Across the UK, education systems are devolved, meaning that England, Wales, Scotland, and Northern Ireland each set their own policies and funding arrangements. This results in both statutory overlaps and important differences in the age thresholds for compulsory education and the nature of post-16 provision.

In England, compulsory education spans ages 5 to 16, but the Education and Skills Act 2008 extends the requirement for participation in education or training until age 18. In contrast, Wales, Scotland, and Northern Ireland require compulsory education only up to age 16, with no statutory obligation to continue beyond this point. Nevertheless, many young people in these nations choose to remain in education or training after 16, pursuing a variety of academic and vocational pathways.

c) Social Care and Leaving-Care Entitlements

In England, the Children (Leaving Care) Act 2000 and amendments to the Children Act 1989 ensure that care leavers receive support up to age 21, and extended support available until age 25 for those engaged in education or training. Wales mirrors England's approach, offering similar entitlements and extensions for care leavers pursuing further education or training. Scotland, however, provides for continuing care and aftercare up to age 26, recognising a broader window for transition into adulthood. In Northern Ireland, support is available up to age 21, and up to 24 for those in education or training.

d) Health Service Age Boundaries

Health service age boundaries play a crucial role in shaping the support available to young people as they navigate key developmental transitions. Across the UK, CAMHS typically

[5] Age of Legal Capacity (Scotland) Act 1991, s.1(1)(b): full legal capacity at age 16.

provide care up to age 18, with the transition to adult services often occurring between ages 16 and 18. While Wales and Northern Ireland generally follow similar patterns to England, Scotland introduces additional variation, with some health services extending support up to age 25.

Annex B: ACMD Prevention Standing Committee at time of publication

Chair of Standing Committee	
Professor Harry Sumnall	Professor in Substance Use, Liverpool John Moores University
Co-Chair of Standing Committee	
Fiona Spargo-Mabbs OBE	Director and Founder, Daniel Spargo-Mabbs Foundation. Chair, Drug Education Forum.
ACMD Members of Standing Committee	
Professor Steve Allsop	Emeritus Professor, National Drug Research Institute at Curtin University, Australia
Professor Anne Campbell	Professor of Substance Use and Mental Health, and Co-Director of the Drug and Alcohol Research Network at Queen's University, Belfast
Professor Colin Davidson	Professor of Neuropharmacology, University of Central Lancashire
Mohammed Fessal	Chief Pharmacist, Change Grow Live
Professor Katy Holloway	Professor of Criminology, University of South Wales
Professor Stephen Husbands	Professor of Medicinal Chemistry, University of Bath
Sapna Lewis	Senior Lawyer, Welsh Government Legal Services Department
Co-optees of Standing Committee	
Dr Emma Ashworth	Chartered Psychologist and Reader (Associate Professor) in Child & Adolescent Mental Health, Liverpool John Moores University
Professor Vashti Berry	Professor in Prevention Science, University of Exeter; NIHR Applied Research Collaboration South West Peninsula (PenARC)
Dr Hannah Carver	Associate Professor in Substance Use, University of Stirling
Dr Brendan Collins	Senior Lecturer, Public Health Economics, Department of Public Health, Policy & Systems, University of Liverpool
Emma Crawshaw	CEO of Crew 2000
Professor Karen Duke	Professor in Criminology, Middlesex University

Angela Hall	Commissioner in North Yorkshire and member of the English Substance Use Commissioners Group
Nicholas Hickmott	Early Intervention Lead, WithYou
Dr Lindsey Hines	Lecturer in Psychology, University of Bath
Professor Ruth McGovern	Professor of Public Health and Social Care, Population Health Sciences Institute, Newcastle University
Jennifer Rushworth-Claeys	Director of Young Person Services, WithYou
Dr Jeremy Segrott	Reader, Centre for Trials Research, Cardiff University
Alice Wiseman	Director of Public Health across Newcastle and Gateshead and Vice President for the Association of Directors of Public Health

Annex C: ACMD Council Membership, at time of report publication

Chair of ACMD Council	
Professor David Wood	Professor of Clinical Toxicology and Consultant Physician, Guy's and St Thomas' NHS Foundation Trust, King's Health Partners and King's College London
ACMD Council Members	
Professor Judith Aldridge	Professor of Criminology at University of Manchester
Professor Steve Allsop	Emeritus Professor, National Drug Research Institute, Curtin University, Australia
Professor Anne Campbell	Professor of Substance Use and Mental Health, and Co-Director of the Drug and Alcohol Research Network at Queen's University, Belfast
Dr Caroline Copeland	Senior Lecturer in Pharmacology & Toxicology, King's College London and Director, National Programme on Substance Use Mortality
Professor Colin Davidson	Professor of Neuropharmacology, University of Central Lancashire
Professor Karen Ersche	Professor of Addiction Neuroscience, University of Cambridge
Mohammed Fessal	Chief Pharmacist, Change Grow Live
Professor Amira Guirguis	Professor of Pharmacy, MPharm Programme Director at Swansea University Medical School
Dr Hilary Hamnett	Associate Professor in Forensic Science, University of Lincoln
Jason Harwin	Director and Co-founder of E-T-E Solutions Limited
Professor Graeme Henderson	Honorary Professor of Pharmacology, School of Physiology, Pharmacology & Neuroscience, University of Bristol
Professor Katy Holloway	Professor of Criminology, University of South Wales
Professor Keith Humphreys	Esther Ting Memorial Professor of Psychiatry, Stanford University, USA
Professor Stephen Husbands	Professor of Medicinal Chemistry, University of Bath
Professor Sunjeev Kamboj	Professor of Translational Clinical Psychology Research Department of Clinical, Educational and Health Psychology, University College London
Professor Roger Knaggs	Professor in Pain Management and Clinical Pharmacy Practice, University of Nottingham
Sapna Lewis	Senior Lawyer, Welsh Government Legal Services Department

Dr Lorna Nisbet	Senior Lecturer and Principal Investigator for Forensic Toxicology at the Leverhulme Research Centre for Forensic Science, University of Dundee
Detective Sergeant Jon Privett	Detective Sergeant, Metropolitan Police Service
Fiona Spargo-Mabbs OBE	Director and Founder, Daniel Spargo-Mabbs Foundation. Chair, Drug Education Forum.
Professor Harry Sumnall	Professor in Substance Use, Liverpool John Moores University
Professor Simon Thomas	Emeritus Professor of Clinical Pharmacology and Therapeutics, Newcastle University

Annex D: Abbreviations used in this report

Abbreviation	Definition
ACE(s)	Adverse childhood experience(s)
ACMD	Advisory Council on the Misuse of Drugs
ADHD	Attention deficit hyperactivity disorder
ALSPAC	Avon Longitudinal Study of Parents and Children
AMHS	Adult Mental Health Services
APMS	Adult Psychiatric Morbidity Survey
CAMHS	Child and Adolescent Mental Health Services
CI	Confidence interval
COVID-19	Coronavirus disease 2019
CSEW	Crime Survey for England and Wales
CYP	Children and young people
DHSC	Department of Health and Social Care
DWP	Department for Work and Pensions
EHCP	Education, Health and Care Plan
EHE	Elective home education
FE	Further education
FSM	Free school meals
GP	General practitioner
HE	Higher education
HEI	Higher education institution
HWB Census	Health and Wellbeing Census Scotland
LGBTQ+	Lesbian, gay, bisexual, trans, and queer or questioning, plus other sexual and gender minority identities
ND	Neurodivergent
NDTMS	National Drug Treatment Monitoring System
NEET	Not in education, employment or training
NHS	National Health Service
NI	Northern Ireland
NICE	National Institute for Health and Care Excellence
NIHR	National Institute for Health and Care Research
NUS	National Union of Students
OHID	Office for Health Improvement and Disparities
ONS	Office for National Statistics
OR	Odds ratio
RCT	Randomised controlled trial
RSHE	Relationships, Sex and Health Education
SALSUS	Scottish Schools Adolescent Lifestyle and Substance Use Survey
SCJS	Scottish Crime and Justice Survey
SDD	Smoking, Drinking and Drug Use among Young People in England survey
SEND	Special educational needs or disabilities
SHeS	Scottish Health Survey
SHRN	School Health Research Network (Wales)
SOS-UK	Students Organising for Sustainability UK
UK	United Kingdom

UNCRC	United Nations Convention on the Rights of the Child
UNODC	United Nations Office on Drugs and Crime
US	United States
YE	Year ending
YPBAS	Young Persons' Behaviour and Attitudes Survey

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