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Trends and research in young people's alcohol and substance use

I was recently privileged to be invited to the Alcohol Education Trust/Mentor conference at Middlesex University on 19th November 2016, when I was asked to talk about trends in drug and alcohol use in young people and factors that are affecting them.

Trends

Things are getting better. There is a consistent pattern of decline in various measures of young people's substance use:

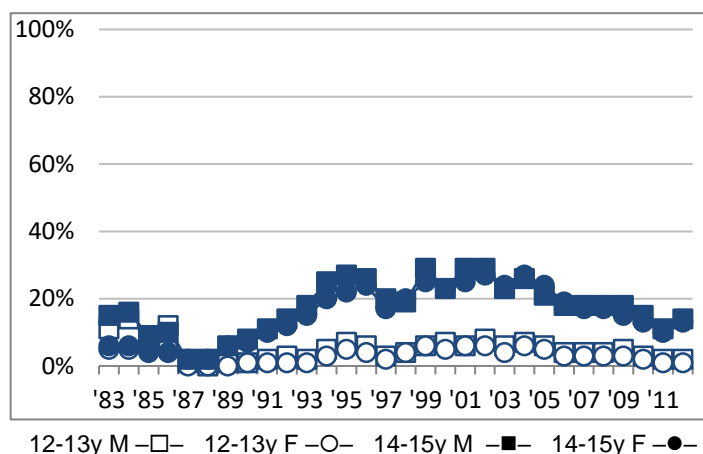
- the proportion of young people who have ever used alcohol has declined in each age group since 2001;
- the proportion of young people who have used alcohol in the last week has declined in each age group since 2000;
- the proportion of young people who have ever used drugs has declined in each age group since 2001;
- the proportion of young people who have used drugs in the last month has declined in each age group since 2001;
- the proportion of young people who have ever used tobacco cigarettes has declined in each age group since 1996; and
- the proportion of young people who are current users of tobacco cigarettes has declined in each age group since 1996.

(all from Fuller, ed., 2015).

All of these series, where available, show a rise from the early 1980s to the middle 1990s. There is an interesting dip and recovery around 1997-2000, but since the early 2000s the trend has been fairly steadily downwards.

We have used a fairly consistent method in our surveys from the late 1980s to the present, although our data sets have not been gathered in a methodical way¹. Nonetheless, we can show the same rise/wobble/decline pattern in our data sets. We show below (Chart 1) the figures seen in the aggregate data sets for pupils in Years 8 and 10 (12-13 years old and 14-15 years old respectively) and by sex.

Chart 1. Ever used cannabis 1983-2012, by year group and Sex



¹ Each year, SHEU produce a report of aggregate school survey results using similar surveys in their *Young People* series, often referred to by news media as 'national data'. The studies that give rise to the reports are large, numerous, and from many parts of the United Kingdom, but they do not form a deliberately-selected sample. The origin and structure of these surveys is described fully in each annual report. Despite the 'accidental' nature of the

sample, the nature of the sample is 'reasonably matched' to the characteristics of all schools in England, and the results seen in the SHEU annual data sets typically matches survey outcomes from other data-collection agencies using structured or random sampling. Evidence supporting these claims can also be found in the SHEU reports. (Balding & Regis, 2015).

These recent declines can be compared to:

- declines in the under-18 conception rates since 1998, (Office of National Statistics, 2015),
- similar trends regarding drug use in 16-24 age range and the whole population (Office of National Statistics, 2016a),
- a general decline in crime rates seen in the UK (Office of National Statistics, 2016a),
- and to a general decline in crime rates in other developed countries (e.g. FBI, 2016).

The reasons for all these welcome declines are not obvious and may never be so (van Dijk *et al.*, 2016), but the overall picture is clear enough.

Risk and Protective Factors

Let us take one connection, one point of the research: *poor family management* has been shown to predict *substance abuse* (youth.gov, 2016). In the jargon, it's a *risk factor*; had it been associated with lower substance use, it would be referred to as a *protective factor*. We can also find risk factors predicting other behaviours that we might see as undesirable. For example, the risk factor of *poor family management* has been shown to predict five other behaviours: *substance abuse*, *delinquency*, *teenage pregnancy*, *school drop-out*, and *violence* (Communities that care, 2016). Our point has become a row.

In fact, dozens of other factors have been shown to predict *substance use* in young people. Moreover, this same long list of factors are also variously related to the row of other undesirable behaviours. What was a row, multiplied by a long list, has become a substantial table (youth.gov, 2016 and Communities that Care, 2005). This might give the impression of unmanageable complexity, but the fact that most of a list of risk factors can each be shown to be related to most of a list of behaviours suggests some common underlying processes going on. There are several projects with a good evidence base showing that it is possible to intervene in these processes successfully and reduce young people's involvement in undesirable behaviours, including Communities That Care.

This is a largely American literature, but we can pick from the research summaries a finding (wellbeing and resilience are protective factors for substance use) and check it in our UK data sets. It can readily be shown (Table 1) that wellbeing (as assessed by WEMWBS, Clarke *et al.*, 2011) and

resilience are negatively correlated with alcohol use in our samples:

Table 1. Links between resilience and wellbeing scores and alcohol among Year 10 students from samples in 7 and 3 local authorities, SHEU 2014

	LAs	N		Male	Female	
Resilience	7	5,423	Low (up to 19)	36	32	
			Med-low (20-22)	29	21	
			Med-high (23-25)	25	15	
			High (26+)	22	11	
	LAs	N		Male	Female	
Wellbeing	3	1,801	14 - 27 (low)	48	36	
			WEMWBS	28 - 41 (med-low)	32	38
			42 - 55 (med-high)	27	26	
			56 - 70 (high)	20	22	

Self-esteem as a protective factor?

While reviewing this material, I was brought up by an entry in youth.gov's summary: high self-esteem was listed as a *protective factor* for undesirable behaviours, which was a small surprise. We discovered many years ago, with Peter Gurney and Ann Brackenridge, that self-esteem was positively associated with increases in alcohol use and experimentation with cannabis in older pupils (e.g., Balding, 1995). That would make it a *risk factor*, while low self-esteem appeared as a protective factor. Our interpretation at the time was that the high-self-esteem group included outgoing, sociable individuals who may be exposed to more opportunities to engage in risky behaviours and perhaps also were less likely to be cautious. Has self-esteem changed sides? Checking this finding in our latest data set seems to show (Table 2) that high self-esteem really is a protective factor now. Self-esteem is measured on a scale with a maximum of 18.

Table 2. Links between self-esteem scores and alcohol use in the last week among Year 10 students from samples in 16 local authorities, SHEU 2014

	LAs	N		M	F
Esteem	16	13,701	Values 0-4 (low)	23	34
			Values 5-9 (med-low)	23	22
			Values 10-14 (med-high)	17	17
			Values 15-18 (high)	16	13

I was curious to follow the history of this change. We can explore this either in the aggregate data sets – which pool information from many, probably quite diverse, communities – or by looking at the association just in one part of the country. In fact, we did both, with similar results.

The results from the single-authority analysis are shown in Table 3.

Table 3. Percentage of Year 10 students from one local authority who used alcohol in the last week, by self-esteem score and by wave of survey, 2002-2014.

N=30,238	2002	2004	2006	2008	2010	2012	2014	2016
Values 0-4 (low)	47	48	48	58	47	40	43	36
Values 5-9 (med-low)	50	49	48	48	46	36	34	36
Values 10-14 (med-high)	50	52	49	49	48	39	36	31
Values 15-18 (high)	55	52	50	51	53	40	34	32

We can see in Table 3 that in the early 2000s, the high self-esteem group showed the highest levels of use of alcohol in the last week (55%). In 2014, we find the low self-esteem group shows the highest levels (43%), and this is seen again in 2016. So, I think we can say that high self-esteem has swapped columns, from being listed under risk factors to protective factors, at least in our data sets, and low self-esteem is now a risk factor. Why this happened is not obvious: perhaps, since high self-esteem is fostered by being in a social group which approves of and supports your actions, then, as alcohol use has declined, we see higher self-esteem scores among those displaying this now-normal lower use.

Trends in wellbeing

In this same local authority data set, with its changing relationship between self-esteem and alcohol use, we can also see a decline in self-esteem among the females in Year 10 (Table 4). The mean self-esteem score dropped from 13.0 in 2002 to 11.0 in 2016.

Table 4. Percentage of Year 10 female pupils scoring in each bracket of self-esteem scores, 2002-2014.

N=16,508	2002	2004	2006	2008	2010	2012	2014	2016
Values 0-4 (low)	2	2	3	4	4	7	11	8
Values 5-9 (med-low)	14	14	15	17	18	23	27	26
Values 10-14 (med-high)	45	42	39	43	45	42	39	41
Values 15-18 (high)	39	42	43	36	32	28	23	25

This suggests that, while the overall trends in alcohol use may be down, there is an unwelcome decline in self-esteem score among young women.

Throughout this article, I have treated these large samples as aggregates, but there is some diversity within these authority-wide samples. For example, we can show a marked disparity in

alcohol use and drug between a whole Year 10 sample and those young people who identify as lesbian, gay or bisexual (LGB).

Table 5. Substance use among Year 10 pupils in a different local authority, all and LGB pupils, 2014.

N=3,529	All Year 10	LGB
Drank last week	35	42
Ever offered drugs	28	38
Ever taken drugs	14	20
Ever tried smoking	34	49

The overall trends in substance use are so positive, that we could conclude that things are only getting better. However, the risk factor (as it now is) of low self-esteem is increasing in older females, and we have evidence of some higher use among vulnerable groups of young people, like the LGB group. There remain substantial challenges of looking after the health and wellbeing of young people in our communities.

For more information about SHEU, visit www.sheu.org.uk

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