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New millennium trends in young people's use of illegal and illicit drugs in Britain

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Received 28 January 2008
Revised 2 February 2008
Accepted 3 February 2008

Abstract

Purpose – The purpose of this paper is to describe trends since 2000 in young people's use of illegal/illicit drugs in Britain, and to place these into a longer-term context alongside recent theorising on youthful drug taking. The implications for health educators are to be examined.

Design/methodology/approach – A selective narrative review of published data and theory forms the approach.

Findings – A steady rise in the prevalence of youthful drug taking in Britain from the 1960s was followed by a sharper rise from 1990 to an all-time peak in the middle of that decade. Rates have not quite returned to this peak since, and from 2000 onwards have declined steadily, though from a historically high level. By 2006/2007, roughly one in five younger adolescents, and one in four older adolescents and young adults, has taken an illegal/illicit drug in the past year. In spite of changes over the past two decades, youthful drug taking in Britain over this period is characterised by considerable continuity. Gender and socio-economic differences in drug taking over this period have remained roughly stable, but changes may be under way in relation to differences by ethnic background.

Practical implications – In Britain, levels of youthful drug taking remain at historically relatively high levels, with recent decreases at least in part probably due to a cohort effect of the drug-involved generation who were teenagers in the 1990s moving into their 30s. Drugs education is not the likely cause of the post-2000 downward trend. Drug “journeys” and the pursuit of pleasure are important considerations for health educators who aim their messages at the majority of young people whose drug use is not seriously problematic, and who are proactive when they do experience problems.

Originality/value – This paper calls for health educators also to focus on the majority of youthful drug use that is relatively unproblematic for young people. These young people require information as they make adjustments in their behaviour, and their needs may sometimes be ignored in favour of those with problematic drug use.

Keywords Health education, Drugs, Education

Paper type Research paper

Introduction

This paper charts recent trends in the use of illegal and illicit drugs by young people in Britain. Sharply rising rates of drug use amongst young people in the early 1990s (also documented in many other developed countries, Bauman and Phongsavan, 1999) captured the attention of politicians, commentators and academic researchers across the UK. The 2000s in Britain have so far been quieter on the political and media front where young people's use of drugs is concerned, and debate has been at least a little more measured. For the moment, policy and media and research attention seems to have turned to alcohol and youthful “binge” drinking (Hayward and Hobbs, 2007). This paper begins by describing British trends in both the prevalence and patterns of drug taking by adolescents and young

adults. Recent theoretical insights into youthful drug taking are discussed, and the implications of all this for health educators are considered.

A caveat on data sources and their limitations

Self-report surveys are widely recognised as the best way to assess general population levels of drug taking (Ramsay and Spiller, 1997). Good prevalence data on drug use by 11-15 year olds in England is produced in the annual "Smoking, Drinking and Drug Use" (SDD) series of surveys. The British Crime Survey (BCS) picks up from age 16 to adulthood, and covers England and Wales. Data generated by these surveys are comparable from 2001 (SDD surveys) and 1996 (BCS). Both surveys under-represent the most drug involved young people[1] and there has been increasing concern that willingness to admit to particular behaviours may be changing over time, thus reducing our ability to identify real changes in behaviour[2]. Because it is essential to place trends within a longer-term context, the best available evidence of pre-2000 trends[3] is reported in this paper.

Trends in drug taking: pre- and post-2000[4]

Pre-2000 trends

Prevalence of use. Quantitative research into drug taking prior to the early 1990s in Britain was rare. Newcombe (1995) conducted an exhaustive review of (approximately) 80 local and 40 national British surveys from 1964, comprising mostly market research and media polls, along with a few government surveys, and even fewer academic surveys[5]. He concluded that amongst young adults (typically aged 16-24), lifetime prevalence of self-reported illicit drug use (for any drug) climbed steadily from less than 5 per cent in the 1960s, to around 10 per cent (5-15 per cent) in the 1970s, to 15-20 per cent in the 1980s, thus approximately doubling each decade.

Changes between 1990 and 1995 (taking in studies using a range of sample types and age bands) were summarised by Measham *et al.* (1998), who noted an approximate doubling of lifetime prevalence rates – this time over only a five year period – from (on average) around one quarter early in the decade to around one half by 1995. Balding's annual Schools Health Education Unit (SHEU) school surveys[6] also demonstrated a similar (approximate) doubling of drug trying[7] prevalence amongst secondary school aged children in the first half of the decade (Balding, 2000).

The second half of the 1990s showed the beginnings of a reversal of this upward trend in youthful drug taking. Plant and Miller (2000) described reductions in drug trying rates amongst 15-16 year olds using comparable data from 1995 and 1999: small but significant reductions in lifetime prevalence rates occurred (for girls from 40 per cent to 33 per cent; for boys from 54 to 40 per cent). Balding's SHEU surveys pinpointed 1996 as the year in which drug trying rates dropped for most age groups in his annual surveys (Balding, 2000). However, the downward trend was reversed only a few years later, returning nearly to peak 1996 rates by the end of the decade. Comparable data from the SDD surveys (from 1998) confirm this late-decade upward trend for 11-15 year olds: the increase in drug taking is small but steady (14 per cent in 1998, 15 per cent in 1999, and 16 per cent in 2000) (Hills and Li, 2007).

Taking the whole period prior to 2000, the trend appears to have been:

- a steady and substantial rise in the prevalence of adolescent drug taking up to 1990;

- followed by a considerably steeper rise from 1990, with a peak around mid-decade; and
- followed by a short-lived drop in prevalence, with rates probably returning near to their peak mid-decade levels by the new millennium.

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The 2000s would start, therefore, with historically very high levels of drug use amongst young people.

It was the arguably (see Newcombe, 2007) very steep rise in drug taking amongst young people in the early 1990s that caught the attention of so many researchers, commentators and policy makers at the time. There is considerable evidence to support the view that the adolescents of the early 1990s were a unique generation in relation to their willingness to experiment with drugs, not least the fact that this age cohort have the status of being the most drug involved during their teens of any cohort before, and as discussed below, since. It also appears that the drug use of that generation (now entering their thirties) carried on into their adulthood at higher rates than had been typical before (Parker *et al.*, 2002; Murphy and Roe, 2007).

Patterns of use. It will be no surprise that this cohort of adolescents during the 1990s, the “children of the decade of dance” may have been influenced by the arrival of ecstasy and rave culture in Britain around this time. Their patterns of use reveal a willingness to experiment with a widening range of illegal and illicit substances. The 1992 BCS shows that almost 8 per cent of 16-19 year olds reported having taken ecstasy in 1991, a drug that had only arrived in Britain as a recreational drug a few years previously (Mott and Mirrlees-Black, 1995). The 1994 BCS (two years later) showed a wide range of substances taken by 16-19 year olds in the past year. Whilst cannabis topped the list (29 per cent), use of a range of other drugs was not inconsiderable: amphetamines (10 per cent), LSD (8 per cent), “poppers” (7 per cent), ecstasy (5 per cent) and magic mushrooms (4 per cent) (Ramsay and Percy, 1996). Many drugs in this list mirror the drugs being consumed in the raves and early dance clubs of the time. Notable by their fairly low (in comparison) past year prevalence rates were cocaine, temazepam, heroin, methadone, crack and steroids, all at 1 per cent or less. The demarcation between the drugs these young people tended to take versus the ones they eschewed seems fairly clear, with the vast majority opting for drugs arguably associated with excitement, fun, relaxation and experimentation rather than for the drugs typically associated with heavy use and treatment.

Identification of these unprecedented levels of drug taking by 1990s adolescents put the issue at the top of political and media agendas. “Scare” stories linking drugs and death particularly through ecstasy (Murji, 1998) resulted in a decade of heightened attention to and fears about youthful drug use. Although levels of youthful drug use were indeed unprecedented, with some young people eager to “pick ‘n’ mix” from a range of psychoactive substances (Parker and Measham, 1994), as many or more young people were unwilling to do so. Even by the mid decade peak, 16-19 year olds who had never taken any illegal/illicit drug were in the majority (55 per cent) (Ramsay and Spiller, 1997), although some regional/local surveys around this time found non-triers to comprise just under half of their samples (e.g. Parker *et al.*, 1998). It is likely, therefore, that around one half of young people around this time were abstainers – even if their drugs status over adolescence (Aldridge *et al.*, 1999), and into adulthood (Williams, 2007) was always subject to change.

Current/regular drug use by this relatively drug-involved age cohort will have been considerably lower than lifetime trying rates. The 1996 BCS data indicated that 45 per cent of 16-19 year olds had tried a drug in their lifetimes; only for 31 per cent had the most recent time been in the past year, and for only 19 per cent had this been in the past month (Ramsay and Spiller, 1997). Even amongst past month adolescent drug takers, it is likely that no more than three quarters of these were regular users (Parker *et al.*, 1998), suggesting that about 15 per cent of 16-19 year olds in 1996 were "regular" drug users. What is clear is that, whilst rates of adolescent drug use in the early 1990s may have been unprecedented, around half of young people were abstinent, and regular users will have been the considerable minority.

Drug taking as "subcultural" and deviant?

Ethnographers and cultural theorists, in work that addressed youthful drug taking prior to the 1990s, tended to recognise and situate drug taking within subcultures. These subcultures were mostly viewed as the product of constrained opportunity amongst the working classes, emerging for example in the USA as retreatists (Cloward and Ohlin, 1960) and marihuana users (Becker, 1953), and in Britain as hippies (Willis, 1976; Young, 1971) and mods (Hebdige, 1976). This body of research is suggestive that the phenomenon of youthful drug taking was viewed by analysts during this time as activity particular to one or another group of young people who exemplified difference: who did not share the norms and values of their conforming counterparts (for an alternative view in which drug using cultures were identified as emerging from within the educated middle classes, see Downes, 1966).

The observations of 1990s researchers looked set to question this characterisation of drug taking as subcultural, deviant activity by those wholly rejecting mainstream values. Adolescent and young adult drug taking had begun to occur across the range of demographic groupings, and included young people in significant numbers who: were both male and female (Parker *et al.*, 1995); lived in both low and high income, non-working and working families (Ramsay and Spiller, 1997); lived in urban and rural situations communities (Forsyth and Barnard, 1999); and brought with them a range of educational attainments and employment aspirations (Measham *et al.*, 2001). These quantitative observations dovetailed with those of a new generation of analysts of youth cultural formations, evident particularly in their questioning of difference between cultural insiders and "ordinary" outsiders (Manning, 2007, p. 21). From the 1990s it appears, drug taking was less likely to be understood as the preserve of "deviant" minorities or of subcultures (but for an opposing view, see Gourley, 2004).

Post-2000 trends

Prevalence of use. Past year prevalence figures for "any drug" are presented in Figure 1. For the group aged 16-24, comparable BCS data go back to 1996. For 11-15 year olds, SDD data are presented from 2001 only, due to a change in the format of drugs questions.

For both age groups, the period post 2000 is marked by small but regular decreases in past year drug taking prevalence. For those aged 11-15, past year drug use hovers at or just under the 20 per cent mark, but a small downward trend is discernible. The downward trend for the older adolescents and young adults (16-24) is clear, falling

Sources: SDD data (Hills and Li, 2007); BCS data (Murphy and Roe, 2007)

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Figure 1.
Past year prevalence (per cent) of "any drug" use for 11-15 (SDD) and 16-24 (BCS) year olds up to 2000 and beyond

from just under one third at the end of the previous decade, steadily to just under one quarter (24 per cent) by 2006/2007. These reductions in drug taking prevalence appear to be real and sustained, with no immediate indication of a change in direction in these trends. However, it is crucial in interpreting post-2000 levels of drug taking to note the exceptionally high levels of drug taking amongst young people that the new millennium inherited. Despite post-2000 reductions therefore, drug taking prevalence remains, when viewed historically, at relatively high levels. Indeed, the percentage of 16-24 year olds having taken a Class A drug in the past 12 months is almost the same in 2006/2007 and a decade earlier (at just over 8 per cent) (Murphy and Roe, 2007).

There are two different mechanisms for change that may operate in these post-millennium downward trends:

- (1) *Period effect*: at least some previously drug-taking individuals are ceasing to have taken drugs in the year prior to their survey participation – that is, some individuals are changing, and people are generally over time less likely to take drugs.
- (2) *Cohort effect*: no one is changing their drug use – instead, year on year, each age band is made up less of the drug-involved generation who were teenagers in the mid 1990s, now moving out into the higher age bands, and more of the less drug involved generation coming up behind.

This generational or cohort effect cannot be discounted in explaining these reductions in drug taking prevalence. Indeed, this explanation might go some way to explaining the decreasing prevalence in the older group of adolescents and young adults. In fact, at least some of this reduction in drug taking prevalence results simply from the teenagers of the 1990s moving into their 20s and 30s, and the way that age-banded prevalence statistics capture this. It may also be significant that most of the teenagers during the mid-1990s peak period for drug use will have disappeared from the 16-24 age band by 2006/2007. If this is the case, and a cohort effect is in operation, we might expect the decreasing prevalence of drug taking in this age group to level off in the next few years.

Of course, all this is complicated by the possibility of a period effect, whereby the population overall is becoming less drug involved. The fact that there are reductions in drug taking prevalence since 2000 in both the older and younger groups is suggestive of at least some of this kind of change too. It is not possible here to tease out the relative contribution of period and cohort effects in explaining the change; it is sufficient to know that a cohort effect explains at least some of the downward trend in drug taking amongst older adolescents and young adults.

Patterns of use. Table I describes changes in individual drugs taken in the past year over a ten-year period for older adolescents and young adults (age 16-24).

These trends are marked by continuity alongside some striking change. For young people in both decades, cannabis remains the drug most likely to be taken. In 1996 the likely “drugs of choice” were cannabis (26.0 per cent), followed by amphetamines (11.8 per cent), ecstasy (6.6 per cent), LSD (4.5 per cent) and poppers (4.6 per cent). Ten years later, important changes had taken place in the drugs young people were most likely to take. By 2006/2007, although cannabis still topped the list (20.9 per cent), this was followed by cocaine powder (6.0 per cent), ecstasy (4.8 per cent), poppers (4.3 per cent) and amphetamines (3.5 per cent). The most important changes over this period concern cocaine powder, amphetamines and LSD. Cocaine powder was a rarely taken drug by young people in 1996 (by 1.3 per cent in the past year), even though this was a peak time for youthful drug use more generally. By 2006/2007, the prevalence of its use was second only to cannabis. LSD, on the other hand, has more or less disappeared from the repertoire of today’s 16-24 year olds. Amphetamines, although still featuring, has experienced a sharp drop in the prevalence of its use, from 11.8 per cent in 1996 to 3.5 per cent ten years later. Both ecstasy and poppers remain relatively enduring choices over the ten-year period, with reductions over this time primarily reflecting the overall reductions in drug taking for the period. Another observation is that early 1990s young people took drugs from a wider repertoire than young people today (though data are not directly comparable[8]). These drug repertoire patterns are consistent with the observation by Williams and Parker (2001), that alcohol, cannabis, ecstasy and cocaine were the “drugs of reasoned choice” amongst young adults at the start of the decade (p. 397).

Table II describes changes in individual drugs taken in the past year over a six-year period for younger adolescents (aged 11-15).

The drug repertoire of this younger group is generally smaller than that for older adolescents and young adults, featuring across the period the use of cannabis followed

Table I.
Past year prevalence (per cent) of drug taking amongst 16-24 year olds for “any drug” and selected drugs, 1996-2006/2007

	1996	2000	2001/2002	2002/2003	2003/2004	2004/2005	2005/2006	2006/2007
Any drug	29.7	29.9	30.0	28.5	28.3	26.5	25.2	24.1
Cannabis	26.0	27.0	27.3	26.2	25.3	23.6	21.4	20.9
Amphetamines	11.8	6.2	5.0	3.8	4.0	3.2	3.3	3.5
Ecstasy	6.6	5.6	6.8	5.8	5.5	4.9	4.3	4.8
LSD	4.5	2.5	1.2	0.9	0.9	0.5	0.9	0.8
Poppers	4.6	3.9	3.8	4.4	4.3	3.6	3.9	4.3
Cocaine powder	1.3	5.2	5.1	5.1	5.2	5.1	5.9	6.0

Source: Murphy and Roe, 2007

by solvents and poppers (notably two drugs that are not strictly illegal, but whose sale is restricted to this age group). For cannabis and solvents, the trend over the six year period is downwards, and of a similar magnitude. For poppers, however, the trend is upwards (from 3.4 per cent in 2001 to 4.2 per cent in 2006). The use of ecstasy and amphetamines and cocaine in this age group is very small (1-2 per cent), but more or less stable over the period.

Overlapping substance use. There is considerable overlap in the consumption of alcohol, tobacco and illicit/illegal drugs. The 2006 SDD survey identified a particularly strong relationship between the use of cigarettes and cannabis, and strong relationships were also identified between the use of cigarettes and alcohol, cannabis and alcohol, and cannabis and Class A drugs. These relationships strengthened with age (Hills, 2007). These relationships were also documented in the 2000 survey.

Gender

Researchers in the 1990s reported a “closing” of the gender gap especially in relation to drug trying: in early adolescence, girls and boys were equally likely to have been offered a drug, to have tried it, and to take it regularly, but differences emerged in later adolescence, with these older boys being more likely to instigate or sustain use than girls, and to take drugs more frequently or be regular users (e.g. Parker *et al.*, 1998). Evidence regarding 11-15 year olds since 2000 suggests that the gender gap remains small. The 2001 SDD survey found only three percentage points difference between boys and girls in past year use of any drug; by 2006, the difference was only one percentage point. The very small differences between boys and girls in drug use (differences between 1-3 per cent) defined in more precise ways (past month use, use of drugs excluding volatile substances) remained stable over this period. For younger adolescents overall, the evidence therefore suggests that girls’ drug use falls just short of boys’ drug use, with relative stability in this difference between 2001 and 2006 (Hills and Li, 2007).

In the 1990s, gender differences in drug use were also reported to be narrowing in dance clubs (Handy *et al.*, 1998), but remained apparent (Measham *et al.*, 2001) with young men being more likely to attend these venues and to consume illegal/illicit drugs in addition to alcohol, and with gender differences evident in individual drug repertoires. Since 2000, gender differences in older adolescents and young adults remain. According to the BCS series, past year drug use amongst young women remained at roughly two thirds of past year use by young men between 1998 and

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	2001	2002	2003	2004	2005	2006
Any drug	20.4	19.7	21.0	17.6	19.1	16.5
Cannabis	13.4	13.2	13.3	11.3	11.7	10.1
Solvents	7.1	6.3	7.6	5.6	6.7	5.1
Poppers	3.4	4.3	4.0	3.4	3.9	4.2
Ecstasy	1.6	1.5	1.4	1.4	1.5	1.6
Cocaine powder	1.2	1.3	1.3	1.4	1.9	1.6
Amphetamines	1.1	1.2	1.2	1.3	1.2	1.2

Source: Hills and Li, 2007

Table II.
Past year prevalence (per cent) of drug taking amongst 11-15 year olds for “any drug” and selected drugs, 2001-2006

2006/2007. Male/female differences in past year use specifically of “Class A” drugs shows little discernible trend over the same period with young women’s use either just over or just under half the past year use of men (Murphy and Roe, 2007). Overall then, the time trends for older adolescents and young adults in relation to gender show more robust gender differences in favour of more drug involvement by young men and with little variation in this over the past ten years.

Socio-economic status

If pre-1990s researchers tended to characterise drug taking as subcultural, deviant, and as activity restricted to the lower classes, the 1990s saw drug-taking spread across income and employment groupings. Ramsay and Spiller (1997), found that for young people aged 16-29, there was little difference in past year use of drugs between income categories (ranging from 26 per cent in the “under £5,000” category to 23 per cent in the category “£30,000 or more”). There were differences by employment category (“full time employed” versus “unemployed”), but again, these were small (22 and 27 per cent respectively), with use by around one quarter of this age group use in both categories (p. 22). Similarly, Parker and colleagues found “working class catchment” of their schools-based samples to be associated with increased drug trying at the age of 14; young people from middle class catchment schools had “caught up” by the age of 15 (Parker *et al.*, 1998). In the 2006 SDD survey, income and social class were found to be unrelated to recent drug taking, although measures of “vulnerability” (truancy and school exclusion) were (Hills and Li, 2007). These results suggest little change since the 1990s, such that the vast majority of drug taking remains fairly evenly spread across socio-economic indicators.

Ethnicity

Research on young people’s drug use does not always address ethnic differences and so time trends are difficult to examine[9]. Researchers in the 1990s tended to divide their samples into “Asian”, “black/African-Caribbean” and “white” based on respondent self-identification. Researchers tended to identify few if any differences in young people’s drug taking between those identifying themselves as “black” or “white”, but substantially lower rates of drug use the “Asian” grouping (Parker *et al.*, 1998; Mott and Mirrlees-Black, 1995).

Research since 2000 has tended to find the highest rates of youthful drug use amongst those in the “white” and “mixed race” categories; this may reflect a change in how researchers measure ethnicity, or a new phenomenon (or both). In 2001/2002, the BCS revised its ethnicity measure to reflect “cultural background”, which alongside the “ethnic boost” sample, allowed in-depth analysis. Aust and Smith (2003) found that amongst those 16-24, past year use of any drug was highest for those from a white background (32 per cent) and a mixed background (33 per cent); substantially lower for those from a black background (18 per cent), and lower yet for those from an Asian background (9 per cent). Regarding Class A drug use, the differences between those from black and Asian backgrounds disappeared (both at 2 per cent), but remained very low compared to past year use of Class A drugs for those from white (10 per cent) and mixed (8 per cent) backgrounds.

Turning to younger adolescents (age 11-15), the SDD (combining 2001 and 2002 data[10]) found the highest rates of past month drug taking amongst pupils in their

mixed ethnicity group, and considerably lower rates in the Asian groups (McManus, 2003). Pupils in the black and white ethnic groups were in the middle, and the order of drug taking prevalence depended on gender. In the 2006 SDD survey, black and mixed ethnicity pupils had increased odds of taking drugs compared to white pupils, who in turn had similar odds to Asians and other ethnic groups (Hills and Li, 2007). This finding is an initial indication that, amongst these younger adolescents, the longstanding finding of very low levels of drug taking amongst Asians may be changing.

The trends in relation to ethnicity and drug taking are not entirely clear here, aside from the consistent finding that those from mixed backgrounds tend to have amongst the highest rates of use along with those from white backgrounds, although age (younger adolescence versus older adolescence and adulthood) seems to be significant in exactly how this works. It appears that youthful drug taking is indeed a “home grown” phenomenon, but one that affects all ethnic/cultural groups. The overall importance of the “mixed” group suggests the possibility that status as recent immigrants may reduce the likelihood of drug taking.

These findings should not be surprising, given ongoing changes to the make-up of the British population in terms of cultural background, in part due to changing immigration patterns over the past few decades. For example, increasing recent immigration from Poland (National Statistics, 2007) could see the arrival of young people in the UK from a country with markedly different patterns of drug use (Hibell *et al.*, 2004). How newcomers to Britain contribute to a shaping of youth culture and behaviour needs to be understood, for example, how country of origin, culture and religion exert their effects (and the converse – how British youth cultures affects newcomers – what factors affect resistance to, and proneness to UK patterns of drug use). In order to chart these effects, it will be essential for survey series to use comparable measures of ethnicity/cultural background and immigration status, and to include ethnic boost samples in order to ensure the statistical power required for analysis.

Problems with use. There is no question that some young people engage in drug use that is risky, actually harmful to them, or problematic in some way for others around them. But as many researchers and policy makers increasingly recognise, the bulk of this drug use occurs in young people who experience considerable disadvantage, resulting for example from homelessness (Wincup *et al.*, 2003), being in the care of the state (Ward *et al.*, 2003), truancy/school exclusion (Becker and Roe, 2005) or offending (Hammersley *et al.*, 2003). Solutions for these young people are not primarily to be found in health education in schools or media campaigns, and must instead recognise the point that some drug use for some people is fundamentally tied up with poverty, deprivation and vulnerability (Pearson, 1987). Although some of these young people may even be captured in the BCS and SDD surveys, many are not. This kind of problematic drug use represents only a tiny fraction of young people who appear in drug trying figures described in this paper, and an even tinier fraction of young people overall.

Young people not marked by indicators of vulnerability may still have problems with their drug taking however, calling into question the simple distinction between “problematic” and “non-problematic” or “recreational” drug use. These mostly low-level problems are likely to be dealt with or accommodated by young people, often

without much difficulty, as part of their “drug journeys”. This should not be surprising, given the occasional and episodic nature of many young people’s drug use, but accommodation of problems can even be found amongst more regular and committed drug takers who seek to juggle their drug taking with other life activities including parenthood and employment (Williams, 2007; Measham *et al.*, 2001).

The normalisation of young people’s drug use. The concept of normalisation has been used, not to explain why young people take drugs, but to describe (and to a lesser extent theorise) the shift that occurred during the 1990s in which young people’s drug use, and its perceptions, changed: drug taking became more prevalent; defied traditional class and gender boundaries; and became “accommodated” to an extent even by abstainers, thus moving from the periphery to the mainstream of youthful behaviour (Parker *et al.*, 1998). The concept of normalisation was not without its critics (e.g. Shiner and Newburn, 1999), and although some have suggested a more nuanced application of the concept (e.g. Shildrick, 2002), many continue to find the analytic utility of the concept compelling, and have extended its application. Huggins (2007) for example observes a move towards a position of accommodation of recreational drug users (if not use) in UK drugs policy. The insight of normalisation has therefore been to recognise that at least some drug taking, and at least some drug takers, are no longer viewed as exclusively or even typically deviant.

The foregoing assessment of post-millennium trends provide us with an opportunity to revisit the normalisation thesis, particularly given the (albeit small) downward trend in drug taking across young people. There is some evidence that normalisation of drug taking (read: the accommodation and acceptance of at least some illicit/illegal substance use) may be ongoing in the 2000s. First, the UK reclassification of cannabis in the Misuse of Drugs Act (downgrading the penalties associated with possession of the drug from Class B to Class C[11]) can be read as acceptance by government of the non-deviant status of many cannabis users. Second, recent evidence that teenagers from an Asian background may have rates of drug taking comparable with whites (even though their rates of use were exceptionally low in comparison only a decade ago) suggests that accommodation actually resulting in substantially changed use has been underway. Third, the entrance into adulthood of the most drug-involved cohort who were adolescents in the 1990s has left behind a new generation with rates of drug taking that remain relatively high; indeed, in spite of differences in drug taking of post-millennium youth compared to their 1990s counterparts, these decades are marked at least as much by continuity as change. Finally, the relative “quiet” in terms of official responses to the apparent problem of youthful drug taking now seems to have been replaced by considerable noise and concern around youthful binge drinking; this in itself might be read as a kind of official accommodation of drug taking. On the other hand, the possible shift away from illegal substances towards alcohol consumption by young people that has been argued to have occurred in Britain over during the last decade (e.g. Measham, 2004) suggests the possibility that the process of normalisation may be reversing for illegal drug use, as does the substantial drop in acceptance that experimenting with cannabis once is “ok” (from 41 per cent amongst 15 year olds in 2001 to 21 per cent in 2006) (Hills, 2007; Natarajan and Boreham, 2002).

Whether we accept the idea that youthful drug taking in the new millennium continues to undergo a process of accommodation and acceptance – of normalisation –

there are implications for health educators. A harm reduction approach might be seen as the obvious implication of normalisation; if drug use is increasingly viewed by young people and others as “ordinary” activity, young people should be helped to prevent or reduce harmful consequences that might arise, much as they might be helped to reduce harm from other “risks” like drinking alcohol or having an unhealthy diet. Indeed, Blackman (2007), characterises normalisation as a “corrective to the stigmatised understanding of young people who consume drugs on a recreational, non-problematic basis, who are neither deviant nor criminal” (p. 57).

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Implications of trends for health educators

In 1998 I co-authored a paper for this journal (Aldridge *et al.*, 1998) in which we were critical of much drugs education, arguing that it was unrealistic to rely on health education to challenge such major developments in adolescent behaviour as evinced by 1990s youthful drug taking, and that effort and expenditure aimed at doing so had increased alongside drugs consumption. What are the implications for health educators of recent trends in youthful drug use ten years on?

Young people are still taking drugs. Roughly one in five younger adolescents, and one in four older adolescents and young adults, has taken an illegal/illicit drug in the past year, and for both the older and younger groups, cannabis dominates the drug repertoire. Although adolescent and young adult drug taking rates have seen a steady but small decline since the beginning of the new millennium, the prevalence of drug taking remains at historically relatively high levels, and at least some of the decline can be explained as the last few of the “dance drug generation” of the 1990s trickling through the annual statistics. Those coming up behind them are not much less drug-involved.

Can drugs education efforts be responsible for recent declines in drug taking? In all probability they cannot. Although the UK nears the top many international leagues tables of youthful drug use (e.g. Hibell *et al.*, 2004), the upward trends for drug taking in the 1990s in the UK are reflected internationally amongst most developed countries (Bauman and Phongsavan, 1999). These trends must be linked at least in part to major social, economic and demographic shifts, and thus not be amendable to quick turnarounds. Moreover, many efforts at effecting change in drug taking behaviour amongst young people with broadly-based education programmes have been shown to be ineffective, actually counter-productive, or with small and variable effects at best. School-based interventions that have abstinence as their goal fail consistently (Hawks *et al.*, 2002), and even though promising possibilities for effecting behaviour change are beginning to be understood (Coggans, 2006), there is unlikely to be any “magic bullet” to stop young people taking drugs any time soon. Still, there remains a place for health educators.

The vast majority of youthful drug use in Britain is not seriously problematic, and when problems do arise, young people for the most part make adjustments to their drug taking in order to avoid experiencing unduly negative consequences (Williams, 2007). They seek information and help in making these adjustments. As the 2006 SDD survey showed (Hills, 2007), “official” individuals were sought out for helpful information (like police, GPs or teachers), although these individuals were no more important than other less “expert” sources like friends and relatives. This finding is consistent with those who have argued that young people who seek to manage risk

may not always privilege “expert” risk knowledge (e.g. Duff, 2003). “Television” was identified as the source most useful overall in the SDD survey (by 78 per cent), interesting because television includes both “expert” and lay perspectives, the latter particularly apparent in one recent dramatic offerings on British television[12]. In general, both drug takers and abstainers were equally likely to rate media sources as helpful to them; however, drug users were more likely to rate as helpful telephone helplines and the Government sponsored drugs campaign FRANK (delivered via television, radio, print media and the internet). So while young people might not exclusively privilege the “expert”, expert knowledge is amongst the sources valued by drug takers.

Emerging health promotion voices encourage approaches that: take into account the meaning of behaviour for the people involved (Crossley, 2002); allow for the fact that resistance to messages that “advise against” certain behaviours may be implicated in their pursuit (Crossley, 2001, Whitehead, 2005); and understand that privileging research evidence about “risk” in the attempt to influence behaviour fails to address other spheres of knowledgeability, for example in relation to the pursuit of pleasure (Fox, 2002; Southgate and Hopwood, 1999). As Whitehead has argued, to “deny the health or life journey may cause more harm than good” (Whitehead, 2005, p. 215). Following the work of Beck (1992), Duff (2003) notes that policy makers look mainly to “prevention science” to provide the risk assessments on which drugs policy is based. He advocates instead that policy makers should not dismiss the lay knowledge and risk assessments engaged in by drug takers as “unsophisticated, irrational and ignorant” (p. 297), particularly as many of the strategies that result from them are effective. Policy makers should seek to incorporate lay knowledge and risk assessments as the basis of their policies. These insights fit well with observations that “risky” behaviour does not always lead to outcomes involving actual harm, and that risk may be only one of a number of competing influences in making drug taking decisions (Fox, 2002; Williams, 2007).

Conclusions

The drug use of young people – whilst incorporating use by a minority that is problematic for the individuals concerned and for those around them – remains as we reach the end of the first decade of the new millennium, mostly relatively unproblematic and managed by users themselves. It is the minority of young people who have poor outcomes (Parker, 2003), and these young people require something different to the drugs education and treatment than is discussed here. Something like half of young people will not have even tried a drug by the time they reach adulthood, and for many, this status will not change during adulthood. For most who do take drugs, their use is occasional and episodic. When they do perceive problems, they respond to these problems by reducing or eliminating their consumption of one or more drugs, or by reducing or attempting to control the perceived negative effects on their lives (Measham *et al.*, 2001; Williams, 2007). The challenge for health educators is twofold. First, it is important not to assume that all drug use is pathological, problematic, and by definition should be stopped. Increasingly, academic researchers are acknowledging this fact in the research and explanations they produce. The second challenge is to support those young people who do take drugs through education. Most young people who take drugs do so in order to enjoy themselves, do not wish to come to

serious harm, and take steps to moderate, even fine-tune their drug taking in order to fit in with other life priorities. Certainly there are some young people's whose drug use is destructive to themselves and others. The remainder of young people – most young people – whose drug use is mainly a part of recreation, time out and celebration, require and seek out information. What they require is support in making the choices they already want to make, and information so that their choices are informed. Health education messages should therefore recognise the overlap between their goals and those of young people – this point has already been recognised as important in the sphere of disease control (Clark *et al.*, 2001)[13].

Decline but
no fall?

Notes

1. Both surveys under-represent the most drug-involved young people, not including, for example in the BCS, those who live in institutional settings (e.g. young offenders institutions) or who sleep rough, and in the SDD surveys, those who are excluded from or often do not attend school. Because these surveys exclude from the outset more drug-involved young people, the samples they generate are not representative of all young people, or of all youthful drug taking. Nevertheless, these surveys are usefully able to address the drug taking of the very large majority of young people.
2. In general, some of the validity limitations of self-report surveys (did respondents tell the truth?) are ameliorated when surveys are used to address trends over time; that is, whatever problems or limitations exist for a survey, they are likely to exist in a similar way across surveys, making comparisons over time less problematic. However, it is possible that young people's willingness to admit to drug use may change over time, relating perhaps to changing social, political or policy contexts (Fendrich and Vaughn, 1994). For example, young people in a school with a newly punitive approach to dealing with drug use amongst its pupils may be less willing to admit these behaviours than pupils who responded in the survey year prior to policy implementation. Goddard (2006) has voiced this concern in relation to trends in smoking and drinking identified by the General Household Survey in Britain. A related consideration concerns declining individual response rates in these surveys: from 90 per cent in 1998 to 85 per cent in 2006 for the SDD surveys, and from 83 per cent in 1996 to 75 per cent in 2006/2007 (e.g. the North West England Longitudinal Study – NWELS – by Parker *et al.*, 1995). Response rates are a concern in research generally because responders and non-responders are almost always different to one another. These declining rates diminish, in a way that is not possible to quantify or estimate here, the extent to which these surveys can be used to assess trends accurately.
3. Large, nationally representative, comparable annual surveys that include questions about drug use have only been available in Britain since the mid to late 1990s; prior to this time, most surveys were local rather than national (Miller and Plant, 1996), one-off rather than annual (SHEU, 2005), or used non-probability sampling techniques (e.g. Balding's Schools Health Education Unit – SHEU – annual surveys).
4. Trends (pre-2000 and post-2000) are considered separately, since pre-2000 data sources are not always directly comparable because of differences in survey methodology and changing question formats. As well, the only consistently available statistic in most published, comparable data pre-2000 was lifetime prevalence measures of drug taking rather than past year prevalence. Past year prevalence is an ideal statistic to use for analysing trends, capturing as it does actual use that occurs in each year. Lifetime prevalence for drug taking represents the percentage of those in a sample who had ever, in their lifetimes, tried a drug. Because it therefore includes those who did not take drugs in the year prior to the survey, it

is less useful for examining changes in use that occur from one year to the next. The pre-2000 trends reported here refer to lifetime prevalence of drug taking; post-2000 trends exclusively refer to past year prevalence.

5. Newcombe (1995), admits that the available data sources result in a “jigsaw puzzle” with some pieces clear, some unclear and some missing; he nevertheless found the identification of trends using these sources “hard to resist” (p. ii). This report is the only published attempt to examine British trends in drug taking using quantitative data prior to 1990. The findings contained within it are crucial to the oft-made argument that drug taking increased over the decades it refers to, although its findings are rarely cited in the literature.
6. Balding’s annual school surveys use a non-probability sampling strategy based on convenience cluster sampling of schools, although the hundreds of schools involved over the course of a calendar year yield very large samples. Despite this, the long-term trends identified by Balding tend to mirror those found using annual comparable cross-sectional data generated from nationally representative samples (Aldridge *et al.*, 1999).
7. The term drug trying is used here when referring to lifetime prevalence. Lifetime prevalence figures include all those who have ever taken a drug at least once, or put another way, all those who have ever tried a drug. Particularly during adolescence, those captured by lifetime prevalence figures will not primarily be drug users. The term drug trying is intended to convey this.
8. 1994 BCS past year use figures found 6 different substances taken by at least 1 in 20 16-19 year olds; the 2006/2007 survey found only four different substances taken by at least 1 in 20 16-24 year olds. This observation rests on less solid ground since the surveys over these two years are not directly comparable (they used a different method of administration), and because the age bands being compared are not identical.
9. Reasons for this are conceptual (ethnicity is conceptually multilayered, involving a range of overlapping statuses including skin colour, nationality, immigration status and culture, making it difficult not only to construct measures of ethnicity, but to disentangle meaning in analyses that result); methodological (for example in the BCS, as discussed by Aust and Smith, 2003); and technical (insufficient statistical power to carry out subgroup analyses resulting from the relatively small proportion of ethnic minorities in the population alongside drug taking remaining in most age groups a relatively rare outcome).
10. Data from both the 2001 and 2002 surveys were combined for this analysis in order to boost ethnic minority sample sizes (Acevedo, 2007).
11. At the time of writing, recent research linking heavy cannabis use amongst adolescents to serious mental health problems has resulted in calls for the reclassification to be reversed. Acevedo describes how the crux of the debate has shifted to health concerns, even though its origins were in efficient use of public resources.
12. In 2007, Channel 4 aired the popular dramatic series “Skins”, following the lives of a group of 17-18 year olds at college. Their use of cannabis and Class A drugs is portrayed, alongside alcohol and tobacco, as ordinary in their psychoactive repertoire, and whilst they endure occasional mishaps, these are not the focus of the story.
13. After 2000, the BCS moved from self-reports relating to a snapshot of one calendar year to a rolling survey, accounting for the change of time category labels from “2000” to “2001/2002”. The SDD series retains calendar year snapshots, but time category labels used in this figure and Table I use the “rolling year” labels to apply to SDD surveys, although this is not strictly accurate. 2001/2002 corresponds to 2001, and so on.

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