

Research Paper

“They walked in and walked straight out of adult treatment”: creating tailored drug outreach and service provision for young adults in England

Karen Duke^{a,*}, Zoë Welch^b

^a Drug and Alcohol Research Centre, Middlesex University, The Burroughs, London, NW4 4BT, UK

^b Research, Strategy and Partnerships, Change Grow Live, 76 King Street, Manchester, M2 4NH, UK



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ABSTRACT

Background: In England and Wales, drug use and related harms among young adults aged 18-25 remain high. They are neglected in existing service provision. Drawing on evaluation findings of a multi-component drug outreach service in England and informed by the concept of ‘emerging adulthood’, this paper explores the possibilities for the development of bespoke interventions for young adults.

Methods: This paper draws on semi-structured interviews (n=19) conducted with managers and practitioners within the outreach service, regional leads for young people’s services, and strategic stakeholders in public health, police and education.

Results: The co-produced outreach model was found to be agile, innovative and responsive to local drug trends. It was able to reach groups vulnerable to drug-related harms, by employing a different conceptualisation of ‘harm reduction’ centered on safety. Outreach interactions were limited in scope at some transition points to adulthood, with contact often lost when individuals reached age 18. Onward referral for those who need more intensive interventions was often difficult from ad hoc interactions, and existing adult treatment services were deemed unsuitable for young adult needs.

Conclusion: Emerging adults aged 18-25 are a diverse group with distinct substance use profiles. Outreach activities are effective for education, harm reduction messaging, and signposting for further support. However, there is a need for the development of bespoke young adult service provision with skilled, specialist staff who can help young adults navigate these transitions without harm.

Background

In England and Wales, those aged 16-24 are the group with the highest rates of drugs use with 15.1% of this cohort using any drug in the last year, 4.5% taking a Class A drug and 2.0% frequently using drugs (i. e. took any drug more than once a month in the last year) (ONS, 2025a). Use tends to peak around the ages of 20-24 and the most commonly used substances are cannabis, cocaine, ketamine and MDMA (ONS, 2025a). Whilst cannabis remains the most widely drug used, there has been a sharp, and widely publicised, increase in the use of ketamine over the past decade amongst 16-24-year-olds (ACMD, 2025a,2026). Research points to the dynamic and evolving nature of substance use among young adults characterised by starting to use substances, switching substances, increasing or decreasing use and stopping use (Andrews and Westling, 2015; Measham et al., 1998). Although they are the age group who are most likely to be using substances, youth-specific provision,

outreach and referrals for specialist substance use support have decreased (Black, 2021). Young adults (aged 18-25) have been particularly neglected in existing service provision and referral figures suggest that adult treatment services may be inappropriate in meeting young adult needs in England (OHID, 2024a). Moreover, there is a lack of research around their needs and the development of appropriate services for this age cohort. Drawing on evaluation findings of a multi-component drug outreach service designed for 16-25-year-olds in England, this paper explores the possibilities for the development of bespoke interventions for young adults.

Emerging adulthood and substance use

Arnett (2000,2014) conceptualises the time between 18 and 25 years of age as ‘emerging adulthood’. This is a distinct period of development characterised by identity exploration, instability, self-focus, feeling

* Corresponding author.

E-mail addresses: k.duke@mdx.ac.uk (K. Duke), zoe.welch@cgl.org.uk (Z. Welch).

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in-between, as well as possibilities, transformations and discoveries. As adolescents move into emerging adulthood, they continue to develop physically, cognitively, emotionally, socially and behaviourally. Studies in developmental psychology demonstrate that the brain continues to develop up to the age of 25 and those in the young adult age group (18 to 25 years of age) still exhibit some adolescent behaviours such as risk-taking, pleasure-seeking, prioritisation of peer group activity and impulsivity (Arnett, 2014; Steinberg et al., 2015). Substance use in emerging adulthood is frequently motivated by positive benefits such as breaking away from the mundane by seeking pleasure, the opportunity to create novel experiences, and having fun with friends in leisure spaces, such as festivals and raves (Lojczyszcz et al., 2023). Most use is recreational, transient, experimental and not necessarily viewed as 'problematic' (Askew, 2016; Williams, 2013). However, some studies have shown that early substance use may be damaging to the developing brain in those aged up to 25 and may exacerbate problems with mental health (Department of Health, 2017; Sheidow et al., 2012). This is often the time when young adults may experiment with different substances and/or escalate their use (Cadigan et al., 2019; Staff et al., 2010). The period from 16 to 25 years of age is important as many health conditions, including substance use problems, emerge during this time and lifelong health behaviours can be confirmed during this phase (Rod et al., 2025; WHO, 2019).

As Arnett (2000, 2014) argues, young adults are navigating a distinct and complex life stage. They are negotiating various transitions and achieving adult milestones such as finishing school, entering further training or higher education, gaining stable employment, developing relationships, and moving out of the family home. However, the traditional socio-demographic markers of adulthood are changing for the current generation in many countries (Furlong et al., 2011; Wright et al., 2024). In the UK, they are staying in education/training for longer, starting work later, remaining in the family home longer, getting married and having children later (if at all) and these transitions are differentiated by class, ethnicity, gender, disability, experiences of care, and geographical location and the intersections between these characteristics (Nuffield Foundation, 2025; Woodman, 2013). For the current generation, these developmental processes have been complicated and prolonged by a number of intersecting crises, including the rising cost of living, lack of affordable housing, high unemployment rates, increasing debt, increasing problems with online harms, mental health and well-being and the lasting impacts of the COVID-19 pandemic on educational attainment and socio-emotional skills (Nuffield Foundation, 2025; Verian, 2025).

These transition points are often when the risk of experimentation or escalating substance use is higher (Andrews and Westling, 2015; Cadigan et al., 2019; Mistry et al., 2015; Merrin et al., 2018; Stone et al., 2012) and may increase loneliness, often leading to more frequent and problematic substance use to cope with the feelings of social isolation (Rhew et al., 2025). Leaving school or home places young adults in new contexts that lend themselves to the introduction to and experimentation with substances (e.g. universities, events and festivals), change the nature of their substance use (e.g. trying new drugs or mixing substances), or where use might escalate or become more embedded. Recreational drug use is often 'normalised' among young adults, who may not recognise the potential risks and harms (Aldridge et al., 2011). Even if they are aware, they are unlikely to engage with specialist drug services (Welch et al., 2025), instead there is often a shift to peer support and the development of their own norms and risk mitigation strategies (Hunt et al., 2007). Escalating use may lead to more entrenched habits or dependency, or the development of other behaviours and unwanted outcomes, including involvement in the criminal justice system (Duke et al., 2020; Gray, 2019) or unplanned pregnancy (Wellings et al., 2013).

Service provision for young adults in England

Legally, a young person becomes an adult on their eighteenth

birthday in the UK and at this point they are transferred to adult systems in health, welfare and criminal justice (NICE, 2016). This transition period raises a number of ethical challenges for young people, parents/carers and practitioners (Vijayarajam et al., 2024). When young people turn 18, many disengage from services by 'ageing out' of young people's provision or finding that transitional arrangements to adult services offering structured, appointment-based support do not meet their needs (Care Quality Commission, 2014; Singh et al., 2010; Yliso et al., 2025). Young people who stay in education will have better access to support services than those who have left school or college (ACMD, 2025b). For 18-year-olds living independently, navigating the complex and fragmented system of support services without parental/carer input can be a significant barrier to engagement (Rigby et al., 2021).

In England and Wales, drug and alcohol treatment is commissioned by local authorities through public health funding (OHID, 2024b). Children and Young People's (CYP) substance use services receive proportionally less funding than adult services (ACMD, 2025b), are subject to fewer regulatory requirements than adult services, and are almost always delivered by non-governmental, third sector organisations (rather than statutory services). This structure allows scope for innovation, but also variability according to local service models, capacity, and commissioning priorities and budgets (ACMD, 2025b; NHS England, 2025). This means that substance use support for young people varies across the country. In a few areas, it extends to age 25, while in others, it covers those up to age 19. However, most young adults aged 18-25 are supported by adult drug and alcohol services or seen only within CYP services as part of temporary transitional arrangements to adult services, which are funded to provide services to those aged 18 and over (NHS England, 2025; OHID, 2022).

There have been increasing calls for young adults to be considered as a distinct group in other policy areas, such as criminal justice (Justice Committee, 2016; Phillips et al., 2025) and health and social care (NHS England, 2019; Rigby et al., 2021). In the development of substance use policy and commissioning services, young adults are rarely treated as a discrete group with specific needs. This creates a specific gap for bespoke service provision tailored to the young adult population. In the UK, this was identified as long ago as the early 1990s, when a response was needed for young adults in the club scene through the Lifeline Safer Dancing campaign (Linnell, 2005; Shapiro, 2017). Recently, Lloyd et al. (2025) identified limited options within adult treatment for non-opiate users and that the current system is centred around opioid use, rather than recreational or emerging drug trends. As discussed above, there are few services which cater specifically for the needs and profiles of young adults. One exception is the 1625 Outreach Service which was commissioned in Derbyshire to meet their unmet needs.

The 1625 outreach service in Derbyshire, England

In 2018, a community-based outreach service (1625 Outreach) was commissioned to provide substance use outreach services by the Derbyshire Police and Crime Commissioner and Derbyshire County Council. It is a co-produced, multi-component, community engagement model specifically targeting those 16-25 years of age. It delivers drug education and harm reduction interventions across universal, selective, and indicated levels of provision (Gordon, 1983; National Research Council and Institute of Medicine, 2009). These 'place-based' interventions are delivered where young people/adults socialise and congregate (e.g. parks, festivals, events, education settings, as well as digital spaces) and aim to reduce the demand for illicit drugs and associated risky behaviours by increasing young adults' knowledge, skills, and resilience (Welch et al., 2025). The service includes universal prevention through information campaigns and interactive digital interventions; selective prevention through education sessions delivered in colleges and alternative education provision for those aged 16 and over; and responsive outreach for targeted populations, for example, street outreach in urban and rural community locations and pop-up stalls at festivals, events and

universities/ training colleges, targeted social media campaigns and training for night-time economy staff. The interventions are guided by multi-agency stakeholder input at local level, targeting outreach interventions at 16-25-year-olds most vulnerable to drug use, and at crucial transition points where their risk of experimentation or escalation is highest, including diverse, under-served groups who typically do not engage with services.

Fig. 1 depicts the outreach delivery model employed by 1625 Outreach. It shows the specific strands of activity and examples of interventions at the universal, selective and indicated levels. It also depicts the underlying ethos of harm reduction and early intervention, situates the service in the wider community through integrated partnership work and highlights the commitment to monitoring, learning and iterative development.

The model has since gained attention from other service commissioners of substance use services across the UK as an innovative approach to provide support to 16-25-year-olds. Research demonstrated that the model's 'whole community' approach, providing consistent and credible drug education, prevention and harm reduction messages, showed promise in reducing drug use and associated harms (Duke et al., 2025; Welch et al., 2025). It is now being commissioned and adapted for delivery in other geographical locations in England.

Building on the analysis of development work reported in Welch et al. (2025) and utilising further feasibility evaluation findings of 1625 Outreach, this paper focuses on the unique part of the service that supports young adults, specifically those 18 to 25 years of age in various place-based settings beyond school. Our focus goes beyond the discussion of this specific service and examines the gap in current provision for

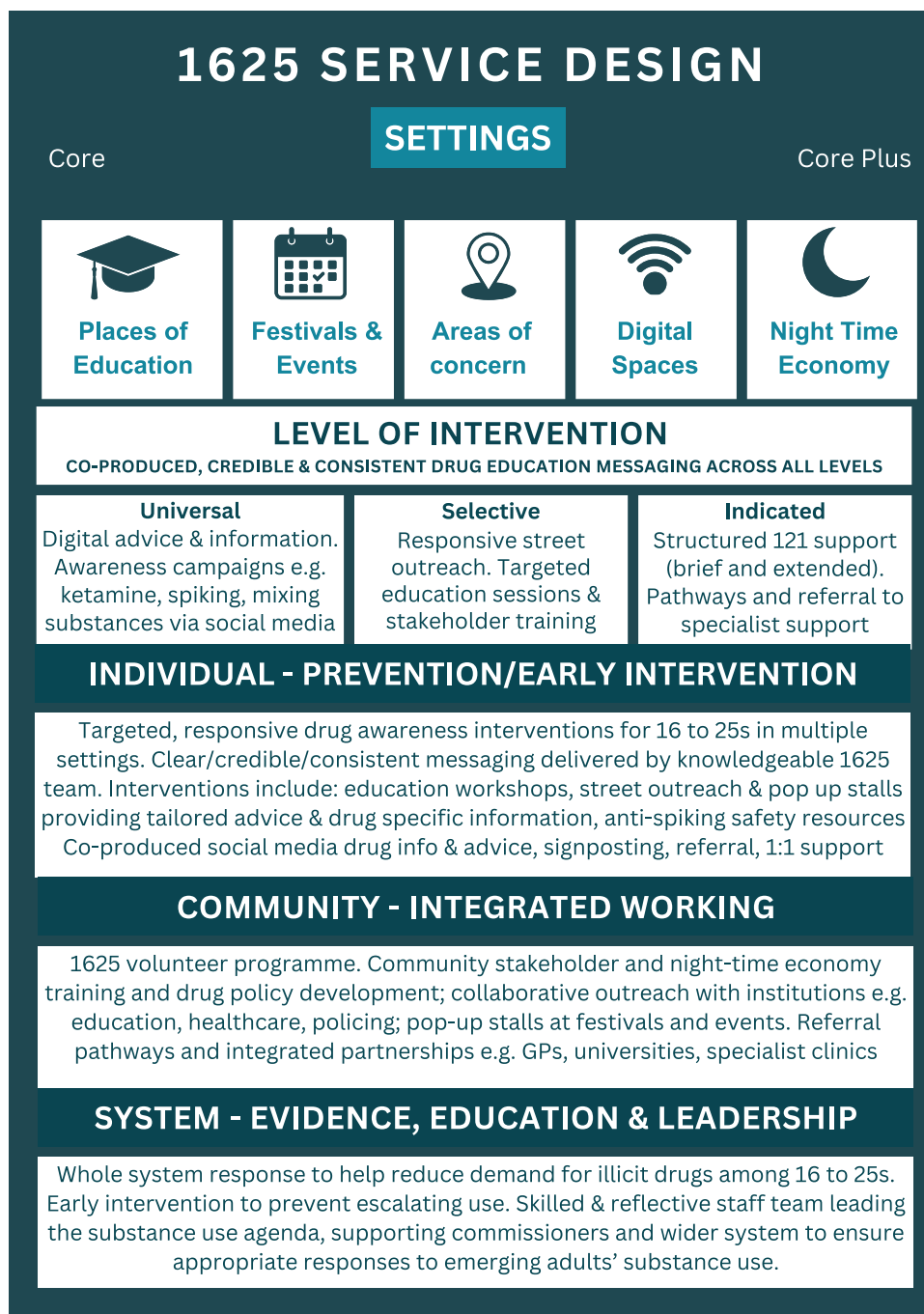


Fig. 1. 1625 Outreach service design.

young adults who need more structured support within the theoretical lens of ‘emerging adulthood’. We explore the harm reduction interventions delivered across a range of settings, the journey from outreach interactions through to referrals for tailored support and how young adults are becoming a focus for developing bespoke services and policies. The paper addresses the following questions:

- How do practitioners view the existing substance use service provision for young adults aged 18-25?
- How was the 1625 Outreach model developed to cater to the needs of young adults?
- What are the challenges and limitations of the existing 1625 Outreach model in relation to young adults?

Methods

This study incorporated two phases. Phase 1, funded by the National Institute for Health Research (NIHR), involved developing the multi-component 1625 Outreach model for evaluation. Phase 1 included observations and shadowing of various outreach activities, focus groups with practitioners and 16-25-year-olds, and semi-structured interviews with key informants. Phase 2 was a feasibility evaluation which tested research tools for this young adult cohort in various settings (i.e. education, community, festivals/events, and online). This involved surveys with young adults in the different settings, along with semi-structured interviews with 1625 Outreach staff and stakeholders working with young adults across Derbyshire.

In terms of the positionality of the authors, Zoe Welch is the Head of the Change Grow Live’s Research Team that sits within the central Strategy and Partnerships Team. The 1625 Outreach service is a separate, locally commissioned service that sits within Change Grow Live’s Children and Young People’s Directorate. She was the PI for the NIHR-funded Phase 1 project. Karen Duke is an independent university researcher who was involved as a Co-I in the Phase 1 NIHR-funded project and PI for the independent Phase 2 feasibility evaluation funded by Change Grow Live.

Although informed by the wider study, this paper specifically draws on the semi-structured interviews conducted with the 1625 Outreach Team members and other community stakeholders in Phase 1 and 2 (total = 19 interviews, see Table 1 for the breakdown). In Phase 1, this included interviews with the 1625 Outreach Team Manager/Leaders (n=3) and Children and Young People (CYP) Regional Leads (n=2), as well as observations of 1625 Outreach Team meetings (n=2) in July 2023. In Phase 2, this included interviews conducted between August and October 2024 with the 1625 Outreach Service Team (n=7) and community stakeholders in local partnership structures relating to substance use and young people (n=7). The community stakeholders were in strategic positions in public health, policing and education.

The aim of the interviews with the 1625 Outreach Team was to understand the rationale for the development of the outreach service, the specific needs of the 18-25 age cohort, co-production of the model,

Table 1
Interviews with 1625 outreach practitioners and community stakeholders.

	Participants	Number
Phase 1	1625 Outreach Team Manager/Team Leader	3
	Children and Young People Regional Leads (CYP)	2
Phase 2	1625 Outreach Team [includes service managers, outreach workers, volunteer coordinator (overseeing the co-ordination of pool of volunteers) & targeted intervention coordinator (offering 1-2-1 support)]	7
	Community stakeholders [includes representatives from education, police, public health domains]	7
Total number of interviews		19

partnerships with local stakeholders, assessment of local needs and priorities; and the limitations of the model. The aim of the interviews with community stakeholders was to explore their roles in developing the model, how they worked in partnership with the 1625 Outreach team and responded to local drug trends and gaps in existing service provision. Some of the interviews were conducted in person (n=10) and others were conducted online via Microsoft Teams (n=9). The interviews lasted between 60 to 90 minutes. All interviews were audio-recorded and transcribed using transcription software.

The interviews were reviewed in Microsoft Word before downloading in NVivo18 for ordering and deriving themes, drawing on Braun and Clarke’s (2006) framework for thematic analysis. The researchers familiarised themselves with the data by reading through the transcriptions from the interviews. An initial coding framework was developed to reflect the aims and research questions for the study, as well as to allow for emergent themes in relation to the needs of young adults. After further analysis, the themes were refined in the coding framework (See Table 2 below for the core themes and sub-themes)

The study received ethical approval from the Middlesex University Social Work and Mental Health Ethics Committee (ID 25367) and was overseen by Change Grow Live’s Research Governance Group, which is responsible for assessing the ethical and practical appropriateness of research being carried out within the organisation. Written informed consent was obtained using participant information sheets and signed consent forms. The participants’ data were anonymised using identity numbers and pseudonyms for individuals and organisations participating in the interviews.

Findings

The analysis identified three core themes and nine sub-themes in relation to developing substance use interventions for young adults. This section begins by discussing the current gaps in existing service provision for young adults by examining the need for early intervention, the difficulties navigating the systems of service provision and the need for a different conceptualisation of ‘harm reduction’ for this group. In the second section, we explore how the 1625 Outreach model was developed to cater to the needs of young adults by examining the involvement of community stakeholders, the development of a unique knowledge and skill set for this cohort, the importance of involving young adults in service development and how the model needed to be flexible and agile to respond to changing drug trends and their corresponding needs. The final section explores the key challenges to the existing 1625 Outreach model in relation to reaching diverse populations of young adults and the need for longer term interventions for those with more entrenched or complex substance use.

Table 2
Themes and sub-themes.

Themes	Sub-themes
Gaps in service provision for young adults	The need for early intervention Navigating the systems of services Conceptualising harm reduction Educating ‘the system’
Building the model aligned to the needs of young adults	Development of bespoke knowledge/skill sets Importance of co-production Agile model responsive to changing needs/trends
Challenges to the existing model	Reaching diverse populations of young adults The need for longer term interventions

Gaps in service provision for young adults

The need for early intervention

In England, children and young people's substance use provision is usually for those aged 12 to 17, with 'transition arrangements' up to age 25 in some cases, depending on local service models and commissioning arrangements (NHS England, 2025). Whilst the guidance on workforce capability for drug and alcohol services stipulates the need for skills to support through childhood, adolescence to young adulthood, the commissioning expectation is then for adult specialist services to adapt and provide age-appropriate care for 18–25-year-olds (NHS England, 2025; OHID, 2022). Interviews with stakeholders in Phases 1 and 2 highlighted that standard adult substance use service models receiving referrals for young adults aged 18–25 were unsuitable in meeting their specific needs. Young adults' more 'recreational' drug-using motivations, patterns of use and drugs of choice differed significantly from the focus on dependent alcohol, opiate and crack use typically found in standard adult services (see OHID, 2024a). Formal structured appointment-based systems (i.e. specific days and time slots) - rather than more informal, low threshold 'drop-ins' - negatively impacted on young adults' attendance. The service environment - perceived as unwelcoming and clinical - created a barrier to engagement. As one of the local service managers explained:

Last year they had a couple of students go to adult treatment. They walked in and walked straight out. The reason why was it looked very clinical. There were people in there that they didn't want to be sat with. (Local Service Manager 2)

The inappropriateness of standard adult substance use services for younger adults is reflected in low numbers presenting for treatment nationally, with people aged 18–24 accounting for 8.3 per cent of the adult population starting substance use treatment across England (OHID, 2024a), despite having the highest rates of drug use (ONS, 2025a). Local Change Grow Live internal service data from 2024 indicated a greater level of engagement of 18–24-year-olds when they are treated within young people's services, rather than in adult services.

Practitioners highlighted that young people were more likely to present at services later in adulthood when their substance use was more entrenched and the negative impact on their lives more significant. One of the 1625 Outreach workers spoke about the importance of employing harm reduction techniques to keep young people 'safe' and early intervention to 'prevent' problems from escalating:

Harm reduction is so crucial to keeping people safe, and the earlier we get that information to young people, the better, so they don't end up down the line being in a worse state and having a much harder time of getting a life back...So instead of just tackling the end problem...you're actually initially getting in there early. (1625 Outreach Worker 2)

The young people who leave school/education settings can be particularly vulnerable without the support offered through schools, colleges and universities. The importance of preventative work at an earlier stage was stressed in order to avoid the escalation of use and presentation at adult services. Again, this was discussed more within a 'prevention framing' as one of the 1625 Outreach workers explained:

They're [under-25s] the ones that we should be engaging with...when you leave school and you're working as a bricklayer, but you're tanking beer every night...It's not such a problem, but when you present to adult services at the age of 30 because you can't get any work anymore 'cause you shake so much in the morning, we're missing out on supporting them at an earlier stage where we can [use] more of a prevention tactic. (1625 Outreach Worker 1)

Navigating the systems of services

Support across health and social care providers presented challenges when young people turned 18. The upper age limit varies across different agencies, creating confusion and opportunities to 'fall out' of the system. Notably, Child and Adolescent Mental Health Services (CAMHS) discharge or implement transitional arrangements to Community Mental Health teams when young people turned 18, whilst some young people's substance use support continues to age 25. This means the system becomes more difficult for both practitioners and young adults to understand and navigate. 'Transitional' or 'bridging' arrangements between services add to the confusion leading to significant drop-off in engagement among those aged 18 to 25. This was widely noted when young adults were receiving support from both a young people's substance use service and CAMHS. As one of the service managers explained:

We've got some services where the YP [young people's] service is holding them to 25, but obviously CAMHS is 18. So you've got this transitional drop-off of support, which is becoming more difficult to navigate when you've got the substances impacting on the psychological end. Ketamine is a perfect example of that. You've got quite a large cohort of young people that might be using it for the dissociative effect to aid their mental health. (Service Manager 1)

The participants argued that the focus of provision needs to provide early intervention through harm reduction advice to prevent escalation of use and encourage continued engagement with services during these transitions to adulthood. As one of the Regional Leads for Children and Young People's (CYP) Services suggested, referring to 'transitional age groups' was unhelpful, since it conflates a transition to adulthood with a transition to adult services:

We talk about transitioning to adult services and how adult services don't see 18, 19-year-olds, but we don't want them to transition to adult services. If we get it right, they won't be needing adult services. (CYP Regional Lead 2)

There were concerns that adult services were being encouraged by policy makers to adapt and provide 'transitional arrangements' which was felt to overlook the need to intervene early, work with young people in the context of their use to prevent escalation and transition to adult services.

Conceptualising 'harm reduction'

The interviews pointed to the lack of shared understanding of what 'harm reduction' means across young people's and adult services and among the young adults themselves. Notions of 'harm reduction' in adult services can still be centred around opiate use and needle and syringe provision for people who inject drugs (Department of Health, 2017). Harm reduction approaches in young people's provision are centred around safety, knowledge and awareness of drugs and mitigating drug-related harms (Fletcher et al., 2010; Kimmel et al., 2021). Within the 1625 Outreach model, this includes promoting the use of drug-checking facilities, e.g. The Loop (Measham, 2019); brief interventions around safer substance use and keeping safe on nights out; and distributing 'harm reduction packs' that included information leaflets on specific drugs, their effects and the risks of different drug combinations; digital resources (QR codes to contact services), 'spikies' (drink covers to prevent drink spiking) and information about other services in the community. One of the 1625 Outreach workers described the problem with the traditional use of the term 'harm reduction':

I've always tried to stray away from using the term 'harm reduction' around young people because if they've got any concept of what that means, generally it's not something that they can associate with...they may know from older relatives that have had certain issues that harm

reduction can mean places to pick up clean injecting equipment for heroin or steroid users. (1625 Outreach Worker 2)

The messages that the 1625 Outreach workers give to young adults are around keeping safe and how to minimise harms from drug use. The workers employ the terms 'safety' and 'keeping safe' in their dialogues with the young adults. The 1625 education outreach worker stressed listening to the young people, not judging them and recognising their agency to make their own decisions around substance use. The tone of the discussion was seen to be important to get right, particularly with young adults:

Listening to them, not judging them...I'm not here to tell them what to do...They're young adults...I just don't want them dying. I want them staying safe. (1625 Education Outreach Worker)

At the local level, the emphasis on harm reduction and preventative public health needed to be understood and consolidated with all community stakeholders to ensure clarity and focus. This was considered essential to ensure that the priorities were aligned with all the expectations of the stakeholders involved in the local partnership. Initially, some of the education stakeholders were reluctant to accept a non-abstinence based approach, but the 1625 Team outlined their approach around keeping young people safe and ensured the rationale was accepted. One of the local stakeholders working in an education setting explained:

They [1625 Team] would explain right from the beginning what the purpose of the work that they were doing was and that it wasn't about cessation messages. It was really about harm minimisation and equipping young people with the right advice and information to keep themselves safe. (Stakeholder 3)

Young adult drug use is usually not entrenched, but changes and evolves during this period of development as people experiment with different drugs. It was clear that flexible and agile services to help young adults navigate through the various life transitions and their specific substance use trajectories were missing from current provision. The 1625 targeted intervention coordinator emphasised the importance of providing 'safe spaces' for young adults to get information and support with their substance use:

Providing them with a safe space to be able to talk...I think that's really important and that different coping mechanisms might help them in the longer run that they may look back be like, 'hey you know, these are alternative ways of coping with this situation and different services I can go to'. (1625 Targeted Intervention Coordinator)

Tailored interventions for 18-25-year-olds are needed that consider the different contexts of drug use at key transition periods, including education to employment (or unemployment), further education/training, and leaving home, particularly for those who are most vulnerable (ACMD, 2022,2025b; Duke et al., 2019). Outreach services show promise in reaching different groups of young people who may be vulnerable to drug-related harms (Fomiatti et al., 2023; Welch et al., 2025).

Building the model aligned to the needs of young adults

Educating 'the system'

Beyond individual outcomes, building a local network of stakeholders allows 1625 Outreach to 'educate the system'. Although stakeholders might have different concerns around young adult drug use and diverse organisational goals, the leadership from 1625 Outreach helps to build stakeholder consensus and to develop a message and model that meets all their needs. The goal is to inspire trust and support professionals and practitioners in the local community to respond appropriately to drug use by young adults. This coordinated and targeted

outreach activity employs a community engagement approach which aims to mitigate immediate risks of drug use and to ensure informed, proportionate responses to drug-related issues across the community.

The 1625 Outreach team trains teachers, the police, and night-time economy staff in how to deal with drugs-related issues with the aim of reducing harm to the young adults involved. They also set up pathways for referrals for young people into structured treatment or support services. Feedback from stakeholders indicated that this capacity-building increased their confidence and resilience to deal with drugs issues. The team's non-judgmental approach, delivery and subject matter expertise was valued by the local stakeholders. As one of the stakeholders from public health explained:

...because they [the 1625 Outreach team] are really approachable, very articulate, but not patronising...They very much know their stuff. I feel like I'm really in the hands of experts. The thing that the kids love about them is that they're non-judgmental. In that room you can tell people anything, and it stays in the room, and nobody judges. (Stakeholder 5)

Within education settings, 1625 Outreach helped staff move towards a more measured and non-stigmatising approach to drug-related issues, including harm reduction policies. The 1625 team manager explained how they supported school administrators and teachers to work in a more harm reduction-oriented way, which did not automatically punish students for drugs possession and use:

It's increasing their knowledge of signs and symptoms and what to look out for and also breaking down some of the stigma - trying to support them in working in a more harm reduction centred focused way. We've supported with policy development in a lot of these settings, trying to change their policy to be more harm reduction centred...as opposed to being 'if you are found in possession'...(1625 Outreach Team Manager 1).

Development of bespoke knowledge and skill sets

At the core of the 1625 Outreach model was a non-hierarchical team able to foster successful partnerships, develop creative interventions on a limited budget and deliver credible, consistent messaging (Welch et al., 2025). Strong leadership facilitated creative thinking, instilled confidence and motivated a dedicated staff team with a particular knowledge and skill set. The team refused to use a generic 'drug worker' job description when recruiting staff. The 1625 team manager argued that their work was seen to be aligned more with youth work, rather than drugs work, requiring confidence to initiate discussions with young adults in a range of settings:

I was asked a while ago, what are the key attributes and skills for an outreach worker? I was like, find me people that have got the gumption to go and approach a group of young people - because that's not for everybody. You can't expect a generic drug worker or practitioner, from a different sector to just be able to do that because it's not easy. So for me, it's aligning operational standards with youth work, more than drug work. Sometimes, there's an expectation that those things are very similar and I would argue that they're really not. Most drug workers are probably quite adaptable in terms of therapeutic skills. I wouldn't necessarily say that's an attribute that our workers need, it's more around confidence and engagement-related skills. (1625 Outreach Team Manager 1)

An open, flexible approach was crucial to working with young adults who may need help with other issues or signposting to other services. The 1625 Outreach team argued that working with young adults required a unique skill set with knowledge and expertise around the difficult transitions they were navigating and their specific needs. Often, their substance use issues were secondary to other problems. The 1625 team manager emphasised the distinctiveness of this life stage in terms of drugs support:

Young adult work is different and it requires something different...we're trying shoehorn it in adult services and then we try and shoehorn it into young people [services]. Then you're trying to align the thoughts and experiences of a 25-year-old with that of a 13-year-old in young people services, and then you're trying to advocate an 18-year-old being the same as a 56-year-old opiate user. They're not, it's a distinct [stage], it's an entity of its own. (1625 Outreach Team Manager 1)

The staff and volunteers working with the service also recognised that they needed tailored training to work with young adults in the different contexts of these place-based outreach settings (e.g. events, festivals, universities). This required flexibility, resilience, sociability, and the ability to work autonomously and to take initiative (Welch et al., 2025). The lived experiences of the team members were also important assets in their skill sets which helped them to engage with and relate to the young adults in various outreach settings.

Importance of co-production

Co-production with young adults was viewed by the team and local stakeholders as crucial in developing the service and keeping it up to date, relevant to their specific needs and accessible for diverse groups. The best example of co-production was the digital strand of the service which was led by 16-25-year-olds. As one of the 1625 outreach workers explained, all social media and education materials were designed, checked and approved by young adults to ensure that the message was relevant and understandable:

Young people are involved on every level of it...Trying to get young people's input on everything...We try to get groups of young people [to] proofread literature that we want to print. How does this come across? Is there anything we need to change? So making sure that all of our information that we give out is relevant. (1625 Outreach Worker 1)

Within the digital strand of the service, social media posts were designed to resonate with the young adults based on their input. This cohort spend much of their lives online, so the team saw social media platforms as important spaces to occupy with their messages. Through the digital strand, the team manager explained how the service 'infiltrates' the day-to-day activities of the young adults with drug information and harm reduction messaging:

It's about engaging young people in an intervention that they're familiar with. So a scroll on social media is quite a natural part of their day-to-day activity...kind of infiltrating their day-to-day activity with specific advice and information in a way that resonates with them...building on social media-based trends...bending and flexing the service to what they're already engaging with in a digital capacity. (1625 Outreach Team Manager 1)

The team valued the lived experiences and privileged the experiential knowledge and expertise of young adults to help shape their service, particularly the digital aspects. The 'right' staff needed to be recruited into the posts to ensure that they would allow young adults to be heard and be active in the service development. Young adults were definitely consulted to provide comments and feedback; however, it was difficult to ascertain how much agency, power and autonomy they had in the design and decision-making processes in relation to all strands of service development. There were also challenges in getting the co-production right across the whole age range. What might be considered important and engaging for 18-20-year-olds could be different for those in their mid-20s.

Agile model responsive to changing needs/trends

A key component of the 1625 Outreach approach was to develop methodologies to engage young adults in their own environments. Different contexts with different groups required multiple methods to

ensure engagement. The model needed to be sufficiently agile and flexible to respond to the changing needs of local young adults as they arise. The freedom to adapt the model was enhanced by the nature of the team who were seen by local stakeholders across the education, public health and policing domains as proactive, collaborative and solutions-focussed in the context of changing patterns of drug use and associated harms:

[Their] personality is can-do, and the ethos is one of partnership and working together, not in silos or precious about any aspect of their work... They're very upfront about what doesn't work and always will then come up with a solution as to what they'll do about it. (Stakeholder 3)

You've got to be able to be responsive to what's going on at the time and not stick solidly to a "this is what we've done"...We've got to move. We've got to flex, particularly [with] young people. Lots of flex with young people because [with] drugs, the trends change, behaviour changes. (Stakeholder 2)

[1625 Outreach] was meant to be flexible and adjust to needs, so a little bit of this in this area and a little bit of that in another...getting the concept right felt like the most important thing. (Stakeholder 1)

The community-based approach facilitated the real-time identification of emerging drug trends. Observations of team meetings showed a flat, non-hierarchical structure that allowed for open discussions around local issues and new drug consumption patterns, promoting an adaptable and rapid response (Welch et al., 2025). For example, in response to increasing ketamine use amongst 16-25-year-olds where heavy and prolonged use had caused bladder damage for some individuals, the team established a referral pathway to a continence clinic. The 1625 Outreach manager explained how this initiative included raising awareness and educating nurses and doctors on the symptoms associated with ketamine use, as well as promoting non-judgmental communication strategies to ensure that young adults would feel safe seeking help:

There is a rising population [of ketamine users] aged between 16 to 25 who are now presenting in certain spaces with really complex issues as a result of not being able to access services...So we looked at the different pathways - working with continence clinics is one of them. We did a little bit of training with them [first-line medical staff] around it - non-judgmental approaches in terms of how you ask those questions. (1625 Outreach Team Manager 1)

The visibility of workers in different local settings was also perceived to establish their credentials with young adults and to build rapport, especially for the brief 'teachable moment'. One of the local stakeholders working in education pointed out how this visibility and continuity helped to establish trusting relationships:

The thing I love about it is that [outreach workers] come into towns...they go to festivals. So we've got a local festival, and our kids go and see them. They go and speak to them, so they get to know them. (Stakeholder 5)

In some cases, the outreach workers were able to build trust and engage with young people over an extended period of time. Some of the young people had experienced education sessions with the 1625 Outreach team in schools when they were aged 16-18 and then continued contact with the team in other events and settings later on as they emerged into adulthood. The 1625 education outreach worker gave examples of how previous students would recognise both the 1625 Outreach brand and the workers in different settings:

Some of the young adults that are coming up to me are students that I worked with at school and they're recognising the brand and they're engaging. I don't need to introduce myself...That barrier has already broken down and they will tell me what they've been up to or get advice about substances. (1625 Education Outreach Worker)

Brand recognition was central to the continuity across the different

delivery strands. The link to social media platforms was a key 'takeaway' from interactions in other settings, ensuring continuity of the message. People were encouraged to use a QR code linked to the 1625 Outreach's social media platform. Attendance at festivals and community events reinforced consistent harm reduction messaging and enhanced brand recognition, establishing 1625 Outreach as a trusted source of support.

Challenges to the existing model

Reaching diverse populations of young adults

As the young adults in the area moved on from school and college, the 1625 Outreach model could continue to work with them through higher education institutions, training colleges, and local events and festivals. It was evident that it was relatively easy to reach those young adults still in education at universities and training colleges, but more difficult for those in employment. One of the 1625 outreach worker discussed how this was an important group of young adults who were missing out on support:

They'll do a short apprenticeship when they leave school and then they'll get into some sort of trade work. They'll be earning quite decent money. They'll be going to the pub every Friday and Saturday night causing themselves some risk from the drinking. But because we don't really have access to that group because we're not going into where they work - they're not at college anymore, they're not at uni. They're just living normal adult lives, but they are still under 25. And in that recreational phase. (1625 Outreach Worker 2)

Apprenticeships, particularly within the construction industries, were identified by the team as an area for future involvement.

Given the growing population of people aged 16 to 24 years in the UK who are not in education, training or employment (NEET) (ONS, 2025b), services need to address the multiple disadvantages they face including negative impacts on mental health and social exclusion, both of which are risk factors for increased substance use. Providing targeted outreach with a clear and visible service identity was seen to be essential by the team. The outreach strand of the service was designed for those aged 16-17 socialising in outside or public spaces where a clear gap in services had been identified. With the decline in spaces like youth clubs and other services, there was nowhere for this cohort to go in the community. The general view of the staff team was that street outreach worked well for 16-17-year-olds, but it became more difficult to access the 18-25-year-olds who were not in education or training settings.

A lot of the outreach was really effective with 16 and 17 year olds, but there were quite a few times when I'd have young people that I'd see on a regular basis...Once they hit 18, all of a sudden, they've got access to different environments...We're not in a park in Chesterfield anymore. We're going night clubbing in Sheffield for the night. (1625 Outreach Worker 1)

The team did not have the resource or capacity to undertake outreach work in the night-time economy, yet this is one of the main ways to reach some young adults not in education and training settings. Whilst there was a desire to focus on the night-time economy, 1625 Outreach was aware of the limited options they were able to provide. Given the lack of resources, they decided to concentrate on delivering training on drug policies, awareness and safety to those working in pubs and clubs instead of attempting outreach in multiple locations across the night-time economy.

The need for longer term interventions

While the outreach approach addresses a gap in current standard service provision, our research indicates a continuing need for bespoke structured treatment (planned and ongoing) specifically for young adults. Outreach activities are effective for education, harm reduction

messaging, confidence-building and signposting for further support. However, this support was difficult without an appropriate young adults' service to refer to as one of the outreach workers explained:

It was a lot of the same groups that I was seeing on a regular basis. You get to the point where there's nothing more that I can discuss with you out here in this setting. If you need more support, this is more than I can offer on an ad hoc basis...It would be an onward referral, but then we've got the dilemma of we can't really take a referral there... (1625 Outreach Worker 2)

For young adults who need more intensive or long-term interventions, the existing adult service provision was seen to be inadequate. As a result, 1625 Outreach created a targeted intervention coordinator role to allow 16-25-year-olds to self-refer for formal, one-to-one appointments within higher education settings (including colleges and universities). These sessions, usually 6-8 in number, were in the format of extended brief interventions. As the targeted intervention coordinator explained the sessions provided an opportunity to refer into more structured treatment or into other relevant services if needed:

The main things are supporting individuals on that one-to-one basis to provide them with harm reduction strategies - ways of protecting themselves, keeping themselves safe. But it also could be a way into a lot of other issues. A lot of other things might come out through my work. Like they might not be known to the pastoral or safeguarding team [support services within the educational institution]. (1625 Targeted Intervention Coordinator)

The team identified the need to develop partnerships and referral pathways into support and treatment that were appropriate for young adults:

So making sure that there are appropriate pathways into treatment via the right partnership agencies that we're not currently reaching in the wider sector. Universities will be a key part of that because at the moment there's probably only about 5 or 6 services that have actually got a university referral pathway. (Service manager 1)

Since universities and Higher Education colleges work mainly with those aged 18 to 25, staff working in these institutions have increasingly needed to think about appropriate responses to drug-related issues. The potential relevance of 1625 Outreach has been recognised by Universities UK in their published guidance on tackling drug supply and demand and improving harm reduction (UUK, 2024).

Discussion

As outlined in the introduction, Arnett (2000; 2014) conceptualises the time between 18 to 25 years of age through the theoretical lens of 'emerging adulthood' where young people continue to develop physically, cognitively, emotionally, socially and behaviourally. Although Arnett's work has continued application for the current Generation Z cohort of 18-25-year-olds, their development and transitions to adulthood have been further complicated and prolonged by a unique set of intersecting structural crises (Nuffield Foundation, 2025). Our research has highlighted the ways in which 1625 Outreach practitioners and community stakeholders have recognised the distinctiveness of the young adult cohort in relation to their substance use, development and needs. They have outlined the case for developmentally appropriate care and support for young adults which involves acknowledging them as a distinct group in substance use treatment/prevention provision and the wider contexts of their substance use which changes rapidly between the ages of 18 and 25.

The practitioners in our study argued that substance use support for young adults should be underpinned by different approaches in relation service structure/environment, by a different framing or conceptualisation of harm reduction and shared understanding of what harm reduction means for this group in different contexts across

agencies. Participants outlined how dynamic, adaptable models are needed which bend and flex to respond to their changing needs, substances and contexts. In the UK, adult substance use services tend to be static and geared towards people who use opiates, crack cocaine and alcohol. These services were viewed as wholly inappropriate for the young adult cohort.

The interviews revealed how the term 'harm reduction' was avoided by practitioners in their work with the young adults. They employed terms like 'safety' and 'keeping safe' which corresponded to their mainly recreational, experimental substance use patterns (e.g. using alcohol, cannabis, ecstasy and ketamine), rather than 'harm reduction' which had particular connotations for the young adults around use of opioids and injecting drug use. Employing the discourse of 'safety' was also more acceptable to some of the community stakeholders (particularly in the education settings) who were initially resistant to any work that might be seen as 'condoning' drug use. The team prioritised building consensus around 'safety' and gaining the cooperation of the stakeholders in the police, education and public health sectors. However, as Volpe (2025) has argued, 'safety' is a ubiquitous governing concept and is employed to mean many different things. It can be fluid and contingent and open to negotiation. In her research, 'safety discourses legitimated interventions that governed 'young people', where younger subjects were constituted as passive, and dependent on adults, governments and services to 'make' safety on their behalf.' (p. 108). In some circumstances, the work of the 1625 Outreach staff oscillated into the prevention space where the focus was to 'prevent' or 'stop' use and/or the escalation of use and 'protect' young people from drug-related harms, particularly in educational settings. In other cases, their work included providing 'harm reduction' packs suitable to their substance use profiles, distributing information about drug checking services and brief interventions on how to use different substances safely, as well as general safety advice on how to keep themselves and their friends 'safe' on nights out and in other settings. In practice, the 1625 model therefore involved a diversity of elements including prevention, promoting safety, care and protection, and providing harm reduction information and resources.

Co-production with local community stakeholders and young adults themselves was a core component of the development of the 1625 Outreach Service. Service design and delivery was co-produced with professionals and practitioners in the local community employing a community engagement model and capacity building framework. This allowed the team to 'educate the system' of local stakeholders which in turn facilitates more proportionate and better-informed responses to drug use across sectors including police, education and the night-time economy. The team was able to develop successful local partnership structures and agile modes of working to respond to emerging drug trends among young adults.

Co-production with young adults was key to developing the service and updating it to ensure relevance and accessibility. As Stowe et al. (2022) argue, young adults should be recognised as 'experts' in emerging drug trends and behaviours. Through their experiential knowledge, they offer unique and important insights into young adult spaces of substance use, as well as access and literacy with new technologies. However, there are very few examples of interventions that have effectively involved young adults in their design, development, implementation and evaluation and ensured their power and autonomy in decision-making. Many of the attempts to include young people in drug policy design in particular have been 'tokenistic' (Stowe et al., 2022; Duke et al., 2022; Volpe, 2025). In the 1625 model, young adults have been actively involved in the development of the different strands of the service. In the digital strand, they led its design and development and their knowledge and experiences were particularly privileged. In the other strands of the service (i.e. pop-ups, festivals, street outreach, education), they have been mainly in informal, consultative roles to provide feedback on the service offer. Giving young adults greater power, autonomy and decision-making in shaping all strands of the service

would further enhance the model in the future.

Nelson (2021) examines emerging adulthood through the lens of affordances which helps us to understand the heterogeneity and variances in trajectories during this phase. All emerging adults do not have equal affordances and may lack opportunities to 'choose' different trajectories or alter trajectories, including decisions around substance use and accessing help and support. Variations in trajectories are differentiated by gender, sexuality, ethnicity, immigration status, neurodiversity, disability, socio-economic status, and education (Schoon, 2015; Skirbekk et al., 2025); culture and context (Fenton et al., 2022; Schulenberg and Schoon, 2012) and by experiences including institutional care, exclusion from school and contact with the criminal justice system (Duke et al., 2020; National Audit Office, 2015). Those who are not in education, employment or training are particularly under-served by existing models of substance use provision. The 1625 Outreach staff acknowledged this as a key limitation of their service and had plans to address it. They also recognised the gap in provision for young adults who need more intensive support, intervention and treatment for their substance use.

With greater capacity and resources, an 'ideal service' for young adults would include all five existing 1625 Outreach strands (Fig. 1) with a stronger presence in the night-time economy, and clear referral routes to bespoke young adult substance use support (including unstructured 'drop-ins') that sit outside standard adult treatment services. Outreach interventions should extend to care leavers (i.e. young adults leaving local authority care at the age of 18), other young adults living in supported accommodation schemes (offering life skills support before independent living), and individuals involved with the criminal justice system. The digital strand could offer remote online interventions, enabling young adults to access support sessions via mobile devices. Young adult interventions should be holistic, providing practical, emotional, and relational support, to address the underlying causes of substance use rather than focusing solely on the substance.

This research was undertaken in one local area in England and is therefore limited in its geographical scope and representativeness. However, this case study shines a light on the under-researched and under-served population of young adults in relation to their substance use needs and what is required for effective service design and development. Given the diversity in the young adult population, further research needs to concentrate more on what works, with whom and in what contexts (Pawson and Tilley, 1997), covering individual, community and system-wide outcomes.

Conclusion

The 1625 Outreach model was developed to align with the needs of young adults and fills an important gap in existing provision locally and nationally. Its multi-component place-based model was found to be agile, innovative and responsive to local drug trends (Duke et al., 2025; Welch et al., 2025). The model sits between young people's and adult services, serving a population of young adults with distinct needs relating to their substance use. However, our research has demonstrated its limitations in its ability to engage young adults over an extended period. Outreach interactions were brief and therefore limited in scope, and contact was often lost when individuals left education or began socialising in the night-time economy. Onward referral was often difficult from ad hoc interactions, and existing adult services offering structured support were deemed unsuitable for young adult needs. Nelson (2021) argues that we have an obligation to take what we know about this life phase to help emerging adults through teaching, research and the development of relevant policy and services. Our research indicates the need to move away from 'transitional' arrangements to standardising bespoke substance use treatment specifically for young adults with specialist staff who can help young adults navigate their trajectories and transitions to adulthood without harm.

Ethics approval and consent to participate

The project received ethical approval from the Middlesex University Social Work and Mental Health Ethics Committee (ID 25367). All participants provided fully informed consent.

Open access

For the purpose of open access, the authors have applied a Creative Commons Attribution (CC BY) licence to any author accepted manuscript version arising from this submission.

CRediT authorship contribution statement

Karen Duke: Writing – review & editing, Writing – original draft, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization. **Zoë Welch:** Writing – review & editing, Writing – original draft, Project administration, Methodology, Investigation, Funding acquisition, Formal analysis, Conceptualization.

Declaration of competing interest

Zoe Welch is the Head of the Change Grow Live's Research Team that sits within the central Strategy and Partnerships Team. The 1625 Outreach service is a separate, locally commissioned service that sits within Change Grow Live's Children and Young People's Directorate. Karen Duke has no conflicts of interest to declare.

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