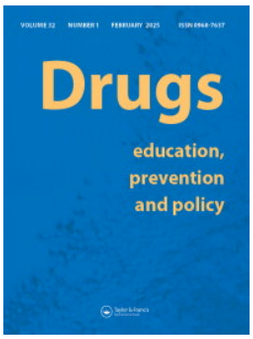

Taylor & Francis
Taylor & Francis Group

Drugs: Education, Prevention and Policy

ISSN: (Print) (Online) Journal homepage: www.tandfonline.com/journals/idep20

# ‘Why don’t we just build it in a square hole?’: developing a multi-component drug outreach service for young people aged 16–25 in England

Zoë Welch, Karen Duke, Katy Hughes, Arun Sondhi & Samantha Wright

**To cite this article:** Zoë Welch, Karen Duke, Katy Hughes, Arun Sondhi & Samantha Wright (06 Mar 2025): ‘Why don’t we just build it in a square hole?’: developing a multi-component drug outreach service for young people aged 16–25 in England, Drugs: Education, Prevention and Policy, DOI: 10.1080/09687637.2025.2470147

**To link to this article:** https://doi.org/10.1080/09687637.2025.2470147



Published online: 06 Mar 2025.

DRUGS: EDUCATION, PREVENTION AND POLICY
https://doi.org/10.1080/09687637.2025.2470147

Taylor & Francis
Taylor & Francis Group



# 'Why don't we just build it in a square hole?': developing a multi-component drug outreach service for young people aged 16–25 in England

Zoë Welch[a], Karen Duke[b], Katy Hughes[a], Arun Sondhi[c] and Samantha Wright[a]

[a]Change Grow Live, Brighton, UK; [b]Drug and Alcohol Research Centre, Middlesex University, London, UK; [c]Therapeutic Solutions (Addictions) Ltd, London, UK

**ABSTRACT**

**Background:** In England, the rise in young people/adults' drug use coincides with a decline in specialist outreach and support services. Current substance use provision particularly neglects young adults. This paper traces the origins of the multi-component '1625 Outreach' model and how it was developed and refined by utilizing community engagement and co-production approaches.

**Methods:** The co-produced, qualitative research design included observations of outreach practitioners in different settings, focus groups with professionals and young people/adults, and semi-structured interviews with key informants.

**Results:** The multi-component model was found to be agile, innovative and responsive to local drug trends. This was facilitated by community partnerships and inter-agency collaboration and the involvement of young people in service development and delivery. Co-designed prevention messages on social media were effective in reaching a wide audience. It was important that the educator was viewed as relatable, trustworthy and knowledgeable, with honest harm reduction messages. Participants preferred strengths-based harm reduction discussions, allowing for exploration of the complexities of drug use.

**Conclusion:** The study highlights the importance of developing credible, strengths-based harm reduction messages co-designed by young people. A coherent multi-component delivery approach with stakeholder engagement can facilitate agile responses to the changing needs of local young people/adults.

**ARTICLE HISTORY**
Received 1 November 2024
Revised 5 February 2025
Accepted 12 February 2025

**KEYWORDS**
Community engagement; young adults; young people; youth transitions; outreach; harm reduction; co-production

## Introduction

Among young people/adults aged 16–24 years in England and Wales, 17.6 per cent of the population have taken illicit drugs in their lifetime, with 4.7 per cent (around 280,000 young people/adults) defined as frequent drug users (monthly use) [Office for National Statistics (ONS), 2023]. Recreational drug use is often 'normalized' and viewed as pleasurable among young people/adults, who are therefore unlikely to recognize the risks of drug-related harms (Aldridge et al., 2011). Even if they are aware of potential risks, young people/adults are unlikely to engage with specialist services for advice or structured interventions. Drug information is more likely to come from peers, creating individualized risk mitigation strategies (Aldridge et al., 2011). The lack of engagement is compounded by the decline in youth-specific services and referrals for specialist substance misuse support for young people/adults in England in the last decade [Office of Health Improvement and Disparities (OHID), 2023]. Tailored services for young people/adults aged 16–25 are needed that consider the particular contexts of drug use and key transition periods, including education to (un)employment, further education/training, and leaving home, particularly for those who are most vulnerable [Duke et al., 2020; Advisory Council on the Misuse of Drugs (ACMD), 2022].

The effectiveness evidence on interventions for adolescent drug use (e.g. aged 12–20 years) is mixed and inconclusive. Evidence for the strength of approaches common to adult service provision such as, motivational interviewing, cognitive behavioral therapy, contingency management, and intensive case management, is limited in scope and not strong enough to draw firm conclusions (Steele et al., 2020). Recent research exploring digital interventions for young people/adults suggests that innovative more digitally-focused approaches may increase accessibility, reduce stigma and enhance appeal, but that more evidence is needed (Fadus et al., 2019; Monarque et al., 2023; O'Logbon et al., 2024).

Outreach activities encompass concepts such as 'prevention', alongside descriptions of setting such as 'detached' or 'street-based' (Andersson, 2013; Shin et al., 2020). Shin et al. (2020) conceptualize outreach activities as having four defining components (purposive, temporary, mobile and devised in collaboration with the community) to address health or social risks and promote pro-social behaviors. Typical

**CONTACT** Karen Duke k.duke@mdx.ac.uk Drug and Alcohol Research Centre, Middlesex University, London, UK

outreach activities involve engaging with young people in locations where they meet up socially and where drugs and alcohol may be consumed. Outreach workers may provide advice, information resources and safety equipment, for example 'spikies'[1] to prevent drink spiking and torches to improve visibility in dark settings.

Outreach services show promise in reaching different groups who may be vulnerable to drug-related harms (Fomiatti et al., 2023). In the UK, outreach has historically targeted high-risk groups such as people who inject drugs (Needle et al., 2017; Stimson et al., 1994) within a community health harm reduction model (Ashton & Seymour, 2010). Currently, however, UK outreach services are fragmented, lack overarching coordination, and depleted due to substantial cuts in resourcing (Black, 2021).

While a recent review of the evidence base (Fomiatti et al., 2023) examining youth drug and alcohol outreach models found the literature limited in scale and scope, some key enablers of effective drug outreach delivery for young people/adults were identified. Co-production was shown to be crucial in designing and disseminating health promotion messages (Aresi et al., 2023; Ballard et al., 2023; Duke et al., 2023; Dunne et al., 2017; Fomiatti et al., 2023), alongside recent lived experience providing insights into communities' needs that are often hidden from mainstream view (Lazarus et al., 2014). The development of trust during the brief interactions between an outreach worker and the young person/adult facilitated by expert subject knowledge (Salazar et al., 2016) and the capacity to relate to that person (Paquette et al., 2019) were identified as essential factors. These elements may differ from those needed in traditional clinical interventions in outpatient or static community settings (Del Boca et al., 2017).

Since many of the young people/adults who might benefit are not engaging with existing services, there is a need for mobile interventions in spaces young people/adults already occupy, which may not be near 'traditional' service provision (Fomiatti et al., 2023; Sumnall, 2023). This may be particularly relevant for young people/adults in non-urban or rural areas, where poor health outcomes are linked to limited access to services (Asthana et al., 2003; Lutfiyya et al., 2012). Moreover, given the key transition points experienced by the 16–25 age group, there is a need for services that can provide consistent support as young people move into new social, education and work environments, and also for signposting or referral pathways that mitigate the risk of youth dropping out of sight (Salazar et al., 2016). For example, outreach at electronic music events may provide a good opportunity for an event-specific approach, incorporating young people/adults in co-design and emphasizing the importance of the educator (relatable, trustworthy and knowledgeable) and the message (honest/candid, non-statistical, harm reduction focused) (Falcon et al., 2023).

Designing the components of an outreach approach requires carefully planned community and stakeholder engagement [European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2023; Fomiatti et al., 2023; Halsall et al., 2022], including consulting with community leaders to acquire and maintain adequate resourcing (Salazar et al., 2016). Engaging community stakeholders effectively requires leadership to coordinate, share information, maintain engagement and build capacity (Halsall et al., 2022; Henderson et al., 2017; Lazarus et al., 2014). The role of a leader should include awareness of the time burden of participation (Lazarus et al., 2014) and ability to adapt processes to local contexts, lever existing partnerships, and align actions to local policy (Halsall et al., 2022). Long-term engagement is more likely if stakeholders can discuss progress and consider the next steps required for long-term system change in partnership (Henderson et al., 2017). Scaffolding the proposed intervention within a clear, strengths-based theoretical and evidence-based framework is also deemed essential (Dell et al., 2013), allowing flexibility to meet changing local demands (Salazar et al., 2016).

In 2018, a community-based outreach service (1625 Outreach) was developed to deliver a combination of prevention interventions (Gordon, 1983): *universal* (targeted at the general population, e.g. social media campaigns), *selective* (targeting subgroups of the population at higher than average risk, e.g. those excluded from formal education) and *indicated* (high-risk groups who have been identified as having an issue, e.g. referrals into structured treatment). Commissioned by the Derbyshire Police and Crime Commissioner (PCC), the range of services was to be delivered in urban and rural settings across the county of Derbyshire, UK (Change Grow Live, 2019). 1625 Outreach has a full-time staff team of six and operates within a wider national charitable organization providing services to adults and young people affected by drugs, alcohol and related issues.

These place-based interventions aim to reduce the demand for illicit drugs and associated risky behaviors by increasing young people/adults' knowledge, skills, and resilience. 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; pop-up stalls at festivals and events, targeted social media campaigns on Instagram and training for night-time economy staff. In relation to indicated prevention, the service also has developed referral pathways into structured and specialist treatment for individuals needing further intervention. The interventions are guided by multi-agency stakeholder input, targeting outreach interventions at young people/adults most vulnerable to drug use. For example, they target young people/adults 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.

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

This paper is based on a study funded by the UK National Institute of Health and Care Research (NIHR) as part of the Innovation Fund to Reduce Demand for Illicit Substances (NIHR205261). This qualitative study was part of Phase 1 of


**Figure 1.** 1625 outreach delivery model.
*Note:* YP = Young People.

the Fund which focused on the development and refinement of interventions and preparing them for evaluation. This paper aims to trace the origins of the 1625 Outreach model and how it was developed and refined by utilizing community engagement and co-production approaches. The research identified the critical ingredients for service development. It addresses the following research questions:

- How was the model designed and tailored to support the needs of young people/adults in the local area?
- How were community engagement approaches employed to develop the multi-component outreach model across urban and rural settings?
- What are the key challenges and threats to the further development of the model?

We refer to 'young people/adults' throughout the paper as this included young people aged 16–17 and those aged 18–25 who are transitioning to adulthood.

## Methods

### *Co-produced research design*

The study draws upon a qualitative, grounded theory research design (Glaser & Strauss, 1967). This approach allowed the research team to explore the origins and design of the 1625 model and how community engagement approaches were used in its continuing development from the perspectives of different stakeholders in the community, including young people/adults. The iterative design allowed for new insights to be developed and refined during the research process. The research was conducted over a period of seven months. The methods included observations, focus groups with practitioners and young people/adults, and semi-structured interviews with key informants from the 1625 Outreach service and regional services (See Table 1).

Before the project began, two young person/adult contributors (one aged 16–17 years and one aged 18–25 years) with lived experience of substance use and of using the 1625

**Table 1.** Elements of the research design.

| Method | Participants/settings |
|---|---|
| Observations: of two outreach practitioners and outreach staff team meetings | -4 Drug education sessions at 3 further education colleges (n = 80 young people, 1 practitioner)<br>-1 Education-to-outreach session (n = 16 young people, 1 practitioner)<br>-3 Responsive (targeted) outreach sessions (n = 18 young people, 1 practitioner)<br>-2 Pop-up events (n = approximately 50 young people, 2 practitioners)<br>-2 Staff/team meetings (n = 7 staff members) |
| Practitioner Focus Group | -Practitioners covering urban and rural settings (n = 12 practitioners) |
| Young People Focus Groups | -Two urban settings (aged 16–17 and 18–25) (n = 6 young people; n = 6 young adults)<br>-One rural setting (18–25) (n = 7 young adults) |
| Semi-structured interviews with outreach service leads and Children and Young People (CYP) regional leads | Service / regional leads (n = 5 practitioners) |
| Stakeholder Advisory Group (SAG) meetings | SAG online meetings (n = 2) (7 people) |
| Patient and Public Involvement (PPI) workshops | Full-day PPI workshops (n = 2) (4 young people) |

Outreach service were recruited to help co-design the research proposal. At the beginning of the project, a Patient and Public Involvement (PPI) Group was established, comprising four young people/adults (two aged 17, one aged 18 and one aged 24). Two full-day workshops with the PPI group were convened by the research team (ZW, KH, SW) using participatory approaches. The first workshop took place prior to data collection and focused on co-design of the research tools. The second workshop took place in the final month of project and focused on a discussion of the preliminary findings. Both workshops incorporated on-location filmmaking methods to design the tools and interpret findings.

A Stakeholder Advisory Group (SAG) comprising seven professionals from local services and organizations oversaw the research and provided local insights on the development of the 1625 model. They met online for 1.5 hours with two members of the research team (ZW, SW) in the first and final month of the project. They were recruited based on their expertise with young people/adults aged 16–25 years, knowledge of substance use patterns and needs, and involvement in local services. This group represented both urban and rural areas and included individuals from commissioning, criminal justice, public health and education services.

### Observations

In the first two months of the project, two 1625 Outreach practitioners were observed by two members of the research team (KH, SW). They observed four types of outreach activity in order to gain an understanding of how the practitioners worked in different settings. The activities represented the main areas of outreach in which the 1625 service was engaged. This included four drug education sessions at three further education colleges (1 hour each); one education-to-outreach which began in a community college setting and was sequentially followed up by street outreach (3 hours); responsive (targeted) outreach in three settings (one rural and two town centers) (2–3 hours each); and two pop-up events where drug information and harm reduction advice was given, one at a university and one at a community college (4 hours each). In each activity, field notes were recorded on an observational template with sections on types of interactions, duration of the individual interactions, the support given to the participants, reception from participants, what went well, and what was challenging.

Two in-person 1625 team meetings (2 hours each) were also observed by members of the research team (ZW, SW, AS) in the second and final month of the project. Observations centered on team structure and dynamics, decision-making, service agility, and adaptations to the model.

### Focus groups

A practitioner focus group was conducted online by two members of the team (ZW, KH). It comprised stakeholders covering both urban and rural settings (n = 12). Participants were recruited purposively across the county and included representatives from education, events welfare provision, criminal justice, commissioning, substance use, and health and well-being services. The group included organizations not currently working with the 1625 Outreach service to broaden perspectives. The practitioner focus group lasted 1.5 hours. It was audio-recorded and professionally transcribed. The aim was to explore the needs of young people in the area, the strengths and limitations of the service and its evolving role in the local context.

Focus groups were conducted with young people/adults representing different age cohorts (16–17 and 18–25 years) from across the county (urban and rural) and at key transition points, including school/college, not in education, employment or training (NEET), and university students. These were conducted in the middle of the project (Months 4, 5, and 6). A purposive sample of young people was recruited to ensure diversity in relation to gender, ability, ethnicity, and socio-economic status. Two focus groups were conducted in urban settings (6 participants each), and one focus group was conducted in a rural setting (n = 7 participants). One of the 16–17 year old focus groups comprised participants with diagnosed neurodivergence, including autism, ADHD, dyslexia and Tourette's syndrome. The focus groups were conducted by two members of the research team (SW and KH) and lasted approximately one hour. They were audio-recorded and professionally transcribed. The aim was to explore young people's experiences of receiving support from the 1625 service, their experiences of co-production and any gaps in the existing model.

### Semi-structured interviews

In the final two months of the project, semi-structured interviews were conducted in person with two service managers from the 1625 service, one team leader, and two regional leads for children and young people's services (n = 5) to

discuss the model and the emerging findings. Three members of the research team were involved in conducting the interviews (ZW, KD, SW) which lasted approximately one hour each. They were audio-recorded and transcribed using transcription software. The purpose of these interviews was to understand the rationale and design of the model, how community engagement and co-production approaches were employed in its development and how it had been adapted to address the changing needs of young people in the local area.

### *Data analysis*

The data generated from the observations, focus groups and interviews were analyzed thematically drawing on Braun and Clarke (2006) framework for thematic analysis. This framework was well suited to the research design as it allows for in-depth analysis of patterns and themes and contextualization of the different perspectives of the stakeholders. The research team (ZW, KD, KH, AS, SW) familiarized themselves with the data by reading through the transcriptions from the focus groups and interviews and the notes from the observation templates and the participatory workshops. An initial coding framework was developed to reflect the study aims as well as to allow for emergent themes. Two members of the research team (KH and SW) performed deductive and inductive coding of the documents. Recurring issues, concepts and themes relating to the development and adaptation of the 1625 model were identified, summarized, compared and refined.

### *Ethics*

The project received ethical approval from the Middlesex University Social Work and Mental Health Ethics Committee (ID 25367) and was overseen by the Change Grow Live Research Governance Group. The participants' data was anonymized using identity numbers and pseudonyms for individuals and organizations participating in the focus groups. For all focus groups and interviews, written informed consent was obtained by using participant information sheets and signed consent forms.

## Results

The analysis identified three core themes and seven sub-themes relating to the development of the service (See Table 2).

We begin by discussing how the model was designed to support young people/adults in the local area by exploring the need for bespoke and specific services for this cohort; the importance of harm reduction as the underpinning philosophy; the development of credible messaging; and the agility and adaptability of the model in responding to changing drug trends and local needs. We then examine how community engagement approaches were employed to develop and refine the multi-component outreach model by examining the formation of the community stakeholder network and co-production with young people/adults. The final section discusses the key challenges and threats to the future development of the model, including stakeholder resistance to harm reduction and the sustainability of the model in terms of staffing and resources.

**Table 2.** Themes.

| Service design | Community engagement | Challenges |
|---|---|---|
| Young people/adult specific design and philosophy | Building the local stakeholder network | Resistance to harm reduction |
| Credible messages | Co-production with young people/adults | Sustainability |
| Agility and adaptability | | |

## Service design

### *Young people/adult specific design and philosophy*

It has been shown that all UK-based outreach services had diminished resources since 2010 (Black, 2021). The development of the 1625 Outreach model introduces a multi-component, place-based delivery model providing interventions for 16–25s across different settings, reaching diverse groups not typically engaging with services at critical transition points where the risk of experimentation or escalating substance use may be heightened. The multi-component approach allows consistent messaging around drugs, alcohol and associated risky behaviors.

Local practitioners felt that the standard adult service models receiving referrals from young adults aged 18-plus were unsuitable in meeting this cohort's specific needs. Young adults' more 'recreational' drug-using motivations, patterns and drugs of choice differed significantly from the focus on dependent alcohol, opiate and crack use typically found in standard adult services. Furthermore, the service environment was perceived as unwelcoming and clinical, which was a barrier to engagement:

> 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. (Service Manager 2).

The inappropriateness of standard adult substance use services for younger adults results in low numbers of young adults presenting for treatment nationally, with people aged 18–24 accounting for 5.6 per cent of the adult drug and alcohol treatment population across England [Office of Health Improvement and Disparities (OHID), 2023]. 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. Practitioners considered that this demonstrated the need for early intervention with the young adult cohort to prevent the escalation of substance use.

While young people's workers were better able to connect with young adults, stakeholders observed that once young people reach 16, they often disengage from services offering structured support, creating a specific gap for a service tailored to the young adult population.

Children and young people's practitioners and the 1625 Outreach team recognized that there were particular skills, similar to youth work, that were needed when working with

the young adult cohort. Standard young people's and adult service provision did not meet their needs. A new approach was therefore required:

> Young people's services are… better equipped to have the kind of skills and attributes that are better at engaging that age range… [16–25s] they're [young person and adult services] battling and then I'm somewhere in the middle going 'instead of trying to shoehorn this square peg into this round hole, why don't we just build it in a square hole?' (Service Manager 1).

> A big part of it is providing a service to a population that's completely under-represented in services generally…It's about creating something that's a little bit different and is a bit more inclusive for that young adult specific pathway. (Regional Lead 2 for Children and Young People (CYP).

The need for tailored interventions for young people/adults was apparent, to provide early intervention through harm reduction advice, prevent escalation of use and encourage continued engagement with services during these transitions to adulthood. However, 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. (Regional Lead 2 for Children and Young People's Services).

Understanding why young people and young adults did not engage with standard service models included a recognition that this cohort did not generally seek structured appointment-based support. Instead, 1625 Outreach was to provide advice, information and any necessary referral pathways through a low-key and informal approach which felt safe, discreet, and unobtrusive:

> So that's something that we're doing…hosting things like anonymized drop-ins – so we wouldn't require any personal information or identifiable information about [themselves] for them to come and engage with us informally. The idea of those drop-in spaces is to be able to facilitate potentially onward referral when it's needed. (Service Manager 1).

The 1625 Outreach approach was centered on an evidence-based harm reduction approach, found to be effective with young people (Kimmel et al., 2021); however, there was still a lack of evidence about what was effective specifically for young adults. Previous drug education across Derbyshire had adopted a fear arousal approach which local stakeholders felt had been ineffective. The young adult focus groups offered insight into potentially more effective educational approaches. Participants reflected critically on the 'fear arousal' drug education messages they had received at school. They perceived this approach as too simple, limited in scope and ultimately ineffective in addressing the context and complexities of substance use:

> My secondary [school] only covered smoking and alcohol. It just showed like the one woman with the hole in her throat and then the alcohol was just a woman that had to get her stomach drained and that was the only advice we were given. (Participant 4 in Urban 18–25 Focus Group).

> People also thought if you do a drug once that the rest of your life is going to be ruined… if you do this, it ruins everything, without actually giving out the advice. (Participant 1 in Urban 18–25 Focus Group).

The place-based harm reduction approach developed by 1625 Outreach was informed by effective practices from other areas of youth provision, such as sexual health:

> The aim was just a bit of a 'suck it and see' approach to harm reduction…we know that's the kind of model that works in other spaces…for example, in sexual health. It was like can we use this approach with young people and young adults and offer them something which is more appropriate to the environments that they're likely to be in? (Team Leader 1).

### *Credible messages*

Stakeholders and practitioners recognized the effectiveness of honest, candid approaches grounded in evidence-based information, tailored to the young people/adult age group. Professionals noted a positive response to interventions and interactive materials, attributing the success to their tailored and engaging nature (SAG Minutes, 6th June, 2023).

The observations in education and outreach sessions found that interactions established trust and connection with young people/adults through common cultural reference points, such as music, technology, film, and fashion. Practitioners acknowledged the importance of being a trusted adult. This was facilitated by their presence in multiple settings allowing for the development of service recognition and relationships over time. Observations highlighted that many young people/adults had repeated contact with the workers extending from education sessions, then outreach, through to festivals and events, in some instances evolving over several years.

It was evident that the 1625 Outreach brand and style were recognizable and the co-produced materials the team used were designed to be inclusive, addressing the needs of a range of young people/adults from 'naïve' to more knowledgeable or 'streetwise'. Stakeholder partners felt that the information provided helped young people/adults prepare for interactions around drugs that they were likely to experience (at university or in the night-time economy), with messaging about how to look after themselves and friends being timely and valuable (SAG Minutes, 6th June, 2023).

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. Young people/adults were encouraged to use a QR code linked to the 1625 Outreach's social media platform. 1625 Outreach's social media content was often cited by the young people/adults as a trusted source of information. Attendance at festivals and community events reinforced consistent harm reduction messaging and enhanced brand recognition, establishing 1625 Outreach as a trusted source of support.

Practitioners in rural and urban settings agreed that the 1625 Outreach team's creativity and credibility alongside the targeted locations meant the service could 'meet them [youth] where they are at' both in terms of their physical location and

emotional state. Stakeholder partners noted that the 1625 Outreach team was able to create an open and trusting environment promoting safety and rapport, encouraging young people/adults to share experiences confidently and honestly (Practitioner Focus Group).

The observation sessions highlighted the 1625 staff's depth of knowledge and ability to relate to young people/adults which gave them the confidence to talk honestly to the workers. The education session observations noted that: 'worker had good knowledge of local trends, used engaging activities (beer goggles etc.), and varied learning methods' (Research Team Observer 2). The observation of a pop-up event echoed these observations with: 'an attractive stall and enthusiastic staff – knowledgeable/helpful/able to engage well with those who approached' (Research Team Observer 1). Outreach observations showed that repeated contact with young people/adults over successive weeks built trusting relationships between young people and the worker (Research Team Observer 2). This was reflected in feedback from the young people/adults themselves:

> He became like a little character in our group, and we were like 'yeah, you know that guy, that 'safe guy', that just tells you about drugs and stuff, yeah, I love him', and he just kind of spread like an urban legend…we all admire him. (Participant 2, Urban 18–25 Focus Group).

Alongside the emphasis on openness and trust, the commitment to reducing harm and promoting safety was central to the service ethos. All the interventions were run under the banner of 'Aware/Safe/Well' and this was evidenced in the focus groups. Young people/adults felt able to discuss their experiences confidently and honestly. They found the information relatable, which better prepared them for situations where they might feel unsafe or come to harm:

> It's nice that instead of 'oh don't do this', it was 'here's how to do things safely, if something bad goes wrong when you're taking something, this is how to deal with it safely'. (Participant 3, Urban 18–25 Focus Group).

A core aspect of the education sessions was the decision to hold them without the presence of teachers. This formed part of the agreement established with participating schools and colleges, with the rationale that having teachers present would inhibit open and honest dialogue in the sessions. Feedback from the focus groups highlighted that young people wanted to receive information from sources other than parents or teachers. This created a more open environment, and students felt empowered by receiving information they deemed to be reliable, meaningful and non-judgmental:

> He [worker] makes the sessions more engaging than if we had like a teacher talking about it…he's very patient as well. (Participant 4, Urban 16–17 Focus Group).

> For some people, it's easier to talk to strangers than their parents…so people who understand about drugs, than just like parents and teachers, who might look down upon you, or change their opinion of you. (Participant 1, Rural 16–17 Focus Group).

In comparing 1625 Outreach school sessions to regular school drug education, the 1625 Outreach sessions were: 'much more informative and less judgmental' (Participant 5, Urban 18–25 Focus Group). The practical resources given out in education sessions, on outreach and at festivals and pop-up events provided an opportunity for detailed discussion about drink spiking and also facilitated conversations about drugs:

> In most areas you get taught about how to avoid it…but when [worker] comes up to us, he has the spikies and things which are more like physical protection. (Participant 5, Urban 18–25 Focus Group).

Tailoring the interventions to young adults (18–25) rather than young people (under 18) was recognized as being an effective means of engagement in both education and outreach settings:

> The biggest thing for us is that we were treated like just people, we weren't treated like students or like kids. We just had this dude come up to us, start chatting and like it was comfortable. I didn't feel threatened at all and normally I'm on high alert. (Participant 4, Urban 18–25 Focus Group).

### *Agility and adaptability*

It was central to the model that there be a range of approaches, providing extensive reach, flexibility and adaptability. The multi-component framework sought to establish a whole-system approach that integrated universal, selective and indicated prevention strategies. Each component of the model was informed and constantly modified through stakeholder engagement and active local knowledge. This approach engaged young people who were not reached by universal drug education, targeting students excluded from school or with additional education needs, as well as those in further/higher education institutions.

Outreach efforts were directed at locations identified as antisocial behavior 'hotspots' by stakeholders such as the police. This was important for engaging with young people/adults at risk of social exclusion or escalating use. Young adults recognized that providing outreach in different settings meant that those not in formal education settings could also receive drug information and support:

> Having [worker's name] come and talk to us at Silk Mill [local area] and other places is really beneficial, because not every teenager goes to school, because some of them drop out, some of them are home schooled. So it's giving these people different ways to access advice, especially if they are never taught about it. (Participant 3 in Urban 18–25 Focus Group).

The community-based approach facilitated the real-time identification of emerging trends. Observations of team meetings showed a flat, non-hierarchical structure that allowed for open discussions of local issues and new drug consumption patterns, promoting an adaptable and rapid response. For example, in response to increasing ketamine use amongst young people/adults in the region where heavy and prolonged use had caused bladder damage for some users, the team established a referral pathway to a continence clinic. This initiative included raising awareness and educating healthcare workers on the symptoms associated with

ketamine use, as well as promoting non-judgmental communication strategies to ensure that young people/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, for example, working with continence clinics is one of them. We did a little bit of training with them [first-line medical staff, for example, General Practitioners] around it – non-judgmental approaches in terms of how you ask those questions. (Service Manager 1).

Consultation with the 1625 team provided an example of using the local practitioner stakeholder network and the young people themselves to identify and respond to emerging trends around a particular substance referred to as 'Madge'.

> We were working on an education provision of really high-risk 16- or 17-year-olds, who were excluded from mainstream education – quite a lot of challenges with that group. The young people within those spaces were really open with us and were talking about the use of a substance called 'Madge'. (Service Manager 1).

At first, workers speculated that they were referring to MDMA, but it was evident the substance was vaped. Through a process of triangulation with the stakeholder network, the 1625 Outreach team were able to identify it as a potent synthetic cannabinoid and rapidly respond to reports of its widespread use by the 16–25 population. Figure 2 describes the flow of information and response.

1625 Outreach's stakeholder network of education providers, the community and police allowed the substance to be identified, increasing awareness amongst partners and developing tailored harm reduction messages about synthetic cannabinoids in vapes.

> Bringing this to the attention of police as you did has led us to hastily identifying the substance, a process which may have taken a number of months. (Derbyshire 1625 Outreach Partnership Working Report, 2023).

It was clear that young people's trust in 1625 Outreach meant the service was a valuable partner in being able to respond to needs and potential harms:

> I think people come to us because we've got the best connection with the ground because young people tell us stuff they don't tell other agencies. So from an intelligence gathering perspective, I think that we're quite influential in a lot of those spaces. (Service Manager 1).

## Community engagement

### *Building a local stakeholder network*

A community engagement approach [European Monitoring Centre for Drugs and Drug Addiction (EMCDDA), 2023] was employed to establish the service, enabling the 1625 team to become trusted members of the local system. The engagement of community stakeholders and practitioners was facilitated by leveraging existing relationships, the wider organization's reputation and the offer of a service that addressed unmet need:

> We were quite fortunate because [the service provider] already had a presence in Derby. We'd got access to a lot of community stakeholders, but not necessarily ones that were relevant to our age range in that 18 to 25 cohort… A lot of it was a bit of cold calling and door knocking. (Service Manager 1).

Maintenance of the network required connecting with existing groups such as police, Community Safety Partnerships, and educational institutions and participating in established meetings to minimize the time burden for stakeholders. The loss of one such strategic meeting, which had been co-hosted by 1625 Outreach and the Police but had never reconvened after COVID, was felt keenly:

> So we used to be the hosts of one of the strategic groups around children and young people's drug use specifically… over COVID it didn't continue and it was never picked back up again afterwards. (Service Manager 1).

This research allowed stakeholders to convene again with the shared objective of deepening their understanding and enhancing the 1625 Outreach model. Establishing the dedicated Stakeholder Advisory Group (SAG) at the outset of the research marked a significant development, bringing together 'experts by experience' to provide detailed insights into the local context. The SAG members could then engage as community

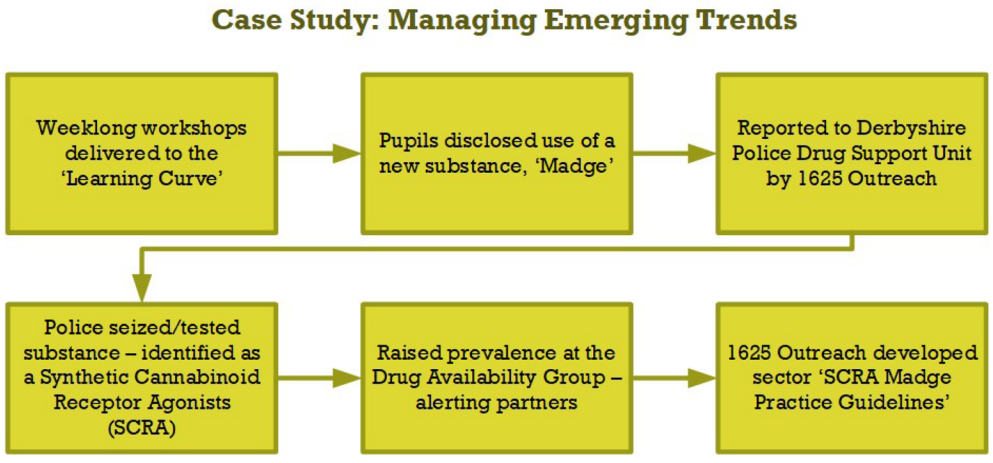


**Figure 2.** Case study: managing emerging trends: responding to reports of new substances.

partners of 1625 Outreach. They shared expertise experiences of service development and ideas for future development. The SAG noted that the 1625 Outreach service was in a key position as 'educators' across all services working with young people/adults. Stakeholders, particularly those from education settings, suggested that 1625 Outreach had proved beneficial in supporting senior managers to reduce stigma from teaching staff about substance use and 'bust myths' around drugs held by parents, teachers and students. The SAG noted that the 1625 service was designed to respond to local problems identified by a wide range of organizations working with young people/adults – including tailoring education sessions to current issues in the local community – rather than offering a 'one size fits all' approach (SAG Minutes, 6th June 2023).

1625 Outreach aimed to use the stakeholder network to establish credibility and help ensure brand recognition of the service as a safe source of information and support, delivering a clear, evidence-based and consistent targeted message across multiple spaces where young people/adults gather.

> I know that what [service lead] did with the different strands of activity was aiming to get that spread. So both big stakeholder networks and then those strands of the digital, outreach, pop-up events at festivals and stuff, just trying to get in as many spaces and raise the profile as much as possible. (Service Manager 2).

The approach aimed to reach seldom-heard groups including those living in rural areas, individuals with neurodivergence, LGBTQI+, and young adults who were not in education, training or employment. These relationships were viewed as important not only in reaching young people/adults, but also in having maximum impact with limited resources.

Having a dedicated team to address young people/adults' recreational drug use provided reassurance for stakeholders across the county, particularly for those in education and the police. The 1625 team's ability to listen to partners' concerns and shape what they offered to their needs was noted by professional stakeholders. Education providers pointed to examples where 1625 Outreach was able to respond quickly to school or college queries about specific incidents, reducing the extent to which the police needed to get involved.

The culture of the 1625 Outreach team felt positive and collegial, offering psychological safety for all staff to be heard (Observer 1, 1625 Team Meeting notes). The team structure was non-hierarchical and democratic. Staff would report on the development of new relationships with stakeholders, engagement with communities they were working with, and how they were continually adapting the model in response to their needs. The team's cohesion and dynamic were partly attributed to the involvement of young people/adults in the recruitment process:

> We have quite a young, dynamic team …I think that's been really helpful. A couple of those young people that were involved in the early stages supported us with recruitment, so interviewing staff to make sure that they got the vibe right. (Service Manager 1).

### *Co-production with young people/adults*

The observations, interviews and focus groups revealed the importance of genuine co-production to help develop each component of the model.

The 1625 Outreach team drew on marketing techniques to involve young people/adults in consulting on branding, designing the content of information materials and developing engagement approaches and interactions across social media. For example, surveys with prize draws on social media informed and refined digital strategy, including how information should be presented across different social media platforms:

> We utilize things like social media quite frequently as part of that co-production consultation…things like market testing with certain content and materials… we'll put out stuff to see which has got the best engagement rate…we make sure that that's targeted to that age range specifically. We also utilize a feedback loop within the education settings that we work in to evaluate the content. (Service Manager 1).

The practitioner focus group and observation of the team meetings demonstrated that digital marketing techniques were employed as a form of co-production to improve social media engagement. These strategies allowed for monitoring trending topics and testing various content delivery styles – for example, during Alcohol Awareness Week, photo content was more popular than talking-head video reels. Similarly, harm reduction advice on nitrous oxide achieved higher engagement when paired with a 'trending' song. The assessment of social media posts was carried out at the end of each month, informing content strategy for the subsequent months. The digital marketing activities were characterized by continuous iteration and evolution to maximize their impact.

Co-production efforts were further supported by introducing volunteering as a service component. Professional stakeholders from education institutions, the police and criminal justice, festival welfare, and mental health organizations noted that volunteering opportunities for students within their festival and night-time economy work allowed volunteers to expand their understanding and skill set. The Practitioner Focus Group highlighted how volunteers could gain valuable work experience in the social care sector whilst actively contributing to the development of interventions, gathering feedback on the interventions and co-designing resources. Involving young volunteers in the delivery of interventions supported the preference young people expressed for information to be provided by someone closer to their age and relatable:

> Get younger people to talk to younger people – you feel like you can talk to someone and you can tell when they're blagging that they know [about drugs] (Participant 3, Urban 16–17 Focus Group).

Co-production opportunities were tailored, with a dialogue and a clear supervisory process that provided support and specific opportunities within a framework in which young people/adults are giving their time for free amid competing demands. The research found that services needed to recognize the short-term nature of engagement or co-production with this group:

> I think being realistic, having a panel of young people or young adults to consult with on a continuous basis just isn't the best method to be able to capture this kind of evolving model. Young people move on…which is what we want. We don't want them to

> engage with services long term. We want to facilitate it when they need it, but we want to give them the skills and knowledge to move on and be fine. (Service Manager 1).

Adapting to a young people/adults' limited timeframe also required fast, creative approaches such as Instagram, surveys via QR codes with targeted prize draws, and place-based consultation and participatory workshops. Co-production was often specific to certain topics or interventions. For example, a 1625 survey on drug and alcohol 'spiking' was shared on social media and through a QR code shared during outreach sessions for young people/adults to complete on their mobile devices. Findings from the survey informed a bespoke spiking information pack with harm reduction resources including cup covers, 'spikies' and torches for visibility in dark settings and to promote safer consumption.

The dynamic and rapid involvement of young people/adults in defining how the 1625 offer evolved allowed for the joint creation of bespoke topics rather than top-down imposition. Focus group discussions with young people/adults included the use of substances as a coping mechanism for deeper concerns, including domestic violence, sexual assault and grooming, peer pressure and bullying. This required access to supporting materials from partner agencies including a referral mechanism to a safeguarding service.

## Challenges

### *Resistance to harm reduction*

The service's harm reduction focus had the potential to be vulnerable to potential changes in the national policy framework, which may shift towards a more punitive attitude to recreational drug use. 1625 Outreach had already had to navigate this and engaged in active communication in education settings and at festivals to reinforce the significance of preventing and reducing harm:

> Something that we learned very quickly with education is that there was a fear – they were scared of us. They were scared of harm reduction. They were scared of the concepts and the methodology that we were going in to use with their students. And they were fearful of repercussions, media, etc., something that we were able to implement off the back of a memorandum of understanding. (Service Manager 1).

> The actual festival companies themselves need to be more accepting that [drug taking] will happen and then they can share stuff like 1625 on their Instagram and be like 'there are people here who can help you'. (Participant 5, Urban 18–25 Focus Group).

As 1625 is a commissioned service, stakeholder attitudes and the policy landscape must be navigated carefully; while the current commissioner was very receptive to the model, the program's capacity to operate depended on this continued support.

In education settings, there were instances where the introduction of harm reduction approaches had been challenged, with practitioners attributing this to schools anticipating parental concerns or objections (Practitioner Focus Group). To manage this, the 1625 team collaborated with schools and colleges to address their concerns and formalize expectations. It was evident that transparency, cooperation, and mutual understanding of responsibilities were crucial in overcoming ethical reservations. This included a move away from 'abstinence versus harm reduction' messaging, and encouraging a non-judgmental dialogue between schools and parents where concerns were raised:

> There was quite a lot of stigma and apprehension around the harm reduction-based model. Just having something that outlines responsibilities on both ends was really helpful, so that there was more of a structured understanding of what we were there to do, particularly because we have policies and an ethos in working with those education providers. [For example], we won't allow teaching staff [from the schools] to be in the room – it really stifles engagement – so we introduced things like a memorandum of understanding based on stakeholder feedback that was helpful. That was a method to be able to capture everybody's working responsibilities, but also offer them a bit more reassurance about what we are there to do. (Service Manager 1).

### *Sustainability*

At the core of 1625 Outreach was a non-hierarchical team able to foster successful partnerships, develop creative interventions on a limited budget and deliver credible, consistent messaging. It was clear from the interviews, stakeholder engagement, observations and focus groups that strong leadership facilitated creative thinking, instilled confidence and motivated a dedicated staff team. The team's culture and shared vision had been pivotal in their ability to work with stakeholders and develop the service. For ongoing sustainability, in the face of any potential leadership or staffing changes or changes in resources, there was a need for a clearly defined model and comprehensive training. This would inform a cohesive recruitment strategy for both staff and volunteers. Understanding the value and impact of the component parts of the model, how it works as a whole and the conditions in place to allow it to thrive would allow the potential for the model to be resourced and replicated in other areas.

The 1625 Outreach team, though small in size, employed innovative methods to leverage existing stakeholder networks. Their capacity and limited resources did, however, constrain their ability to fully meet the demands of the community, reach underserved populations and address all unmet need, particularly in rural areas, where focus group participants consistently highlighted the scarcity of safe and accessible youth services. While the current scope of 1625 Outreach's work was insufficient to replace the previous universal youth service, 1625 Outreach was seen to be providing a 'good safety net' in plugging the gaps left from disinvestment in youth service provision (SAG Minutes and Rural Practitioner Focus Group). Nonetheless, the team's impact remained limited by the size of the staff team and the available resources.

Capacity and limited resources were major challenges not only in responding to commissioning needs, but also in providing a service across a large geographical area. The team of six were working across one of the largest counties of England (by area). This presented a challenge when providing outreach on foot, with workers reporting walking up to eight

miles in an evening, which felt unsustainable (Team Meeting 1 observation notes).

The lack of capacity to provide *in situ* interventions in the night-time economy was noted by stakeholders, who felt that without a stronger presence in this sector, reaching individuals aged 18 to 25 who are not in education would be increasingly difficult (Stakeholder Focus Group). While there was a desire to focus on the night-time economy, 1625 Outreach was aware of the limited options they were able to provide, and decided to concentrate on delivering training on drug policies, awareness and safety to those working in pubs and clubs instead of attempting outreach across the night-time economy:

> It was about lack of resource – the night-time economy is a huge industry. It was never realistic that we were going to be able to engage with all night-time economy stakeholders on a large scale. We weren't in a position where we could have workers on the street every Friday and Saturday night. (Service Manager 1).

## Discussion

The findings from this study highlight the core components required to establish a working drug and alcohol outreach model for young people/adults. They show that there is a gap in service delivery for young people/adults (aged 16 to 25 years) where the age range traverses from 'traditional' youth services into adult provision (starting at age 18 years) within one local authority area in the United Kingdom.

We found three main themes from our analysis: attention to service design, the importance of community engagement and recognition of the challenges in implementing a young adult-focused outreach service. The core service delivery elements broadly align with Fomiatti et al. (2023) literature review. Our findings suggest that young people/adults must be intrinsically involved at all stages of the service design through digital marketing techniques to understand the rapidly changing perceptions of substance use needs. Engaging young people/adults in the planning, developing, implementing, and evaluation of drug prevention programs has a strong evidence base (Aresi et al., 2023; Duke et al., 2023; Dunne et al., 2017; Valdez et al., 2020) and can ensure that services are tailored to and meet the needs of local young people. Our findings show that young people/adults' involvement in these processes will be transitory. Given the transitional phase of young people/adult's lives at this age, this challenges the continuity of co-production and co-design in the service model. Additionally, to avoid piecemeal or tokenistic engagement, we suggest mechanisms need to be in place to monitor and address changes in young people/adult involvement, offering opportunities for one-off contributions as well as more involved input across the different components. The offer of structured, time-bound, peer volunteering programs that include supervision within workforce planning can incentivize engagement for those seeking future career enhancement (Giancaspro & Manuti, 2021).

Similar to reviews of the international evidence [Advisory Council on the Misuse of Drugs (ACMD), 2022; Public Health England, 2015] and standards for drug prevention [United Nations Office on Drugs and Crime (UNODC), 2018], a key finding of this study is that top-down messages focused on 'fear-arousal' rarely have salience with young people/adults.

This age-group actively rejects fear-based messaging based on abstinence alone, but has responded well to positive harm-reduction focused advice. This makes them feel safer and more in control, which is consistent with the literature (Kelly et al., 2006; Krieger et al., 2013). The educator's credibility as relatable, trustworthy and knowledgeable, and the message (honest/candid, non-statistically focused, harm reduction focused) was shown to work better than other approaches (Pender, 2011). Our findings show that messages from a trusted professional (e.g. 'Safe-Man') allowed for imparting key strengths-based health promotion during short teachable moments (Lawson & Flocke, 2009).

Our results confirm that digital strategies can be effective (Monarque et al., 2023; O'Logbon et al., 2024) and that carefully tailored messages should be flexibly designed to vary by social media platform. In this context, short videos, talking heads, graphics or cartoons may be deployed to convey nuanced health promotion messages, but only once they have been co-designed and tested by young people/adults and appropriately formatted. Although social media has been used to enable alcohol consumption, we suggest that co-produced, local social media campaigns may act as a counterbalance to impart nuanced drug harm reduction information. Social media as a means of digital health promotion messages is in its early stages, but our initial findings suggest that this is a promising approach within substance use contexts as it empowers young people/adults within preferred communication channels and reduces future barriers to accessing services (Evans et al., 2020; Liverpool et al., 2020; Malloy et al., 2023).

Our findings also align with Fomiatti et al.'s review (2021) and the wider literature (Collinson & Best, 2019; Salazar et al., 2016; Simmons et al., 2008), in our theme highlighting the importance of effective community partnerships and inter-agency collaboration as essential in providing an agile and flexible response to emerging needs within local areas. We argue that these two components are interconnected, and cultivating stakeholder relationships is a prerequisite for creating a working environment for flexible responses to emerge. We also conclude that community partnerships are vital to sustainability and long-term resourcing.

The 1625 model further highlights the importance of being sufficiently flexible to develop a place-based approach for effectively engaging young people/adults. This involves reaching them in various settings such as festivals and events, educational institutions and the night-time economy (Falcon et al., 2023). Much work on young people's drug outreach is concentrated in urban areas owing to the concentration of need and practical access to the target population (Mercado et al., 2024; Pullen & Oser, 2014). Efforts to engage young people/adults within rural areas have proven more logistically challenging, highlighting the need for tailored social media and online support where face-to-face interactions might not be feasible.

Finally, similar to Fomiatti et al. (2023) findings, we highlight the challenges to service provision and argue that the harm reduction 'offer' as a means of preventing harm and escalation of substance use needs to be theoretically scaffolded clearly and transparently. This allowed for a discussion over stakeholder expectations, where abstinence is the preferred model

compared to a harm reduction approach. Our focus groups with young people/adults found a clear preference for strengths-based harm reduction discussions that allow for the space to discuss more complex issues (encompassing a wide range of topics, including domestic violence, sexual assault, peer pressure, bullying and family relationship problems), which aligns with the wider literature (Dell et al., 2013).

While the outreach approach addresses a gap in current standard service provision, our research indicates a continuing need for bespoke structured treatment specifically for young adults. Outreach activities are effective for education, harm reduction messaging, confidence-building and signposting for further support, however for young people/adults who need more intensive or long-term interventions, the existing adult service provision is inadequate. As in other areas of policy and service provision (Rigby et al., 2021), there is a need for bespoke young adult treatment services. Our findings highlight the need for further research in this area.

This paper has traced the origins of the 1625 Outreach model and how it was developed and refined. It identifies crucial elements of service development in a context of constrained resources. It has not attempted to provide quantitative evidence of the effectiveness of this model. Further work is needed to determine what contextual and environmental elements act as enablers and barriers to the development of young adult service provision.

## Conclusion

We have explored the development of a multi-component model of substance use prevention in one local authority area in England for young people/adults aged 16 to 25 years who may fall outside of traditional youth or adult service provision. The 1625 Outreach service was working towards a co-produced, community engagement approach as a whole system integrated model within which the various outreach strands were embedded. Our findings concur with Fomiatti et al. (2023) review of the literature to highlight the importance of developing credible strengths-based harm reduction and health promotion messages that have been co-designed by young people/adults. We highlight the importance of developing a coherent electronic social media strategy across multiple platforms. The service model should be aligned with effective stakeholder engagement to facilitate an agile response to meet the needs of local young people/adults as they emerge.

## Note

1. Spikies are bottle covers to protect bottled drinks from being spiked with unknown substances. These and other materials offer both practical harm reduction, but also are used as engagement tools to have conversations about staying safe.

## Disclosure statement

Zoë Welch, Katy Hughes and Sam Wright were all employees in Change Grow Live's Research team at the time of the research. The Research team sits within the central Strategy and Partnerships team. Derbyshire 1625 Outreach is a separate, locally commissioned service that sits within Change Grow Live's Children and Young People's Directorate. The remaining authors have no conflicts of interest to declare.

## Ethical approval

The project received ethical approval from the Middlesex University Social Work and Mental Health Ethics Committee (ID 25367) and was overseen by the Change Grow Live Research Governance Group.

## Open access



## Funding

This paper is based on a study funded by the National Institute of Health and Care Research (UK) (NIHR) as part of the Innovation Fund to Reduce Demand for Illicit Substances (NIHR205261). The views expressed are those of the authors and not necessarily those of the NIHR or the Department of Health and Social Care.

## ORCID

Zoë Welch http://orcid.org/0000-0002-4358-4048
Karen Duke http://orcid.org/0000-0002-2567-4218
Katy Hughes http://orcid.org/0009-0005-9881-8314
Arun Sondhi http://orcid.org/0000-0002-4748-5522
Samantha Wright http://orcid.org/0000-0003-2045-8433

## Data availability statement

The datasets generated and/or analyzed during the current study are not publicly available due to potential for identifying participants, but are available from the corresponding author on reasonable request.

## References

Advisory Council on the Misuse of Drugs (ACMD). (2022). *Drug misuse prevention review*. London: ACMD. https://assets.publishing.service.gov.uk/media/628254fbd3bf7f1f433ae0e6/16052022_-_ACMD_Drug_Misuse_Prevention_Report_-_Final__Published_version_.pdf

Aldridge, J., Measham, F., & Williams, L. (2011). *Illegal leisure revisited: Changing patterns of alcohol and drug use in adolescents and young adults*. Routledge.

Andersson, B. (2013). Finding ways to the hard to reach - considerations on the content and concept of outreach work. *European Journal of Social Work*, *16*(2), 171–186. https://doi.org/10.1080/13691457.2011.618118

Aresi, G., Ferrari, V., Marta, E., & Simões, F. (2023). Youth involvement in alcohol and drug prevention: A systematic review. *Journal of Community & Applied Social Psychology*, *33*(5), 1256–1279. https://doi.org/10.1002/casp.2704

Ashton, J. R., & Seymour, H. (2010). Public health and the origins of the Mersey model of harm reduction. *The International Journal on Drug Policy*, *21*(2), 94–96. https://doi.org/10.1016/j.drugpo.2010.01.004

Asthana, S., Gibson, A., Moon, G., & Brigham, P. (2003). Allocating resources for health and social care: The significance of rurality. *Health & Social Care in the Community*, *11*(6), 486–493. https://doi.org/10.1046/j.1365-2524.2003.00454.x

Ballard, P. J., Kennedy, H. K., Collura, J. J., Vidrascu, E., & Torres, C. G. (2023). Engaging youth as leaders and partners can improve sub-

stance use prevention: A call to action to support youth engagement practice and research. *Substance Abuse Treatment, Prevention, and Policy*, *18*, 71. https://doi.org/10.1186/s13011-023-00582-7

Black, D. C. (2021). *Review of drugs part two: Prevention, treatment and recovery: Annexes*. Department of Health & Social Care.

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, *3*(2), 77–101. https://doi.org/10.1191/1478088706qp063oa

Change Grow Live. (2019). *Derbyshire 1625 outreach impact report. Prepared for Derbyshire 1625 outreach for Derbyshire police and crime commissioner*. Change Grow Live, Derbyshire.

Collinson, B., & Best, D. (2019). Promoting recovery from substance misuse through engagement with community assets: Asset based community engagement. *Substance Abuse: Research and Treatment*, *13*, 1178221819876575. https://doi.org/10.1177/1178221819876575

Del Boca, F. K., McRee, B., Vendetti, J., & Damon, D. (2017). The SBIRT program matrix: A conceptual framework for program implementation and evaluation. *Addiction (Abingdon, England)*, *112*(Suppl. 2), 12–22. https://doi.org/10.1111/add.13656

Dell, C. A., Duncan, C. R., DesRoches, A., Bendig, M., Steeves, M., Turner, H., Quaife, T., McCann, C., & Enns, B. (2013). Back to the basics: Identifying positive youth development as the theoretical framework for a youth drug prevention program in rural Saskatchewan, Canada amidst a program evaluation. *Substance Abuse Treatment, Prevention, and Policy*, *8*,36. https://doi.org/10.1186/1747-597X-8-36

Duke, K., Gleeson, H., Dabrowska, K., Dich Herold, M., Rolando, S., & Thom, B. (2023). Building cultures of participation: involving young people in contact with the criminal justice system in the development of drug interventions in the United Kingdom, Denmark, Italy and Poland. *Youth Justice*, *23*(1), 97–116. https://doi.org/10.1177/14732254221075206

Duke, K., Thom, B., & Gleeson, H. (2020). Framing 'drug prevention' for young people in contact with the criminal justice system in England: Views from practitioners in the field. *Journal of Youth Studies*, *23*(4), 511–529. https://doi.org/10.1080/13676261.2019.1632818

Dunne, T., Bishop, L., Avery, S., & Darcy, S. (2017). A review of effective youth engagement strategies for mental health and substance use interventions. *The Journal of Adolescent Health: Official Publication of the Society for Adolescent Medicine*, *60*(5), 487–512. https://doi.org/10.1016/j.jadohealth.2016.11.019

European Monitoring Centre for Drugs and Drug Addiction (EMCDDA). (2023). *Local communities and drugs: Health and social responses*. EMCDDA.

Evans, W., Andrade, E., Pratt, M., Mottern, A., Chavez, S., Calzetta-Raymond, A., & Gu, J. (2020). Peer-to-peer social media as an effective prevention strategy: Quasi-experimental evaluation. *JMIR mHealth and uHealth*, *8*(5), e16207. https://doi.org/10.2196/16207

Fadus, M. C., Squeglia, L. M., Valadez, E. A., Tomko, R. L., Bryant, B. E., & Gray, K. M. (2019). Adolescent substance use disorder treatment: An update on evidence-based strategies. *Current Psychiatry Reports*, *21*(10), 96. https://doi.org/10.1007/s11920-019-1086-0

Falcon, A., Halstead, V. A., & McCabe, B. E. (2023). College students' experiences with substance use at electronic music events: A qualitative study. *Journal of American College Health: J of ACH*, *71*(3), 686–694. https://doi.org/10.1080/07448481.2021.1904953

Fomiatti, R., Farrugia, A., Fraser, S., & Hocking, S. (2023). Improving the effectiveness and inclusiveness of alcohol and other drug outreach models for young people: A literature review. *Drugs: Education, Prevention and Policy*, *30*(2), 105–114. https://doi.org/10.1080/09687637.2021.1975652

Giancaspro, M. L., & Manuti, A. (2021). Learning to be employable through volunteering: A qualitative study on the development of employability capital of young people. *Frontiers in Psychology*, *12*, 574232. https://doi.org/10.3389/fpsyg.2021.574232

Glaser, B. G., & Strauss, A. L. (1967). *The discovery of grounded theory: Strategies for qualitative research*. Aldine Publishing. [Database].

Gordon, R. S.Jr. (1983). An operational classification of disease prevention. *Public Health Reports (Washington, D.C.: 1974)*, *98*(2), 107–109.

Halsall, T., Mahmoud, K., Pouliot, A., & Iyer, S. N. (2022). Building engagement to support adoption of community-based substance use prevention initiatives. *BMC Public Health*, *22*(1), 2213. https://doi.org/10.1186/s12889-022-14496-9

Henderson, J. L., Chaim, G., & Brownlie, E. B. (2017). Collaborating with community-based services to promote evidence-based practice: Process description of a national initiative to improve services for youth with mental health and substance use problems. *Psychological Services*, *14*(3), 361–372. https://doi.org/10.1037/ser0000145

Kelly, K. J., Comello, M. L. G., & Slater, M. D. (2006). Development of an aspirational campaign to prevent youth substance use: "Be Under Your Own Influence". *Social Marketing Quarterly*, *12*(2), 14–27. https://doi.org/10.1080/15245000600721735

Kimmel, S. D., Gaeta, J. M., Hadland, S. E., Hallett, E., & Marshall, B. D. L. (2021). Principles of harm reduction for young people who use drugs. *Pediatrics*, *147*(Suppl. 2), S240–S248. https://doi.org/10.1542/peds.2020-023523G

Krieger, J. L., Coveleski, S., Hecht, M. L., Miller-Day, M., Graham, J. W., Pettigrew, J., & Kootsikas, A. (2013). From kids, through kids, to kids: Examining the social influence strategies used by adolescents to promote prevention among peers. *Health Communication*, *28*(7), 683–695. https://doi.org/10.1080/10410236.2012.7628

Lawson, P. J., & Flocke, S. A. (2009). Teachable moments for health behavior change: A concept analysis. *Patient Education and Counseling*, *76*(1), 25–30. https://doi.org/10.1016/j.pec.2008.11

Lazarus, L., Shaw, A., LeBlanc, S., Martin, A., Marshall, Z., Weersink, K., Lin, D., Mandryk, K., & Tyndall, M. W, PROUD Community Advisory Committee. (2014). Establishing a community-based participatory research partnership among people who use drugs in Ottawa: The PROUD cohort study. *Harm Reduction Journal*, *11*(1), 26. https://doi.org/10.1186/1477-7517-11-26

Liverpool, S., Mota, C. P., Sales, C. M. D., Čuš, A., Carletto, S., Hancheva, C., Sousa, S., Cerón, S. C., Moreno-Peral, P., Pietrabissa, G., Moltrecht, B., Ulberg, R., Ferreira, N., & Edbrooke-Childs, J. (2020). Engaging children and young people in digital mental health interventions: Systematic review of modes of delivery, facilitators, and barriers. *Journal of Medical Internet Research*, *22*(6), e16317. https://doi.org/10.2196/16317

Lutfiyya, M. N., McCullough, J. E., Haller, I. V., Waring, S. C., Bianco, J. A., & Lipsky, M. S. (2012). Rurality as a root or fundamental social determinant of health. *Disease-a-Month: DM*, *58*(11), 620–628. https://doi.org/10.1016/j.disamonth.2012.08.005

Malloy, J., Partridge, S. R., Kemper, J. A., Braakhuis, A., & Roy, R. (2023). Co-design of digital health interventions with young people: A scoping review. *Digital Health*, *9*, 20552076231219117. https://doi.org/10.1177/20552076231219117

Mercado, M., Drobnyh, K., Gentry, K., Law, L., Shuman, S., Dibarrart, F., … Ferguson, K. (2024). Engagement in outreach services among persons experiencing unsheltered homelessness in a Southwestern Urban County: A spatial study, Preprint (Version 1), available at Research Square. https://doi.org/10.21203/rs.3.rs-5327707/v1

Monarque, M., Sabetti, J., & Ferrari, M. (2023). Digital interventions for substance use disorders in young people: Rapid review. *Substance Abuse Treatment, Prevention, and Policy*, *18*(1), 13. https://doi.org/10.1186/s13011-023-00518-1

Needle, R. H., Burrows, D., Friedman, S. R., Dorabjee, J., Touzé, G., Badrieva, L., & Latkin, C. (2017). Effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users. In *Drug abuse: Prevention and treatment* (pp. 189–201). Routledge.

O'Logbon, J., Wickersham, A., Williamson, C., & Leightley, D. (2024). The effectiveness of digital health technologies for reducing substance use among young people: A systematic review & meta-analysis. *Journal of Mental Health (Abingdon, England)*, *33*(5), 645–673. https://doi.org/10.1080/09638237.2023.2245902

Office for National Statistics (ONS). (2023). *Drug misuse in England and Wales: Year ending March 2023*. https://www.ons.gov.uk/peoplepopulationandcommunity/crimeandjustice/articles/drugmisuseinenglandandwales/yearendingmarch2023

Office of Health Improvement and Disparities (OHID) (2023). (2023). *Adult substance misuse treatment statistics 2022 to 2023: Report Updated 21*

December. https://www.gov.uk/government/statistics/substance-misuse-treatment-for-adults-statistics-2022-to-2023/adult-substance-misuse-treatment-statistics-2022-to-2023-report

Paquette, K. L., Pannella Winn, L. A., Wilkey, C. M., Ferreira, K. N., & Donegan, L. R. W. (2019). A framework for integrating young peers in recovery into adolescent substance use prevention and early intervention. *Addictive Behaviors*, *99*, 106080. https://doi.org/10.1016/j.addbeh.2019.106080

Pender, N. J. (2011). Heath promotion model manual. University of Michigan.

Public Health England. (2015). The international evidence on the prevention of drug and alcohol use: Summary and examples of implementation in England.

Pullen, E., & Oser, C. (2014). Barriers to substance abuse treatment in rural and urban communities: Counsellor perspectives. *Substance Use & Misuse*, *49*(7), 891–901. https://doi.org/10.3109/10826084.2014.891615

Rigby, E., Hagell, A., Davis, M., Gleeson, H., Mathews, G., & Turner, G. (2021). Getting health services right for 16–25 year-olds. *Archives of Disease in Childhood*, *106*(1), 9–13. https://doi.org/10.1136/archdischild-2019-318648

Salazar, A. M., Roe, S. S., Ullrich, J. S., & Haggerty, K. P. (2016). Professional and youth perspectives on higher education-focused interventions for youth transitioning from foster care. *Children and Youth Services Review*, *64*, 23–34. https://doi.org/10.1016/j.childyouth.2016.02.027

Shin, H. Y., Kim, K. Y., & Kang, P. (2020). Concept analysis of community health outreach. *BMC Health Services Research*, *20*(1), 417. https://doi.org/10.1186/s12913-020-05266-7

Simmons, R., Ungemack, J., Sussman, J., Anderson, R., Adorno, S., Aguayo, J., Black, K., Hodge, S., & Tirnady, R. (2008). Bringing adolescents into substance abuse treatment through community outreach and engagement: The Hartford Youth Project. *Journal of Psychoactive Drugs*, *40*(1), 41–54. https://doi.org/10.1080/02791072.2008.10399760

Steele, D. W., Becker, S. J., Danko, K. J., et al. (2020). Interventions for substance use disorders in adolescents: A systematic review. Agency for Healthcare Research and Quality (US), Rockville (MD). PMID: 32479039. https://www.ncbi.nlm.nih.gov/books/NBK557291/

Stimson, G. V., Eaton, G., Rhodes, T., & Power, R. (1994). Potential development of community oriented HIV outreach among drug injectors in the UK. *Addiction (Abingdon, England)*, *89*(12), 1601–1611. https://doi.org/10.1111/j.1360-0443.1994.tb03761.x

Sumnall, H. (2023). *Understanding recent changes in young people's drug use in the UK: Findings from the AMOUNT project, Webinar 5th October 2023*. Liverpool John Moores University.

United Nations Office on Drugs and Crime (UNODC). (2018). *International standards on drug use prevention* (2nd ed.). Vienna: UNODC. https://www.unodc.org/unodc/en/prevention/prevention-standards.html

Valdez, E. S., Skobic, I., Valdez, L., O Garcia, D., Korchmaros, J., Stevens, S., Sabo, S., & Carvajal, S. (2020). Youth participatory action research for youth substance use prevention: A systematic review. *Substance Use & Misuse*, *55*(2), 314–328. https://doi.org/10.1080/10826084.2019.1668014