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Understanding the needs of local youth to inform drug and alcohol prevention and harm reduction services: A qualitative study

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Abstract

Issue addressed: Reducing drug and alcohol harm is a public health priority and the Australian government has adopted a harm minimisation approach to policy. Understanding the needs of local youth is necessary for the design of relevant prevention and harm reduction services.

Methods: Using 5 unstructured focus groups and 10 interviews involving 30 participants recruited from different settings, this study explored youth perspectives around alcohol and other drugs and the psychosocial factors that influence their substance use.

Results: Three main themes were identified. First, young people perceived that drugs fell into a hierarchy related to the harm they cause and the stigma associated with use. Second, the importance of validating a young person's experience with using drugs (regardless of where they were placed on their substance-use trajectory) as a measure to increase the credibility of drug education programs. Third, the significant influence of peers on young people's drug attitudes and behaviours.

Conclusions: Drug and alcohol education strategies must be more explicit regarding harm across all drug types, regardless of legal status or perceived social acceptability. Prevention services would benefit from including lived realities from young people's varied and changing experiences with using substances. Peer involvement in the design of preventive strategies (and involvement in participatory research to identify felt needs) is paramount to ensure teachings are grounded in a young person's social context and lived realities.

So what?: This study provides information to guide the development of appropriate and authentic drug and alcohol prevention and harm reduction services for young people.

KEYWORDS

adolescent, focus groups, harm reduction, health education, social environment

1 | INTRODUCTION

Drug and alcohol use in Australia is a complex public health issue, contributing to thousands of deaths, substantial illness and injury, family and relationship breakdown, lost productivity, violence, incarceration and community wellbeing and safety issues.[1] While drug harm impacts all population groups, young people represent a vulnerable demographic.[2–4] In 2015, for example, alcohol and illicit drug use were the leading causes of total burden of disease in males aged 15-24 and the second and third leading causes for females

aged 15-24 in Australia.[3–4] The most recent National Drug Strategy Household Survey found young people aged 14-29 years were more likely to binge drink, and to have used cannabis, ecstasy or cocaine in the previous 12 months than any other population group.[1] Delaying drug and alcohol use among young people is a priority and delaying initiation has long-term protective effects against the harmful use of substances and negative health outcomes.[5–7]

Since the late 1980s, the Australian government has worked to reduce drug-related harm among populations by adopting a harm minimisation approach to policy, based on the three pillars of demand reduction, supply reduction and harm reduction.[1] This includes the commitment toward funding for preventive and harm reduction strategies.[8] Despite the implementation of a range of alcohol and other drug (AOD) prevention initiatives,[9] published literature has not consistently demonstrated their effectiveness in reducing actual substance use among program participants.[10,11] Some of the most effective AOD preventive programs have been successful because they first identified and then addressed the needs of the target population.[12–14] This suggests that formative research at the planning stage is important, when the goal is to learn as much as possible about how the target demographic thinks and behaves in relation to the issues being addressed.[15] Young peoples' interest and enthusiasm must be engaged and health promotion material should relate to the experiences, skills, knowledge and socio-cultural norms of the target group.[14] A commitment to community participation and community empowerment also reflects the priorities outlined in the Ottawa Charter for Health Promotion.[16] Wright and colleagues[15] argue that assessing the needs of a community should involve both epidemiological and qualitative methods to determine priority areas which incorporate consumer voices.

1.1 | Setting

South Western Sydney Local Health District (SWSLHD) represents one of the most ethnically diverse and populous health districts in New South Wales (NSW), with close to 50% of the population born overseas and 51% speaking a language other than English at home.[17] The region is a major point of refugee settlement and home to some of the largest Aboriginal communities in metropolitan Sydney.[17,18] The latest census data shows that four of the seven Local Government Areas (LGA) rank among the most disadvantaged areas of NSW in terms of employment, income and educational status.[19] More residents in SWSLHD report very high psychological distress compared to the NSW average[20] and the demand for holistic and integrated alcohol and other drug and mental health services is high.[18] Community understanding of and education about alcohol and other drug issues is considered a priority for the region.[18] The number of young people living in the region continues to grow and by 2026 is expected to reach over 339 500.[17] Underage binge drinking appears to be one of the top AOD issues, with roughly one third of young people aged 16-24 years drinking alcohol at risky levels in 2003.[21] The lack of more timely age-specific data, due to the periodic nature of state survey data collection, impedes the ability to address alcohol and drug issues for youth populations.

Youth Solutions is a youth drug and alcohol prevention and health promotion charity based in South Western Sydney. Youth Solutions work with young people aged 12-25, developing and delivering AOD education and harm reduction programs to local schools and community groups, in an effort to prevent and reduce alcohol and drug related harm among young people. Charity organisations, like Youth Solutions, are often reliant on population survey data to identify the needs of their target audience. The results presented in this paper form part of a broader research aim to build capacity for small charities and the Non-Government Organisation (NGO) sector to prioritise internal formative research, with a purpose to qualitatively explore the felt needs of the individuals, families and communities they support.

The purpose of the research was to inform AOD preventive strategies for young people in South Western Sydney. It was guided by three research questions.

1. What are the drug and alcohol priorities among young people living in South West Sydney?
2. What are the psychosocial influences on young people's drug and alcohol attitudes and behaviours?
3. What are the lessons for designing appropriate and inclusive alcohol and drug prevention and harm reduction programs for young people?

2 | METHODS

2.1 | Approach

The research used a constructivist grounded theory (CGT) approach,[22] recognising the active co-creation of knowledge that exists in qualitative research studies. Researchers and research participants each have their own socially constructed reality and findings therefore represent a collation of interpretations of multiple lived realities,[23] mutually constructed by the researchers and participants in this study. A CGT approach treats research as a social construct and acknowledges the value of subjectivities and that an individual's experience can shape what stands as facts.[22]

2.2 | Ethics

Ethics approval was received from the Human Research Ethics Committee at Western Sydney University (H12964) and through the State Education Research Applications Process (RN 2018864). The team also sought ethics from the Aboriginal Health & Medical Research Council Ethics Committee (RN 1496/19), due to the large proportion of Aboriginal and Torres Strait Islander people living in the region (although no young people identified as Aboriginal or Torres Strait Islander). Potential participants were given an

information sheet about the study and gave their written and verbal consent prior to participating. For young people under 16 years, parental, guardian or caseworker consent was also sought.

2.3 | Recruitment

Participants were recruited using purposive sampling techniques.[24] We sought to recruit young people aged 12-25 from South Western Sydney. Participants were recruited from alcohol and other drug and mental health services and from the broader community. We employed a range of strategies to recruit participants including posts on social media (Youth Solutions' Facebook page), stories in Youth Solutions' Newsletter, and information about the study on Youth Solutions' website. To begin, we relied on Youth Solutions' existing networks with local Youth AOD and mental health services to recruit participants, and as the study progressed, on snowball techniques to recruit the remaining participants. Recruitment was limited by funds, and ceased once we had reached 30 participants.

2.4 | Data collection

Semi-structured, audio-taped interviews (n = 10) and focus groups (n = 5) lasting between 60 and 90 minutes were conducted in 2019 by author 1 and author 2 and were guided by four broad 'conversation starters':

1. Tell me about your experiences with using alcohol (and other drugs) …
2. What influences your alcohol and drug use?
3. What about help services for alcohol and other drug issues? Can you tell me about any services you have accessed?
4. What are your thoughts on alcohol and drug education programs?

Refreshments were provided and participants also received a $20 music or clothing voucher as reimbursement for their time.

2.5 | Data analysis and interpretation

All transcripts were uploaded to QSR NVivo 12 which was used as a tool to manage the data. Initial data coding, analyses and interpretation were conducted independently by author 1 and author 2. Initially, we used open coding techniques[25] (assigning labels to data to summarise in a word or short phrase the issue or concept based on their meaning) to identify narratives that specifically related to the psychosocial factors that shaped young people's drug use, and the narratives surrounding preventive strategies. Author 1 and author 2 read and re-read transcripts (and listened to audio), employing a constant comparative method[26] to identify similarities and differences in the data. Primary findings were discussed among the broader research team for interpretation mid-way through the data collection and analysis phase, and again at the completion of data collection.

3 | RESULTS

3.1 | Participants

In total, 30 young people participated in the study, aged 13-25 years with 47% aged less than 18 years (mean = 18 years, SD = 4). Eleven participants were recruited from AOD and mental health services in SWS and nineteen young people were recruited from the broader community. Of the sample, 53% were female, and 47% were male. Over two-thirds of the sample (n = 21, 70%) were from low socio-economic areas of advantage, with close to one third from moderate (n = 4, 13%) to high (n = 5, 17%) socio-economic areas of advantage.

Three broad qualitative themes were identified: drug hierarchies, harm recognition depends on experience, and the influence of peers. Participants took up different positions across these themes depending on where they were along developmental and substance use trajectories. Participants' substance use trajectories, in particular, varied: from those who had experienced significant harm and were seeking support from a treatment or counselling service; to those who were experimenting, moving to more habitual use and at the time of study experiencing no adverse consequences from their drug use; to those who had been abstinent their entire lives due to family members fighting drug dependencies or growing up in areas exposed to drug dealing and drug use. Differences between males and females and across socio-demographic groups were not prominent in the data.

3.2 | Drug Hierarchies: *"I've done drugs, but meth is the one thing I will never touch"*

The first theme identified from participant's narratives related to the socialisation of particular types of drugs, with participants describing drugs through a hierarchical lens. For example, often cited as "bad" or "hard" drugs, substances such as heroin and crystal methamphetamine were perceived to cause significant harm to communities, families and individuals, when compared to "soft" substances. This appeared to be influenced by a number of factors, including media portrayals (for example, news stories and movies), music, but most importantly, the accessibility of products, and the level at which young people came across these substances in their own social lives.

As shown in Figure 1, substances that were perceived to cause the most harm were drugs that were shamed, feared, stigmatised and which participants perceived as socially unacceptable. Participants repeatedly associated 'addiction' with heroin *"it's so easy to get addicted, you just shoot it with a needle"* (Male 23 yrs, previous user) and labels like "junkie" were often used to describe the "problem people" who used crystal methamphetamine. The

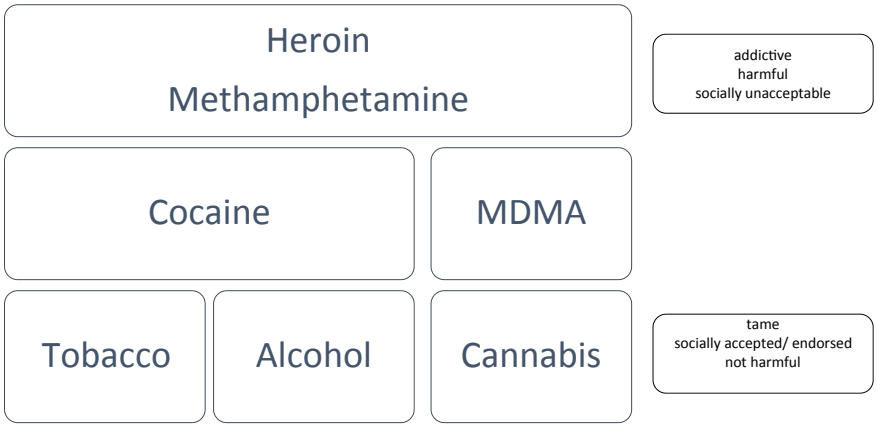

FIGURE 1 Drug hierarchy: young peoples perceptions

following young male (15 yrs, never used) implied that such drug users were "out of sight, out of mind" explaining: *"I don't know anyone that would fit the category of an ice addict"*. To a lesser degree, cocaine was also feared and stigmatised among participants. Participants described a lack of interest in experimenting with substances that were perceived as "hard," acknowledging the unease they felt when they came across them in their social lives. The following quotation is illustrative of this notion.

> I went to a party probably last year or the year before and there were people shooting up in the bathrooms, and doing lines of cocaine off each other and stuff. That made me feel really uncomfortable, so I left. I was uncomfortable and I wanted to go home. I feel like weed is so normal these days whereas cocaine, they are, they're just things you don't come across very often.
>
> (Female 23 years, never used)

Alcohol, tobacco and cannabis were more often described as "normal," "tame" and for one young man (19 years, sometimes used), unlikely to "hurt anyone" and who recommended "if you had to use something, use weed." This finding was consistent, despite participants having different experiences with drug use (and harm), and appeared to stem directly from social norms and the familiarity of these substances in participants every day discourse. For the young man quoted below, smoking tobacco was a weekly venture for his social group, and when compared to other illicit substances that were used among the group, a relatively minor affair:

> For my friends, they smoke every weekend. I know, like smoking, it's not good for you but it's not the worst, it's still very, very tame compared to everything else.
>
> (Male 25 years, sometimes used)

The socialisation of cannabis was also evident, and was a drug that was repeatedly compared to and categorised with alcohol and tobacco. Participants described being offered "weed" at parties, with a few participants incorrectly believing that recreational cannabis use was legal in NSW for people aged 18 and over. Participants were aware of the physiological effects of the drug, and if used, would often use in more informal and relaxed social environments. For example, while hanging out with mates in a home environment, watching cartoons and eating nachos (Male, 23 years, frequent user). Participant's lived experience of cannabis was generally positive (as explored in greater detail in theme 2). Conversations about cannabis were also common among the participants' peer group, and a common part of social gatherings for almost all participants.

> I think weed is really normal, like if you go to a party, the odds are that people are gonna be either talking about it, or smoking it. I've never been offered anything else, except for weed.
>
> (Female, 21 years, sometimes used)

3.3 | Harm recognition depends on experience: *"I've never experienced that and neither has anyone I know"*

The second theme identified from participants' narratives related to the inconsistencies between drug and alcohol education and young people's personal and social experiences. Participants early in their substance use trajectory, in particular, expressed distrust in preventive strategies, due to the fact that the information taught often contradicted their own experiences. Looking back, a 23-year-old male (frequent user) participant explained: *"my health teacher exaggerated the effects of weed, not only had I not experienced that, but no one I know had experienced that effect either"*. Thus there was a discord between experience and education, which had the effect of invalidating education messages about the long-term consequences of drug use and led some participants to rely on their friends for harm reduction information:

> My friends know everything about it, they know how to recognise an overdose, know how much to take for a specific person and how their body size will affect it, and how someone will react, what you

> will feel, and what to expect when you take a drug and how to treat someone and stay safe while you are on it.
>
> (Male, 19 years, frequently used)

Participants early in their substance use trajectories also focused on the "good experiences" and "great memories" of their drug use. Positive experiences included successfully "self-medicating" for past trauma and present mental illness, to being better able to connect and open up to their peers, to the successful management of physical health concerns, including using cannabis to gain weight.

> Marijuana helps keep me sane, keeps me level headed, helps me with my stress levels, particularly throughout the week if I'm having a stressful week. I feel calm, peace of mind, it helps me sleep better and in this weather, it keeps me warm too. I still use it, only once a fortnight now, and it's close to the weekend, that way it doesn't interfere with my responsibilities, I can still go places and show up for my appointments.
>
> (Male 23 years, frequently used)

For one male participant (19 years, frequently used) who was beginning to routinely use MDMA and cannabis, his experiences with these substances led to an inability to understand how they caused harm for individuals, and why public health set out to prevent and discourage use: "I've seen so much good come from MDMA and I don't see why it's so frowned upon given my experience." At times, drug use was the vector for peer support, authenticity and transparency and this was particularly the case with participants who used MDMA in capsule form ('caps').

> When you do caps, you feel so good. I had two of my mates do caps for the first time on the weekend, they described it as such a clean experience compared to getting drunk, they felt more in control of themselves and aware of what they were doing. They said they made stronger relationships that night than half of their friends have had for like 7 years. It's just pure euphoria doing caps, a full serotonin release straight through your body, it's the greatest thing for us.
>
> (Male 19 years, frequently used)

These experiences appeared to further invalidate health promotion and AOD support messages for participants, particularly messages that were rooted in abstinence and "zero tolerance" approaches. Participants believed that harm reduction efforts which aimed to convey the realities of long-term drug use (and its consequences) needed to incorporate lived experience, with an honest acknowledgement of the positive and negative effects that drugs may have for individuals: "show an experience, rather than saying drugs are bad, don't take them" (Female, 16 yrs, never used). The following young male (15 yrs, sometimes used) explained that he would like to hear from someone who had walked that path: "*I would talk to someone who has gone through this stuff, someone who has life experience*".

In contrast to the positives some experienced, participants at the end of their drug trajectory or who had been using for a longer period of time, reported having experienced harm from drug use, describing how drug use had limited their opportunities, led to poor decision making and contributed to mental illness or trauma. A 19-year-old male (previous user) who was positioned at the end of his substance-use trajectory described how using cannabis and alcohol with an undiagnosed mental illness further exacerbated his condition and led to suicidal ideation. He spoke about the need to step away from alcohol in particular to manage his mental illness:

> I was buying bottles of whisky every week. I went through that in under a week, then I bought another one. I bought two in a week and it just went like that. I drunk the whole thing to myself in one night, in a couple of hours, which I think is like 20 standard drinks. I passed out and threw up, my mum ended up calling the ambulance on me 'cause she thought I was dead. I shouldn't drink, well I can't drink at all now because with the medication I'm on and just the whole mental health side of things. I'll wake up and pretty much feel suicidal, I can't drink so there's no temptation.
>
> (Male, 19 years, previously used)

Another female described the harm she had experienced while intoxicated, which had led to an incident that caused significant trauma, for herself and her family. She detailed her experience of being sexually abused at a nineteenth birthday party she had attended, and the complications in court that followed. She encouraged adolescents and those beginning to experiment with drugs not to fall into the trap of feeling invincible and in control. She said:

> A lot of people my age don't realise the enemies ahead of us. You can't have rose coloured goggles on and think that nothing is going to happen. For me it went from carefree drinking, to OK shit there is repercussions for this.
>
> (Female, 21 years, previously used)

While the legal and moral responsibility for sexual assault always rests with the perpetrator, this participant's experience contests the view that substance use is always a positive experience.

3.4 | The influence of peers: *"they were all doing it, I was curious, so I tried it"*

The influence of peers on the experimentation of drug use was evident in numerous accounts and peer contexts appeared to be the launching pad into more frequent and habitual drug use. Participants described being introduced to substances, particularly alcohol,

tobacco and cannabis, in social environments with their peers. For participants who described being part of communities where drug use was more common, experimentation was natural, a standard part of their social realities, as indicated by a 16-year-old male (sometimes used): *"I smoke to fit in with my friends, you just grow into it"*. Another young female (25 years, frequent user) explained that her peer group was the site of knowledge transfer: *"I learnt how to do drugs from my friends, my friends were drug users, they taught me and they looked after me, then you learn yourself, and then you pass on that knowledge, it's a journey, it's a community, it's a family"*. Others attributed the intrigue of experimentation and the desire to "experience" the effects that their friends had as the primary motivator to use drugs.

> It's who you hang out with, you meet the people, you'll find out what they actually do and then they'll be like 'try it', next minute you will want to do it, next minute you crave it and then it becomes this normal thing that you just keep doing. It's the people you hang out with, they feed it to you.
>
> (Female, 15 years, previously used)

Participants described an inherent pressure to use (and to continue using), which was not always welcomed and at times frustratingly difficult for participants to overcome, as indicated by a 25-year-old male (sometimes used): *"they made me feel bad for wanting to quit smoking and made me feel bad for wanting to slow down my drinking"*. At times, nonparticipation carried social sanctions for participants, resulting in name calling and labels, as indicated by a 21-year-old female (sometimes used) *"don't be a bitch, just do it"*. The following male, despite efforts to quit using tobacco, described an implicit pressure to smoke at the parties which he attended with his mates.

> My friends smoke, that doesn't help. It's hard to make a good decision when you're intoxicated, like wanting a cigarette and acting on impulse. I feel like there's a bit of pressure, maybe that's what they expect me to do, they really want me to have one, there is always one person at a party who is handing out cigarettes, turning it into a bigger party.
>
> (Male 23 years, frequently used)

Participants' narratives implied that alcohol and other drug education programs should recognise the implicit (and at times explicit) pressure that young people experience with regards to drug use, and equip young people with the skills to navigate a social context that may encourage risk decision making. Older participants believed that it was the role of youth prevention services to share knowledge and skills to prepare young people to make their own decisions, regardless of whether they chose to use drugs or not.

> I think scenarios are good. I remember doing scenarios when I was in school and they would be like 'oh you're at a party and your friend offers you this and what do you do?', especially for kids that like, don't necessarily want to drink, it helps them, kind of get the vocabulary to be able to talk to their friend about not wanting to. Or if they want to take drugs, or have alcohol, then they know the appropriate standard drinks that they can have, that would be still safe and not put them in a situation that they don't wanna be in.
>
> (Female, 21 years, never used)

For those less familiar with drug use, and who were only experimenting or had only recently become more habitual users, peer influences played an important role in keeping them "safer" around drugs, supporting them by implementing harm reduction measures while using together. This included testing pills and sharing knowledge with each other about "correct" dosage. Friends who understood how to minimise harm while using drugs were admired, and for the more "naïve" drug user, friends were an important part in providing a "safer" place to experiment with drug use. Some participants had friends who routinely tested their own drugs, understood the dangers of laced pills, and were aware of what to do if a friend over dosed. For these participants, drug checking appeared to function as an education tool about the risk of exposure to unexpected substances.

> We went on our schoolies trip and smoked weed for the first time, then did MDMA for the first time. All me mates around me were teaching me about it because I had a couple of guys that were doing it while they were at school, they had experience with it, knew how to manage it, knew how to do it properly, so I had that really good support of knowing what I'm doing and how to do it.
>
> (Male, 19 years, frequently used)

Participants who were not involved with illicit substances believed there was merit in young people being the advocates and leaders of preventive strategies, noting that the gold standard would be young people looking after young people; championing their own services and directing their own journey towards harm minimisation and risk management.

> The ideal drug and alcohol treatment services for someone my age should be something friendship based, if you and all your friends clean yourselves up together than it becomes a lot easier because you can go 'let's all go out for dinner instead of going home to do lines, instead of going home to smoke bongs'.
>
> (Female, 21 years, previously used)

4 | DISCUSSION

This study investigated the psychosocial factors that influence young people's drug use, seeking to identify the lessons in developing appropriate preventive strategies for young people. The findings raise four main points for further discussion.

First, the findings show that for some young people there exists a clear drug hierarchy with stigmatised drugs, namely heroin, crystal methamphetamine, and to a lesser degree cocaine, at the top of the harm pyramid. This has implications for the way in which other drugs (often those which are legal, highly accessible and socially accepted) are silenced as drugs which can cause harm for individuals and communities despite evidence to the contrary. The most obvious examples are alcohol and tobacco; while overall consumption of these substances has been declining among young people, these substances significantly contribute to the burden of disease among adolescents[2,27] and continue to enjoy strong cultural accommodation (a dimension of normalisation whereby certain drugs are accepted by society more broadly as a "liveable with" reality[28]) in Australia.[29]

Another implication for public health is the gradual socialisation and perceived normalisation of cannabis (and to a lesser degree MDMA) use among young people. Over the past decade there has been considerable debate about whether or not cannabis, when used recreationally, is harmful.[30] This does not debunk, however, that cannabis use can have significant negative health and psychosocial outcomes for some users.[31] Parker and colleagues'[28] theoretical model on the normalisation of drugs in society is useful in understanding the dimensions of how substances, like cannabis, may become socialised into an individual's every day and normalised within society more broadly. Parker et al[28] propose the following five key dimensions to normalisation: the access and availability of those products, the willingness of people to try and experiment products, whether products have been recently or regularly used, whether products are socially accepted, and whether products are culturally accommodated. Preventive efforts must not lose sight of the important messages surrounding substances which are legal, accessible, more commonly used and socially accepted. Preventive strategies must work to denormalise substances (not in an effort to stigmatise) rather, to allow space for young people to choose not to use substances, and to not suffer social sanctions as a result. Drawing upon prevalence data around the historically low levels of tobacco use and age of initiation of alcohol use among Australian secondary students[32] may assist prevention services in challenging the normalisation process. Furthermore, while cannabis remains the most commonly used illicit substance among young people,[32] recent data shows that 15% of secondary aged students had used cannabis in the last year, and only 5% had used within the past week.[32] Perhaps contrary to popular belief, the majority of young people of secondary age do not use cannabis. Health education also has a role to play in balancing the sensationalised hype around specific drugs in the media. We would argue that scare tactics of past drug campaigns related to what participants labelled as "hard" drugs, may work to stigmatise and contribute to "drug hierarchies," which can be unhelpful, misleading and reinforce the normalisation of "soft" drugs. We would argue that drug education must be explicit regarding harm across all drug types, regardless of legal status or the level to which they are socially endorsed.

Second, our findings demonstrate the need to "authenticate" drug and alcohol health education for young people. We would argue that the incorporation of lived realities within strategies may work to ground the information in a young persons' experience. While it is understood that abstinence approaches to alcohol and other drug education are ineffective, lived experience and the active inclusion of people who use drugs in the design and delivery of AOD projects is generally not encouraged in the health promotion field, specifically for preventive projects which are targeted at school groups and facilitated in more traditional settings.[14,33] Some researchers argue, however, that the participation of people who use drugs is an essential element of harm reduction work (indeed one of its key principles).[34,35] Health information must be contextually relevant and responsive to the lived experiences of youth perspectives[36] and regardless of the guiding principle, must be rooted in honesty and authenticity, with a primary purpose to empower young people. We would argue that this looks like validating the physiological and emotional experiences of drug use, and working towards validating the realities of potential consequences through the incorporation of lived experience. For Youth Solutions, the lived experiences of participants in this study have been incorporated in "decision scenario" activities and "referral pathway options" exercises, that we believe will resonate better with the young people we provide services for. Research conducted by Holleran-Steiker and colleagues[35] shows the value in true testimonials of those from various walks of life, including those who had wrestled with substance use and those who decided to abstain. When lived realities are incorporated they have the effect of grounding the preventive strategies in the social, geographical and cultural contexts of the "consumer" or target audience.[37]

Third, our findings suggest the value of involving peer workers in prevention and harm reduction work. Research continues to mount around the benefits of peer-led strategies. Peer-based programs have been shown to improve the reach of services to individuals who are marginalised and otherwise not engaged,[38] have better outcomes with regard to participant mental health and life satisfaction, and have shown to have a more effective and higher rate of health information exchange.[39] Peer to peer interaction in a group setting has also been shown to assist young people seeking treatment for drug dependency, helping to reduce fears around medical procedures and treatment side effects.[40] It is vital, therefore, that services designed to assist young people in keeping safe, and staying healthy, must actively involve young people in service design and delivery, deliberately drawing upon a young person's realities to guide risk management and preventive strategies.[37] The findings from this study validate the existence of youth advisory groups in preventive work, and stress the importance of continual investment in efforts that broaden the demographics and life experiences of the young people engaged in such groups. For Youth Solutions, the lesson has

been to nurture and truly upskill peer workers who are part of our existing Youth Advisory Group. We would also argue for the active recruitment of culturally diverse young people (represented by differences across socio-economic status, gender, sexuality, religion, ability, ethnicity, language etc) with varied lived experience with drug use, to encourage young people to drive harm reduction strategies among their peer groups. We believe this strategy could also serve to validate drug information on both illegal and legal substances, as the young people in our study placed high value on the drug knowledge and experiences of their friends.

Finally, our findings demonstrate the value of formative research in guiding appropriate prevention strategies, that we would argue, should form an integral step in the evaluation process for health promotion activities. While it is often feasible to rely on state population survey data to identify priorities and needs, where qualitative data is lacking, health promotion services can struggle to keep pace with the changing needs of their specific local target groups. Qualitative research serves to complement population survey data and ensure that strategies are contextually relevant to the communities who are on the receiving end of local prevention and harm reduction efforts.

4.1 | Limitations

Young people are a heterogeneous group and the themes identified in this research are not presented as representative of all young people's experiences (indeed this is not the purpose or scope of qualitative research). We also acknowledge that the study was not co-designed with young people and that there was no attempt to follow up with participants at the data interpretation and analysis stage of the study. The region in which Youth Solutions services, as well as having areas of significant socio-economic disadvantage, represents one of the most ethnically diverse populations in Sydney and we had hoped to explore more fully psychosocial influences on young people's drug and alcohol attitudes and behaviours. Within our sample of 30 recruited from services and the broader community, gender and socio-economic differences were not prominent. Only two participants were from culturally and linguistically diverse backgrounds (Samoa and Lebanon) and no participants identified as Aboriginal or Torres Strait Islander. Further research is required into the social and cultural factors that influence young people's drug use. Additionally, we found the age range of 13-25 to be quite large and would recommend future studies seeking to explore young people's perspectives be more selective.

5 | CONCLUSION

The present study provides information to guide the development of appropriate drug and alcohol preventive strategies for small community-based organisations like Youth Solutions, and others. Drug and alcohol education strategies must work to be more explicit regarding harm across all drug types, regardless of legal status or their perceived social acceptability. Drug hierarchies do not serve to protect young people, rather instil a false sense of security about the level of risk of certain substances, and contribute to the stigmatisation of others. Involving youth realities (in some capacity) in health education strategies is a strong recommendation of this study and there are ways to embed these perspectives at the design stage of health education strategies. Peer involvement in the design and implementation of drug and alcohol prevention and intervention strategies is paramount to ensure teachings are grounded in a young person's social context. Our findings suggest that this strategy could go a long way in validating health information, and empowering young people to champion their own health decisions. Our findings show how young people support each other to stay well while using substances and this is a strength that could be incorporated into health promotion programs alongside the need for explicit discussion of harm associated with legal and illegal drugs. Finally, continual work to explore the felt needs of communities who are on the receiving end of preventive strategies is paramount, and should form an integral step in the evaluation process for prevention services, like Youth Solutions.

CONFLICT OF INTEREST

The authors declare no conflicts of interest.

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