Public Health Scotland

# Consensus approach on prevention of substance use harm among children and young people

## Technical report


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Public Health Scotland is Scotland's national agency for improving and protecting the health and wellbeing of Scotland's people.



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# Contents

# 1. Introduction

## 1.1. Aim

This report presents the findings from a Delphi process commissioned by Public Health Scotland (PHS). The work aims to build an agreed approach to substance use harm prevention among children and young people.

## 1.2. Rationale

Scotland has existing public health commitments to reduce substance use harms, including the Scottish Government's Tobacco and vaping framework: roadmap to 2034. However, currently there is no overarching national approach to address the complex area of substance use harm prevention for children and young people. This has resulted in variations in substance use harm prevention approaches across the country.

PHS is the lead national agency for improving and protecting the health and wellbeing of the Scottish population. Its responsibilities include work to prevent disease; prolong healthy life; and promote health and wellbeing across the country. Reducing harms from drugs, alcohol and tobacco are strategic priorities for PHS.

PHS is seeking to support consistency through an evidence-informed approach, based on consensus-building and collaboration. To establish consensus, PHS used the Delphi method. This is a multi-stage stakeholder engagement technique that supports the development of consensus on a particular topic. It does this by bringing together and engaging with a panel of people with relevant experience and expertise.

## 1.3. Policy context

The national consensus approach will contribute to supporting the Scottish Government National Mission Outcomes Framework which has the overall aim of reducing drug and alcohol deaths and related harms.

Specifically, the national consensus will support:

- National Mission Outcome 1(a): Young people receive evidence-based, effective support in relation to substance use.
- The work also links with outcome 1(b): People have early access to support for emerging problem drug use, and will embody the cross-cutting priorities.
- The work will also contribute to the Alcohol Framework, the Tobacco and vaping framework: roadmap to 2034.

PHS were commissioned to deliver this development work on behalf of the Scottish Government.

## 1.4. Methodology

The Delphi process is a structured approach that uses a series of activities to gather information on a complex area from a panel of experts, including young people. It is an approach rather than a fixed method and is adapted to meet the project needs.[*] The approach involves multiple rounds of engagement; the first is an open discussion on a range of key questions, from which main themes or statements are extracted. The second, and any subsequent rounds, consists of presenting outputs from the previous round of consultation to the expert panel and asking them to consider areas of agreement.

Social research agency The Lines Between (TLB) was commissioned to support the delivery of the Delphi method. The process comprised of three rounds, summarised in Figure 1 and detailed below.

[*] Linstone HA and Turoff M. 'Introduction' in The Delphi Method Techniques and Applications, pp. 3–12. Reading, Mass, USA: Addison-Wesley Publishing Company; 1975.

## Figure 1: Summary of methodology

**Round 1: October 2022 - February 2023**

- Sessions exploring substance use harm prevention for children and young people took place:
  - TLB facilitated 10 focus groups with an expert panel made up of 90 stakeholders from a range of professional backgrounds.
  - Young Scot, Fast Forward and Youthlink facilitated a series of engagement sessions with a panel of 24 young people.
- Data from all sessions was analysed.
- 247 statements were produced to reflect the ideas raised in the sessions.

**Round 2: September - November 2024**

- The Round 1 statements were mapped and consolidated into 68 statements under 10 themes.
- Further engagement took place to identify areas of agreement and disagreement:
  - TLB facilitated 10 structured workshops with 60 professional stakeholders and a focus group with 4 students.
  - YoungScot, Fast Forward, Children's Parliament and Time 4 Us Children & Family Service within Transform Forth Valley engaged with 176 children and young people through various methods including interactive sessions and a survey.
- Data collected was analysed.
- Statements were amended and refined based on feedback.

**Round 3: February - March 2025**

- A questionnaire presenting the refined statements was shared with the professional stakeholder panel and received 42 responses.
- With support from youth agencies involved in Round 2, bespoke tools and activities were designed to gather input from 47 children and young people.
- Statements with 75% or higher level of agreement were considered to have reached consensus.

### 1.4.1 Children and young people's involvement

Children and young people are at the heart of this work and incorporating their voice in developing the consensus was a priority for PHS from the outset. PHS worked with specialist youth partners Young Scot, Fast Forward and YouthLink Scotland, to identify how young people would like to be involved and to gather their views on substance use and harm prevention. Young Scot, Fast Forward and YouthLink Scotland facilitated a series of engagement sessions with a panel of 24 young people from October to December 2022. The report from these sessions captured their views on preventing substance use harm among children and young people and how they would like to be engaged with in the consensus approach. They produced a series of 30 statements and requested to input into the Delphi via a dedicated focus group (see Round 1 methods below).

As part of ongoing commitments within the Delphi process and the **incorporation of the United Nations Convention on the Rights of the Child (UNCRC) into Scots law** to promote children and young people's participation in service design and delivery, additional steps to incorporate the views and experiences of children and young people appropriately and meaningfully in the consensus were taken for rounds 2 and 3. Delivery of the Delphi method included dedicated development work and engagement activity with third sector youth partners. These included Young Scot, Fast Forward, the Time 4 Us Children and Family service within Transform Forth Valley and Children's Parliament. The aim was to involve children and young people between the ages of 10 to 18, plus the recruitment of students between the ages of 18 to 25 to participate in the process (see Round 2 and 3 methods below).

### 1.4.2 Round 1 of the Delphi process

PHS used existing networks to recruit the panel of experts to participate in 10 focus groups throughout January and February 2023 (hosted on Microsoft Teams). In total, 90 stakeholders, including public health officials, academics and educators, youth workers, and individuals working in health, mental health, recovery, and addiction services, local authorities, Alcohol and Drug Partnerships, Health and Social Care

Partnerships, Children and Family Services, and NHS boards, took part in the first stage of the Delphi process.

Stakeholders' understanding of the most effective approaches to preventing substance use harm among children and young people was explored in these focus groups. Participants also reflected on the challenges Scotland faces in protecting its young people from substance use-related harm.

A focus group attended by three young people was held in February 2023. Feedback from initial youth participation sessions and statements, and the focus group was incorporated into the report on Round 1.

All focus groups were recorded and transcribed. TLB analysed and used the data to inform the development of a list of 247 draft statements for potential inclusion in a consensus approach. These statements captured proposed actions, commitments and recommendations to reflect the issues discussed in the focus groups.

### 1.4.3 Round 2 of the Delphi process

Round 2 took place in 2024 and involved a series of structured online workshops with the expert panel. All participants from Round 1 were invited to participate, and gaps in representation were addressed through targeted invitations. These included those working in the community safety and justice sector, remote and rural communities and people with lived experience of substance use.

The purpose of Round 2 was to identify areas of agreement and disagreement based on data gathered in Round 1. This stage involved a mapping exercise to consolidate the 247 statements produced in Round 1 and identify any overlap across them. The initial list of 247 was condensed to 68 statements under 10 themes; all the ideas and sentiments from the original list were retained.

Ten online workshops were held between September and November 2024. In total, 60 stakeholders attended the workshops, representing a wide range of organisations, sectors, and locations across Scotland.

Each workshop was recorded and transcribed. All qualitative data gathered from the workshops was then analysed using a coding framework, which sought to establish areas of agreement and where further refinement was needed. The coding framework was developed using an inductive approach; each transcript was reviewed in full and key themes were derived directly from the data itself.

In addition, four third sector partner organisations (Young Scot, Fast Forward, the Time 4 Us Children and Family service within Transform Forth Valley and Children's Parliament) were commissioned to deliver direct engagement activity with children and young people, with support from TLB and specially designed resources to help gather views and feedback. Partner agencies provided data from these activities for TLB to incorporate into the wider analysis. To reach those aged 18 to 25 years, TLB utilised existing connections to recruit students from Edinburgh Napier University to participate in online focus groups. In total 180 young people participated in Round 2.

### 1.4.4 Round 3 of the Delphi process

Following analysis of the data collected during Round 2, the statements were reviewed to reflect the key concepts identified by participants. An online questionnaire of 77 statements was presented to the expert panel. Panellists were asked to indicate the extent to which they agreed with each statement[*], and were then given the opportunity to provide open text comments explaining their responses. Complete questionnaire responses were received from 42 panellists.

Working with the partner youth agencies, bespoke tools and activities were used to gather input from children and young people. This was also primarily facilitated through an online survey, with one group utilising a discussion-based activity that produced equivalent quantitative results. In total, 47 children and young people took part in Round 3, and there were 28 responses.

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[*] A Likert scale with the following options was used: 'Strongly agree', 'Agree', 'Disagree', 'Strongly disagree' and 'Don't know'.

A threshold of 75% (or higher) agreement by the panel members on each statement was considered sufficient for inclusion in the final consensus and considered against the evidence base as required. This level of agreement has been considered appropriate in previous Delphi studies.[*] Areas of less agreement are highlighted in the findings to allow for further exploration where appropriate.

TLB has also undertaken a descriptive literature review to consider the extent to which the Delphi outputs align with existing evidence in this area. This evidence is highlighted within the findings below, in areas where there was less agreement among participants.

## 1.5. Definitions of key terms

Throughout the report, some technical terms are used which reflect the complex nature of discussions around substance use harm prevention and the language used throughout the Delphi process. As this may impact readability, a list of key terms and their definitions is provided below.

| Term | Definition |
|---|---|
| The panel / panel members / panellists | 'The panel', 'panel members' and 'panellists' refer to the professional stakeholders and children and young people consulted throughout the study. |
| Consensus | Consensus is general agreement on an idea or issue. Consensus does not have to be unanimous. Throughout this report, statements are deemed to have reached consensus if 75% of the stakeholder panel agreed or strongly agreed with them in the Round 3 questionnaire. Statements that met this threshold have been included in the final consensus approach. |

[*] Barrios et al, Consensus in the Delphi method: What makes a decision change?, 2021, Technological Forecasting and Social Change

| Term | Definition |
|---|---|
| Universal prevention measures | Universal prevention measures are actions targeted at the entire population to improve overall population health and reduce health risks. These measures affect everyone, regardless of individual risk levels and aim to develop skills, values and norms. For example, education programmes delivered in schools. |
| Targeted/selective prevention measures | Targeted/selective prevention measures are actions targeted at improving opportunities and resilience of vulnerable groups who are deemed to be at higher risk of substance use harm due to difficult living and social conditions. For example, youth work programmes for young people who are care experienced. |
| Environmental prevention measures | Environmental prevention policies and interventions seek to change the context (physical, digital, economic, social, regulatory etc) to promote the availability of healthier options and influence positive social norms, values and attitudes in order to prevent the likelihood of substance use harm by reducing opportunities for unhealthy or risky behaviour. An example is the smoking ban that has profoundly changed the social acceptance of smoking across population groups. |
| Indicated prevention measures | Indicated prevention measures are actions targeted at individuals who are experiencing early signs of substance use harm, or those who exhibit behavioural characteristics or psychological problems that may be predictive for substance use harm later in life. For example, one-to-one counselling and mental health support. |
| Primary prevention | Primary prevention is action that tries to stop problems happening. This can be either through actions at a population level that reduce risks or those that address the cause of the problem. An example here is raising the age at which people can purchase tobacco products. |

| Term | Definition |
| --- | --- |
| Secondary prevention | Secondary prevention is action which focuses on early detection of a problem to:<br>• support early intervention and treatment<br>• reduce the level of harm<br>For example, alcohol brief interventions, which seek to modify behaviour in people who regularly drink more than the low-risk guidance level. |
| Tertiary prevention | Tertiary prevention is action that attempts to minimise the harm of a problem through careful management. An example of this would be referral to a treatment programme. |
| Harm-reduction measures | Harm reduction measures are ways to minimise the risk of serious/immediate harm from using substances. They include injecting equipment provision (IEP) and access to Naloxone, a medicine which can reverse the immediate effects of overdose. |
| Risk factors | Risk factors increase the likelihood of beginning substance use and of regular and harmful use. |
| Protective factors | Protective factors decrease the likelihood of substance use or reduce the impact of risk factors. |

# 2. Findings

This chapter sets out findings from the final round of the Delphi study. First, quantitative results from the online questionnaire are presented. This is followed by analysis of the open text comments, and reflections on engagement with children and young people. Areas where consensus has not been reached are supplemented by a short descriptive review of relevant existing literature.

Tables with purple headers represent the views of the stakeholder panel, while those with light-blue headers show the views of children and young people. The rows highlighted in grey signify questions that fall below 75% and did not reach a consensus. In some tables in this report, totals are not 100% due to rounding. ‘Total agree’ includes the percentage of panellists who selected ‘agree’ or ‘strongly agree’. ‘Total disagree’ includes the percentage of panellists who selected ‘disagree’ or ‘strongly disagree’.

## 2.1. Scope and context

The first section of the survey explored views on the scope and context of a future substance use harm prevention strategy for children and young people.

## Table 1a: The need for a strategy and implementation plan (stakeholder panel, n=42)

| Statement | Total Agree (%)* | Total Disagree (%)† | Don't know/Not answered (%) |
|---|---|---|---|
| Scotland should have a national substance use harm prevention strategy for children and young people. | 100 | 0 | 0 |
| An implementation plan should be developed to underpin the delivery of the strategy. | 100 | 0 | 0 |

## Table 1b: The need for a strategy and implementation plan (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Scotland needs a national strategy to keep children and young people safe from substance use harm. | 100 | 0 | 0 |
| An action plan should be developed to help deliver the strategy. | 100 | 0 | 0 |

The panel agreed unanimously about the need for a national substance use harm prevention strategy and implementation plan. As with previous rounds of the study, the panel recognised the lack of cohesion, co-ordination and consistency in this area and welcomed the introduction of a national substance use harm prevention strategy targeted at children and young people. The reference to an implementation plan was

* 'Total agree' includes the percentage of panellists who selected 'agree' or 'strongly agree'.

† 'Total disagree' includes the percentage of panellists who selected 'disagree' or 'strongly disagree'.

particularly well received, with panellists describing this as ‘crucial’ in clarifying roles and responsibilities and ensuring that action is taken.

The young people surveyed also agreed unanimously on these statements.

## Table 2a: Scope of the strategy (stakeholder panel, n=42)

| The national substance use harm prevention strategy for children and young people should cover outcomes related to: | Total Agree (%) | Total Disagree (%) | Don’t know/Not answered (%) |
|---|---|---|---|
| Alcohol | 100 | 0 | 0 |
| Other drugs, including psychoactive drugs subject to control by the Psychoactive Substances Act | 98 | 0 | 2 |
| Tobacco | 93 | 7 | 0 |
| Nicotine products (e.g. nicotine pouches) | 93 | 7 | 0 |
| E-cigarettes and vaping | 93 | 7 | 0 |
| Energy drinks | 69 | 14 | 17 |
| Any substance or behaviour which, when used repeatedly has a recognised potential to damage a young person’s health, cause disability, limit their ability to work and create problems in home, school or community life | 64 | 17 | 19 |
| Gambling | 62 | 26 | 12 |

## Table 2b: Scope of the strategy (children and young people, n=28)

| The strategy should have measures and goals which relate to: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Alcohol | 96 | 0 | 4 |
| Other drugs, including psychoactive drugs subject to control by the Psychoactive Substances Act | 89 | 4 | 8 |
| E-cigarettes and vaping | 86 | 7 | 7 |
| Nicotine products (e.g. nicotine pouches) | 82 | 7 | 11 |
| Tobacco | 82 | 11 | 8 |
| Any substance or behaviour which, when used repeatedly has a recognised potential to damage a young person's health, cause disability, limit their ability to work and create problems in home, school or community life | 79 | 4 | 18 |
| Gambling | 71 | 18 | 11 |
| Energy Drinks | 36 | 57 | 8 |

Panellists reached consensus that the future strategy should cover alcohol and other drugs, tobacco, nicotine products and e-cigarettes/vapes. However, as with previous rounds, there was less consensus on whether gambling and energy drinks should be included within the scope of the strategy. Those in favour saw benefit in including a wide range of harmful activities, while others felt a strong focus on a specific set of substances was needed to maximise the impact of the strategy. Some felt that gambling warrants its own harm prevention strategy, and a few felt that harms related to energy drinks should be considered under the National Good Food Nation Plan.

Feedback from children and young people aligned with the views of the professional stakeholder panel. However, they expressed stronger disagreement on the inclusion of energy drinks; only 36% agreed with their inclusion, compared with 69% of the professional stakeholder panel.

### Table 3a: Definition of children and young people (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The term 'child' or 'young person' should be consistent with definitions set out in 2014 Children and Young People (Scotland) Act. | 79 | 12 | 10 |

### Table 3b: Definition of children and young people (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| We should use the definitions of 'child' and 'young person' provided in the 2014 Children and Young People (Scotland) Act. | 79 | 11 | 11 |

Both the professional stakeholder panel and the children and young people surveyed reached consensus that the terms 'child' and 'young person' should be consistent with definitions set out in 2014 Children and Young People (Scotland) Act. Section 97(1) of the 2014 Act states: 'child' means a person who has not attained the age of 18 years. Statutory Guidance notes that the terms 'young people' and 'young person' are used to refer to older children (e.g. 12 to 17 years old) and those adults still eligible to receive a "children's service" (e.g. care leavers aged 18 to 25 years old).

## Table 4: Alignment with other legislation and policies (stakeholder panel, n=42)

| The national substance harm prevention strategy for children and young people should be aligned to: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Children and Young People (Scotland) Act 2014 | 95 | 0 | 5 |
| Getting It Right For Every Child (GIRFEC) | 93 | 0 | 7 |
| United Nations Convention on the Rights of the Child (UNCRC) | 90 | 2 | 7 |

Panellists agreed that the substance use harm prevention strategy should align to GIRFEC, UNCRC and the Children and Young People's Act 2014, but also suggested other strategies and frameworks in open comments, such as:

- The Promise
- Equality Act 2010
- Scotland's National Mental Health and Wellbeing Strategy

### Table 5a: Term of the strategy (stakeholder panel, n=42)

| In order to deliver generational change and remain responsive to social and contextual changes: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Action plans should be updated annually | 83 | 7 | 10 |
| The national substance use harm prevention strategy for children and young people should have a 10-year vision | 74 | 19 | 7 |

### Table 5b: Term of the strategy (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The strategy should have a 10-year vision with regular reviews to ensure that it remains up to date. | 79 | 18 | 4 |

Only 74% of the professional stakeholder panel agreed with the proposed 10-year term of the strategy. Those who disagreed described a 10-year term as too long, given the rate at which substance use trends change; a few suggested that a shorter term of 3 or 5 years would be more appropriate. A number of young people who responded to the survey also expressed their preference for a 5-year term.

However, considering the wider context, a 10-year term has been set for several current national plans and strategies related to substance use harm. This includes NHS England's **strategic plan** for the drug and alcohol treatment and recovery workforce, the UK Government's '**From harm to hope**: A 10-year drugs plan to cut crime and save lives' and Northern Ireland's Substance Use Strategy: **Preventing Harm, Empowering Recovery**.

More broadly, a **review** by Ireland's Health Information and Quality Authority found the average term of the international public health strategies included in their review to be 8 years, with a minimum of term of two years and a maximum of 21 years.

Alternatively, some prevention strategies do not define a specific term, but rather commit to regular review and update, such as **Equally Safe**: Scotland's Strategy for Preventing and Eradicating Violence Against Women and Girls.

### Table 6a: Approaches to prevention (stakeholder panel, n=42)

| A substance use harm prevention strategy for children and young people should reflect: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Environmental/ecological approaches (approaches which help to create places where children and young people can live, work and play without being exposed to substances or substance use. Examples include fewer outlets selling products like alcohol or vapes and not being exposed to alcohol or gambling advertising.) | 100 | 0 | 0 |
| Indicated approaches (Those who might have started experiencing related problems and at risk of further harms) | 98 | 0 | 2 |
| Universal approaches (approaches delivered to the whole population) | 95 | 5 | 0 |
| Selective/targeted approaches (targeted prevention for individuals, groups, and communities most at risk) | 95 | 2 | 2 |

### Table 6b: Approaches to prevention (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The strategy should ensure that everyone has the same access to substance use harm prevention education and support, no matter where you live. However, it should also recognise that some children, young people and families may be at greater risk of harm and they should be identified and given extra help. | 96 | 0 | 4 |

## Table 7: Online environmental / ecological approaches (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Environmental / Ecological approaches should also influence the digital environment (e.g. online advertising) | 93 | 0 | 7 |

The statements in Tables 6 and 7 received high levels of approval from the panel. Open text comments from the professional stakeholder panel focused on the need for a combination of different approaches, with each playing an important role in harm minimisation and prevention. Young people also expressed high levels of approval (96%) for an approach which encompasses both universal and targeted approaches (Table 6b).

## Table 8: Prevention measures (stakeholder panel, n=42)

| A substance use harm prevention strategy for children and young people should contain a mixture of measures which: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| a) Prevent the onset of substance use (primary prevention) | 95 | 5 | 0 |
| b) Recognise and support people with substance use early (secondary prevention) | 98 | 2 | 0 |
| c) Minimise the knock-on negative consequences of substance use (tertiary prevention) | 93 | 5 | 2 |
| d) Reduce the risk of harm amongst people already using substances (harm reduction) | 95 | 5 | 0 |

The statement in Table 8 was also well received by the panel, with open comments reflecting a need for a range of prevention measures.

## Table 9: Life course approach (stakeholder panel, n=42)

| Evidence based universal preventative actions should be available for people at different stages of life: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Pregnancy | 95 | 0 | 5 |
| Parents | 95 | 0 | 5 |
| Age 11 to 18 | 95 | 0 | 5 |
| Over 18 | 93 | 0 | 7 |
| Age 5 to 11 | 93 | 2 | 5 |
| Early childhood (under 5) | 86 | 5 | 10 |

## Table 10: Universal prevention approaches (stakeholder panel, n=42)

| Universal prevention approaches: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Should not be based on fear, threats or scaremonger | 100 | 0 | 0 |
| Should be evaluated where the evidence base is limited or lacking | 98 | 0 | 2 |
| Should build life skills, address normative attitudes and beliefs | 95 | 2 | 2 |

## Table 11: Targeted prevention approaches (stakeholder panel, n=42)

| Targeted prevention approaches: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Should meet the needs of young people whose risk and protective factors impact on their vulnerability and likelihood of experiencing harms from substances | 100 | 0 | 0 |
| Should focus on skill development and social interaction including with peers | 95 | 0 | 5 |

The statements presented in Tables 9, 10 and 11 all achieved a high level of consensus. Panellists broadly agreed with the sentiment that all people should have access to services which meet their needs at a time they need it. One added that a comprehensive life-course approach is needed, and another highlighted the importance of supporting healthy pregnancies.

## Table 12: Delivering prevention measures (stakeholder panel, n=42)

| Agencies with opportunities to deliver targeted prevention and early intervention include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Specialist services for young people who are in care | 95 | 0 | 5 |
| Schools | 95 | 2 | 2 |
| Youth work / youth organisations | 93 | 0 | 7 |
| Community based health services (including but not exclusive to mental health, school nursing, health visiting, sexual health) | 93 | 0 | 7 |
| Acute health services (accident and emergency) | 90 | 2 | 7 |

## Table 13: Early intervention and harm reduction approaches (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Early intervention and harm-reduction approaches should be non-judgemental and trauma informed. | 98 | 0 | 2 |

The stakeholder panel approved the delivery of targeted prevention and early intervention in schools, youth organisations, community-based health services, acute health services, and specialist services. They also showed particularly strong levels of support (98%) for the use of non-judgemental and trauma-informed approaches to early intervention and harm reduction.

## Table 14a: Whole-systems approach (stakeholder panel, n=42)

| There should be a collaborative, whole systems approach to substance use harm prevention – everybody has a role to play. This includes: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Local authorities, NHS boards and Integration Joint Boards (IJBs) | 100 | 0 | 0 |
| Public health agencies | 100 | 0 | 0 |
| Youth work services | 100 | 0 | 0 |
| Housing/homelessness services and residential care | 100 | 0 | 0 |
| Parents, carers and families | 100 | 0 | 0 |
| The Scottish Government | 98 | 0 | 2 |
| Young people | 98 | 0 | 2 |
| Communities | 98 | 0 | 2 |
| Education settings (including early years, school and Further and Higher Education settings) | 98 | 2 | 0 |
| Social work | 98 | 2 | 0 |
| Third sector services | 98 | 2 | 0 |
| Health services & practitioners (including GPs, link workers, school nurses, family nurses, health visitors and midwives) | 95 | 2 | 2 |
| Justice sector (including prisons, youth offending and probation services) | 98 | 2 | 0 |
| Mainstream media and social media | 95 | 2 | 2 |
| Licensing boards | 95 | 2 | 2 |
| Police | 93 | 5 | 2 |
| Retail and hospitality (nighttime economy) | 93 | 7 | 0 |
| Alcohol/tobacco/gambling industries | 79 | 14 | 7 |

## Table 14b: Whole-systems approach (children and young people, n=28)

| Everyone should work together to keep children and young people safe from substance use harm. This includes: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The Scottish Government | 100 | 0 | 0 |
| Youth work services | 96 | 0 | 4 |
| Third sector services (e.g. charities) | 96 | 0 | 4 |
| Local authorities/councils | 96 | 4 | 0 |
| Public health agencies (like PHS) | 93 | 0 | 8 |
| Health services and practitioners (e.g. GPs, doctors, nurses) | 93 | 4 | 4 |
| Alcohol/tobacco/gambling industries (companies and businesses who make money from selling alcohol and tobacco/nicotine products or gambling) | 89 | 7 | 4 |
| Education settings (e.g. school and colleges) | 86 | 11 | 4 |
| Young people | 82 | 7 | 11 |
| Police | 82 | 11 | 8 |
| Licensing boards | 82 | 15 | 4 |
| Social work | 75 | 18 | 7 |
| Parents, carers and families | 75 | 21 | 4 |
| Communities | 71 | 18 | 11 |
| Mainstream media and social media | 71 | 25 | 4 |
| Housing/homelessness services | 64 | 32 | 4 |
| Retail & hospitality (e.g. bars, restaurants and night clubs) | 64 | 29 | 7 |
| Justice sector (e.g. prisons and courts) | 61 | 29 | 11 |

The role of the police was also debated throughout the Delphi process. While some panellists agreed that the police have an important role to play in substance use harm prevention, particularly in a protective role or in reducing violence, others were critical of law enforcement-based approaches to substance use harm prevention. Issues raised by the panel included challenges around young people's relationships with and trust in the police, the difficulties of the police having a punitive role and the fact that police approaches do not always align well with trauma-informed and stigma-informed approaches.

Some participants welcomed their involvement, noting successful partnerships with community or campus police officers in delivering training or education to young people around the risks of substance use. However, others were critical of law enforcement-based approaches to education, noting that it is often based on fear and intimidation, not delivered in a trauma-informed way (e.g. with the use of distressing images or vignettes) and focuses on the criminalisation and vilification of people who use drugs.

There were high levels of agreement among the professional stakeholder panel that all of the groups/agencies referenced above have a role to play in protecting children and young people from substance use-related harm, with the exception of the alcohol, tobacco and gambling industries; 14% of the panel disagreed that they have a role to play in harm prevention. Questions were raised about the role of the alcohol and tobacco industry in protecting children and young people from substance use-related harm. Those who disagreed described the profit-driven agenda of such industries as at odds with, and at risk of undermining, harm prevention efforts.

Children and young people held slightly different views from the panel, with fewer of the agencies achieving the 75% consensus threshold. For example, only 61% of young people felt that the justice sector had a role to play, compared with 98% of the professional panel. Similarly, only 64% of young people felt retail and hospitality sectors had a role to play, compared with 93% of the professional stakeholder panel. In contrast, 89% young people felt strongly about a role for alcohol/gambling/tobacco industries, compared with lower support (79%) from the professional panel.

The Framework Convention on Tobacco Control (WHO FCTC) states that industry should not be involved in substance use harm prevention; this is a statutory requirement across Scotland. On alcohol-related issues, the WHO similarly provides public health guidance to counter the commercial interests of industry.*

## Table 15: Roles and responsibilities (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| There is a need to further set out the roles and responsibilities of organisations, services and workforce who can implement a prevention strategy. | 98 | 0 | 2 |

There was clear support for the above statement, with the panel recognising the importance of setting out roles and responsibilities of those involved in implementing the strategy. Among open text comments, there were some suggestions on the best way to determine these roles, including:

- a tiered approach with key organisations at various levels coordinated by a local oversight group
- the creation of a working group to determine and communicate these roles
- a national protocol around information sharing between partner agencies.

* World Health Organization. Regional Office for Europe. (2024). Empowering public health advocates to navigate alcohol policy challenges: alcohol policy playbook. **https://iris.who.int/handle/10665/379378**

## Table 16: Consistency in provision (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| There is a need for greater consistency in the equity of substance use harm prevention between local authority areas. | 88 | 0 | 12 |

Panellists agreed with the principles of consistency and equity of access to targeted substance use harm prevention for those in need, regardless of location, and were keen to move away from a 'postcode lottery' system of service availability and funding. Participants emphasised the need for flexibility in provision, to take local needs and circumstances into account, for example the specific needs of urban and rural communities.

## Table 17: Outcomes for a substance use prevention strategy (stakeholder panel, n=42)

| Intended outcomes for a substance use prevention strategy should include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Wellbeing outcomes in children and young people | 100 | 0 | 0 |
| Indicators related to risk factors | 95 | 0 | 5 |
| Indicators related to protective factors | 95 | 0 | 5 |
| Substance use specific outcomes (e.g. ever using a substance, regular use of substance, age at use of substance) | 90 | 2 | 7 |

The professional stakeholder panel agreed with the proposed intended outcomes for a substance use prevention strategy as set out in Table 17. A few felt it was important to distinguish the type of substance being used, and there was also a request to align wellbeing outcomes to the **GIRFEC SHANARRI** indicators.

## Table 18a: Involving children and young people (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Children and young people should be involved in the development of substance use harm prevention strategies; participation should be meaningful, not tokenistic, involve a diverse range of voices (including those with lived/living experience) and involve feedback loops (i.e. an opportunity for young people to understand how their input has been used). | 100 | 0 | 0 |

## Table 18b: Involving children and young people (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Children and young people should be involved in the development of the strategy. Participation should be meaningful (not tokenistic or a tick box exercise), involve a diverse range of voices (including those with lived/living experience) and involve feedback loops. | 93 | 0 | 8 |

## Table 19a: Facilitating participation of young people (stakeholder panel, n=42)

| To facilitate the participation of young people there should be: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The creation of a young person's panel | 81 | 7 | 12 |
| Local engagement activities (e.g. surveys and events) | 76 | 10 | 14 |

## Table 19b: Facilitating participation of young people (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Children and young people across Scotland should be able to share their views on substance use harm prevention through events and surveys. A young person's panel could also be created to make sure children and young people's voices are heard. | 100 | 0 | 0 |

There were high levels of agreement among both the professional stakeholder panel and the young people surveyed that children and young people should be involved in developing and designing substance use harm prevention strategies and approaches. A higher proportion of young people agreed that this should be done through local engagement activities and a young person's panel than the stakeholder panel (100% compared with 76% and 81% respectively). Stakeholders felt these methods do not always capture adequate representation from different groups, including those most at risk or actively using substances.

The need for the involvement of children and young people affected by substance use, whether this is their own personal use or a family member's, was emphasised in open text comments.

## Table 20a: Impact of stigma (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The impact of stigma on substance use harm prevention should be recognised and addressed. | 95 | 0 | 5 |

### Table 20b: Impact of stigma (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The impact of stigma on substance use harm prevention should be recognised and addressed. | 100 | 0 | 0 |

Both the stakeholder panel and young people strongly agreed that the impact of stigma should be recognised and addressed. In open text comments, stigma and fear of stigma were identified as significant barriers to many aspects of harm prevention and accessing support.

## 2.2. Governance and accountability

The next set of statements fall under the theme of governance and accountability. There were mixed views on these statements, with some aspects failing to meet the 75% approval threshold for inclusion in the consensus approach. It should be noted that this often resulted from high levels of 'don't know' or blank responses, as opposed to explicit disagreement.

### Table 21a: The need for long-term funding (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Scotland's substance use harm prevention strategy must be accompanied with long-term, secure funding and investment. | 100 | 0 | 0 |

## Table 21b: The need for long-term funding (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The strategy needs long-term, secure funding for it to be successful in protecting children and young people from harm. | 100 | 0 | 0 |

This was one of the most highly rated statements, with unanimous approval from both the professional stakeholder panel and young people surveyed. Furthermore, 39/42 of the stakeholder panel indicated they 'strongly agreed' that there is a need for long-term, secure funding and investment alongside the strategy (the remainder selected 'agree'). This has been a prominent area of discussion throughout the Delphi process, with panellists emphasising the need for adequate investment to embed approaches that protect children and young people from substance use-related harm.

## Table 22: Ministerial responsibility (stakeholder panel, n=42)

| Responsibility for substance use harm prevention for children and young people should fall within the Ministerial Portfolio of: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Children and young people | 93 | 5 | 2 |
| Public health | 83 | 7 | 10 |
| Drugs and alcohol | 83 | 10 | 7 |
| Health | 76 | 12 | 12 |
| Education | 67 | 19 | 14 |

The panel reached consensus that responsibility for substance use harm prevention for children and young people should fall within one of the Ministerial Portfolios of Drugs and Alcohol, Children and Young People, Health and Public Health, with the strongest indication of support for the portfolio of Children and Young People. Roughly one fifth (19%) disagreed that such responsibility should fall under the Ministerial Portfolio of Education. Open text comments reflected on a need for a more collaborative whole systems approach, with responsibility shared between the proposed portfolios and others, including Economy, Culture, Social Justice, Community Safety, Climate Action, Social Care, Mental Wellbeing, Sport, Equalities and Housing.

## Table 23: Development and delivery of services (stakeholder panel, n=42)

| Preventative, early intervention and harm reduction services for young people should be developed, delivered and governed through: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Alcohol and drug partnerships | 88 | 2 | 10 |
| Integrated children's services strategic planning | 81 | 5 | 14 |
| Community planning partnerships | 69 | 14 | 17 |
| Justice partnerships | 57 | 19 | 24 |

While panellists reached consensus that preventative, early intervention and harm reduction services for young people should be developed, delivered and governed through alcohol and drug partnerships and integrated children's services strategic planning, there were lower levels of support for the inclusion of community planning partnerships (69%) and justice partnerships (57%) in the consensus approach.

### Table 24: Advocacy (stakeholder panel, n=42)

| Additional advocacy for young people to ensure that they and their families have access to safe and consistent support should be provided by: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Children's commissioner | 69 | 5 | 26 |
| Specialist commissioner for drugs and alcohol | 64 | 7 | 29 |

The panel did not reach consensus on the provision of advocacy by either a specialist commissioner for drugs and alcohol or by the children's commissioner, meaning neither aspect of this statement reached the 75% approval threshold for inclusion in the consensus approach. While there were low levels of explicit disagreement, over a quarter of the panel provided 'don't know' or blank responses.

## 2.3. Information

All statements related to approaches to information were met with high levels of support from the panel.

### Table 25a: Information, guidance and resources (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| There is a need for centralised guidance or standards to ensure that those involved in substance use harm prevention activity take a consistent approach and deliver a consistent message. | 86 | 7 | 7 |
| Information about substances should be delivered as part of a multi component approach which also includes changes to the environment, evidence-based interventions for the whole population and targeted population prevention measures. | 86 | 5 | 10 |
| It is important that information, guidance and resources remain up-to-date, relevant and responsive to local issues and trends. | 100 | 0 | 0 |
| It is the responsibility of the Scottish Government to ensure that information, guidance and resources remain up to date through strategic commissioning of updates. | 88 | 7 | 5 |

## Table 25b: Information, guidance and resources (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| It is important that information, education and guidance remain up-to-date, relevant and responsive to local issues and trends. | 100 | 0 | 0 |

The idea of centralised guidance and standards being implemented was broadly welcomed, with 86% of the panel agreeing with this statement. However, a few highlighted the need for flexibility to allow approaches to adapt to meet the specific needs of the local context, communities, and individuals. Others commented on the need for evaluation to ensure standards are being met. One recommended that PHS should be responsible for producing and disseminating centralised guidance/standards, while another referred to the European Prevention Curriculum as a useful guide.

Responses to the stakeholder panel and young people surveys showed unanimous agreement on the need for information, guidance and resources to remain up-to-date, relevant and responsive to local issues and trends. While 88% of the panel felt it is the Scottish Government's responsibility to ensure that information, guidance and resources remain up to date, a few panellists disagreed and felt this responsibility should either fall with or be shared with other agencies, such as local government or a new dedicated specialist team.

## 2.4. Education-based initiatives

All statements under the theme of education-based initiatives achieved over 75% agreement and are therefore included in the full consensus approach.

### Table 26a: Educational principles (stakeholder panel, n=42)

| Information and education around substance use harm prevention should: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Be non-judgemental | 100 | 0 | 0 |
| Be evidence based | 100 | 0 | 0 |
| Empower young people to make informed decisions | 100 | 0 | 0 |
| Focus on building resilience and decision-making skills | 98 | 2 | 0 |
| Educate children and young people about the marketing/targeting tactics and commercial interests of relevant industries (e.g. alcohol) | 95 | 0 | 5 |
| Be delivered as part of other activities/support and not as stand-alone/siloed education | 83 | 7 | 10 |

### Table 26b: Educational principles (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Information and education around substance use harm should not be judgemental, dictatorial or coercive but factual, evidence-based, reliable and honest information which empowers young people to make informed decisions. | 100 | 0 | 0 |

There was unanimous agreement among both the young people surveyed and professional stakeholder panel that information and education around substance use harm prevention should be non-judgemental, evidence-based and empower young people to make informed decisions.

### Table 27a: Educational settings (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Scotland should have a single, evidence based universal prevention framework to meet the health and wellbeing outcomes related to substance use within Curriculum for excellence. | 78 | 5 | 17 |
| It is essential that substance use harm prevention information is also delivered outwith school settings to reach young people who are not engaged with education or have low attendance. | 100 | 0 | 0 |

### Table 27b: Educational settings (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| It is important that substance use harm prevention efforts are also delivered outwith school settings to reach young people who are not engaged with education or have low attendance. | 100 | 0 | 0 |

Panellists broadly supported the idea of a single evidence-based universal prevention framework to inform the Curriculum for Excellence. It was raised in open comments that this would require flexibility to account for local contexts and trends.

The professional stakeholder panel and the children and young people surveyed unanimously agreed that substance use harm prevention information should be delivered outwith school settings. Panellists once again noted the vulnerability and

risk of those young people who may not be attending school. The COVID-19 pandemic was also cited as having affected school attendance, with an increase in part-time timetables and homeschooling. One young person advocated for an online safe space for people who do not want to speak face-to-face or might be scared to do so.

### Table 28a: Educational methods (stakeholder panel, n=42)

| There are a range of ways to educate young people about substance use harms and promote healthy behaviours. These include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Lessons in a classroom | 93 | 7 | 0 |
| Lessons in a youth work setting | 93 | 5 | 2 |
| Social media | 88 | 7 | 5 |
| Peer education (including lived/living experience) | 81 | 7 | 12 |
| Storytelling / drama / theatre | 81 | 10 | 10 |
| Popular culture (movies, television) | 79 | 14 | 7 |

### Table 28b: Educational methods (children and young people, n=28)

| There are a range of ways to educate young people about substance use harms and promote healthy behaviours. These include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Peer education (including lived/living experience) | 93 | 0 | 8 |
| Lessons in a youth work setting | 93 | 4 | 4 |
| Social media | 89 | 11 | 0 |
| Lessons in a classroom setting | 82 | 15 | 4 |
| Popular culture (movies, television) | 64 | 29 | 8 |
| Storytelling / drama / theatre | 57 | 21 | 22 |

The professional stakeholder panel agreed with all of the proposed ways to educate young people about substance use harms and promote healthy behaviours. Several panellists highlighted that parents/carers/families, as legally recognised primary educators in Scotland, should play a role in educating and sharing information about substance use harms and healthy behaviours. Both the panel and the children and young people showed strong support for youth work as a setting for substance use harm education.

While 81% of the professional stakeholder panel agreed that storytelling, drama and theatre can be used to educate children and young people about substance use harms, the young people surveyed were less supportive; only 57% agreed with this statement. The wider literature consulted also indicates limited effectiveness of arts-based interventions. A **literature review** published by the Scottish Government cites evidence indicating that theatre/drama-based education is ineffective in preventing illegal drug use. Some studies (Maina et all (2022) do report benefits of using arts-based initiatives as a vehicle to deliver messages on substance use prevention, including the ability to deliver engaging, fun and helpful interventions which can increase knowledge and change attitudes and practices on substance use among youth. These studies do not, however, provide evidence of long-term success in preventing substance use harm.

## Table 29a: Groups involved in education (stakeholder panel, n=42)

| The following groups should be involved in sharing substance use harm prevention information with children and young people, and should be supported to do so in a way that maximises effectiveness and equity. | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Youth workers | 100 | 0 | 0 |
| Teachers | 95 | 5 | 0 |
| Other external agencies (e.g. third sector, health bodies) | 88 | 2 | 10 |
| People with lived/living experience | 81 | 10 | 10 |
| Police | 71 | 29 | 0 |

## Table 29b: Groups involved in education (children and young people, n=28)

| The following groups should be involved in delivering substance use harm prevention education to children and young people: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| People with lived/living experience | 96 | 4 | 0 |
| Youth workers | 96 | 0 | 4 |
| Teachers | 82 | 11 | 8 |
| Police | 79 | 18 | 4 |

Panellists reached a consensus that teachers, youth workers, people with lived/living experience, and other external agencies should be involved in sharing substance use harm prevention information with children and young people.

There were mixed views on the involvement of people with lived/living experience, with some feeling that they would have a positive effect and others questioning the lack of evidence base to support this. A Scottish Government **literature review** examining the evidence of the effectiveness of different types of drug prevention and education for children and young people notes that 'using ex-drug users as testimonials in the classroom – an approach anecdotally considered to be popular in secondary schools in the UK – is also associated with no or negative prevention outcomes.' Across all phases of the present study, children and young people showed a consistent preference for the inclusion of lived/living experience in information or education about substance use harm prevention. However **international guidelines** from the WHO and UN System do not support the use of these approaches.

As with previous rounds, there was less agreement on the role of the police. Young people showed higher levels of agreement than the expert panel (79% compared with 71%). Issues raised by the panel included the difficulties of the police having a punitive role and the fact that police approaches do not always align well with trauma- and stigma-informed approaches. In fact, a UK **study** by Jackson et al (2022) found that experiencing a police stop by age 14 is linked with higher rates of

alcohol, cigarette, e-cigarette, and illicit drug use at age 17; as a result, it called for further research into a possible causal link between the potential negative psychological effects of police stops and substance use trajectories.

Panellists also highlighted the challenges around young people's relationships with and trust in the police, which aligned with views expressed by the children and young people in our study. Data from **ethnographic research** (Deuchar et al, 2019) found that views on the police differed throughout Scotland. The young people interviewed in the East of Scotland had more positive views of the police and trust in the justice system. In contrast, young people in the West of Scotland, particularly young men, were less likely to have trusting relationships with the police and this was attributed to the use of stop and search as a deterrent.

In addition, the panel cited specific tensions between the police and marginalised groups, such as ethnic minorities or LGBTQIA+ young people. It is well evidenced that children aged 10–17 from certain ethnic groups are overrepresented in rates of arrests, stop and searches, and the monthly youth custody population (Youth Endowment Fund, 2025). A recent Scottish Government (2023) report offers mixed evidence on interactions between minority ethnic groups and the police. The survey found that people from all minority ethnic groups are more likely to hold positive views of the police than the national average. There are, however, exceptions where minority ethnic groups have a more negative view of the justice system in relation to the fairness around the treatment of those accused of a crime.

Trust in the police among LGBTQIA+ young people is also low; a recent Scottish Government **evidence review** highlighted that the service where people felt the least comfortable about disclosing their non-binary gender was with the police, with 69% of respondents saying they never felt comfortable (Scottish Trans, 2016). In 2022, LGBT Youth Scotland found that only 11% of non-binary young people felt confident in reporting a hate crime to the police.

### Table 30a: Discussing substance use (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Building relationships is key to having supportive conversations about substance use and harm reduction. | 98 | 2 | 0 |
| Young people should feel comfortable discussing their substance use with a trusted adult and confident they will not be punished for it. | 98 | 0 | 2 |

### Table 30b: Discussing substance use (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Building relationships is key to having supportive conversations about substance use and harm reduction. | 100 | 0 | 0 |
| Young people should feel comfortable discussing their substance use with a trusted adult and confident they will not be punished for it. | 96 | 4 | 0 |

Strong consensus was evident across the statements in Tables 30a and 30b, with clear support for the use of relationship-based practice. Some panellists commented that trusting relationships with non-judgemental and approachable people were key in enabling young people to discuss substance use and subsequently be provided with or signposted to support. However, panellists cautioned how this would sit within legal frameworks and responsibilities, particularly with those in professional roles such as teachers and social workers.

The young people surveyed also expressed clear support for these statements, with 100% agreeing on the importance of building relationships and 96% agreeing that

young people should feel comfortable discussing their substance use with a trusted adult without fear of judgement or punitive consequences.

## 2.5. Data and research

The statements under the theme of data and research were well received by the panel, with all achieving over the 75% threshold of agreement.

### Table 31a: Data sources and topics (stakeholder, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The national approach to substance use harm prevention should be data driven and evidence based. | 98 | 0 | 2 |
| Different sources of data and evidence should inform the strategy and determine priority areas (including lived/living experience, public health data, practitioner experience, academic expertise and international best practice). | 98 | 2 | 0 |
| More timely, regular and effective data gathering and recording methods are needed to monitor: substance use among children and young people; risk factors and protective factors; and effectiveness of substance use harm prevention activities. | 93 | 5 | 2 |

The above statements received strong support from the panel, with agreement that the national approach should be data-driven and evidence-based, informed by sources including public health data and lived/living experience, and supported by more regular and effective data collection.

## Table 31b: Data sources and topics (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The strategy should be based on up-to-date research and data, including studies from experts and people's real-life experiences. | 93 | 0 | 7 |
| We need to collect and record information more often and in better ways to keep track of: how many children and young people are using substances like alcohol and drugs; what things make it more likely or less likely for them to use these substances; and how well our efforts to prevent substance use are working. | 96 | 0 | 4 |

Young people's survey responses aligned with the panel in the area of data and research, particularly with support for lived experience informing approaches to substance use harm prevention.

While supportive of the use of data and evidence in the strategy, the panel reiterated concerns from previous rounds about possible limitations, including:

- Gaps in current data and evidence base, including a lack of data about drug prevalence among children and young people.
- Applicability of existing evidence across population groups.
- The need for data to be independent from industry/funding influence.
- Participant engagement – i.e. SALSUS missed groups of young people by focusing on those who attended school.

Throughout the Delphi process, panellists emphasised the importance of utilising different methodologies, particularly qualitative research. Open comments addressed

the importance of including personal, lived experiences of individuals and communities and gaining more information about the barriers they may face.

The panel also highlighted the importance of local data input alongside a national picture, particularly when considering Scotland's varied demographics. One panellist cited a disparity between national survey results and the experiences of young people reported by local services, including the types of substances that should be of primary concern.

### Table 32: National surveys (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| National surveys should be used to collect data about substance use among children and young people; risk factors and protective factors. | 81 | 5 | 14 |

Although the panel reached a consensus on using national surveys to collect data on substance use in children and young people, concerns were raised about over-surveying and over-recording data. Some panellists mentioned the need to rebuild young people's trust after the recent Health and Wellbeing Census (Scottish Government, 2021); this census has been criticised on several ethics-related grounds, including 'opt-out' consent, and the lack of anonymity of the initial dataset, where students could be identified by their Scottish Candidate Numbers.

## Table 33: Further data and research (stakeholder panel, n=42)

| Further data/research is needed on: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Influence of social media and popular culture on children and young people substance use | 90 | 0 | 10 |
| Current service provision | 88 | 2 | 10 |
| Health consequences of vaping | 88 | 7 | 5 |
| Links between inequalities and substance use harm and protective factors that improve health outcomes | 81 | 14 | 5 |
| Causative factors, such as family, social, cultural and structural issues that are predictive of future substance use harm | 76 | 14 | 10 |
| Scottish application of Icelandic Prevention Model principles | 67 | 14 | 19 |
| Impact of COVID on substance use among children & young people | 62 | 21 | 17 |

Panellists reached consensus on the need for further data/research on causative factors; links between inequalities and substance use harm and protective factors that improve health outcomes; the influence of social media and popular culture; current service provision; and the health consequences of vaping.

While they agreed on these areas, they also acknowledged that there is already a large existing body of research on causative factors, inequalities, and protective factors.

The panel did not agree on the inclusion of further data/research on the impact of COVID-19 on substance use among children and young people, but did not expand on their reasons for this in the open comments. Literature on the impact of COVID-19 on the substance use of children and young people is very conflicted, with studies

showing mixed results of both increases and decreases in substance use (Stout et al, 2024).

Themes raised by the existing literature are the influence of peer relationships on substance use and the resulting reduction in use during the COVID-19 pandemic, when young people were separated from their peers. For example, longitudinal research on UK students found a significant decrease in alcohol consumption under COVID-19 lockdowns, presumed by researchers to be attributable to the lack of social opportunities for alcohol use (Evans et al, 2021).

Research on the nicotine use of young people found mixed effects of COVID-19 on smoking and vaping behaviour (McNeill et al, 2022). The ITC Youth survey reported that 8% of past year vapers reporting quitting vaping and 15% reported cutting down, both due to the COVID-19 pandemic. However, 15% reported vaping more as an effect of the pandemic. Similar effects were found in cigarette use.

A consensus was also not reached on including further data/research on the Scottish application of the Icelandic Prevention Model. While the Icelandic Prevention Model has received international praise for its results in Iceland, the European Society for Prevention Research drew attention to the limited research of its impact in other locations. Planet Youth pilots of the Icelandic Prevention Model in areas across Scotland were only briefly mentioned throughout the Delphi process.

The Planet Youth model was discussed in relation to focus on community support and access to leisure activities serving as key protective factors. While the Icelandic Prevention Model has received international praise for its results in Iceland, there is little research confirming its successful implementation in other locations. Panellist comments, therefore, cautioned against adopting other cultural approaches at great financial cost, highlighting how the Icelandic outlook and culture differ significantly from Scotland's and cautioned against adopting other cultural approaches at great financial cost. This reflects findings from previous research on adapting the IPM for Scotland, in which stakeholders described barriers relating to funding, political systems, and cultural differences (Carver et al, 2021). Concerns over differing social contexts have also been replicated in other research on the challenges of applying the IPM (Konig et al, 2021), describing how Iceland's high ratings in social relations

and perceived quality of support from social networks are key for a model based on increased social control and support (Sigfusdottir et al, 2011).

### Table 34: Minimum dataset (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| A minimum dataset to support planning and delivery of preventative action should be developed and shared across different policy areas/agencies. | 86 | 0 | 14 |

Panellists agreed with a minimum dataset in principle. Concerns were raised over sustaining the impartiality of third sector services from the interests of short-term funders.

## 2.6. Targeted prevention measures

All of the statements under the theme of targeted prevention measures achieved over 75% agreement.

### Table 35: Targeted prevention programmes (stakeholder panel, n=42)

| Programmes of targeted prevention are needed for: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Children and young people affected by a family member's substance use | 98 | 0 | 2 |
| Children, young people and families who have experienced trauma | 95 | 2 | 2 |
| Children, young people and families affected by a substance-related death | 95 | 2 | 2 |

| Programmes of targeted prevention are needed for: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Families with severe, complex and multiple disadvantages e.g. living in poverty, in poor housing, experience of the justice system | 95 | 5 | 0 |
| Education settings and wider communities affected by a substance-related death | 88 | 5 | 7 |

There was a strong consensus for the inclusion of programmes of targeted prevention for certain individuals and families. In open comments, however, panellists advocated for targeting systemic issues, such as poverty and support for those who have experienced trauma. Some specifically stressed the need to support children and young people who have been affected by a substance-related death, but cautioned against increasing stigma in this situation, and reflected that the support may come too late.

### Table 36: Designing targeted prevention measures (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Risk and protective factors are complex and interdependent; this complexity should be considered when designing targeted preventative and early intervention or harm reduction measures. | 98 | 2 | 0 |
| Targeted prevention measures should recognise and be tailored to the requirements of particular population subgroups e.g. based on gender, young people who identify as LGBTQ, young people from traveller or ethnic minority communities. | 79 | 17 | 5 |

Although it passed the threshold for inclusion in the consensus approach, providing targeted prevention measures for particular population subgroups was a moderately contentious issue within the open comments. Many panellists disagreed with tailoring approaches based on assumptions about gender/sexuality/culture and advocated instead for tailoring to the needs of the individual. Some panellists acknowledged that, although there are a disproportionate number of LGBTQ+ people who experience negative outcomes from substance use, specifically targeting the group might increase stigma around gender or sexuality. An alternative approach would be to recognise the impact that prejudice might have on individuals.

## Table 37: Principles of targeted prevention (stakeholder panel, n=42)

| Principles for targeted prevention include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Proactively going to where young people are | 98 | 0 | 2 |
| Multiagency working | 98 | 0 | 2 |
| Resilience building | 98 | 0 | 2 |
| Whole family approaches | 95 | 0 | 5 |
| Trauma informed | 95 | 0 | 5 |
| In situations of exploitation, considering the child to be a victim, not a perpetrator and ensuring appropriate safeguarding | 95 | 0 | 5 |
| Defined pathways | 93 | 2 | 5 |

All aspects of the statement in Table 37 received strong support from the panel. However, open comments noted that whole family approaches may not always be productive for the individual child or young person.

## Table 38: Access to targeted prevention (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| There should be consistency in targeted prevention approaches available across different local authority areas; children, young people and families should have equal access to support regardless of where they live. | 93 | 2 | 5 |
| More should be done to raise awareness of availability, and improve accessibility and acceptability of existing support services for young people who use substances. | 95 | 0 | 5 |

Both of these statements achieved a high level of consensus. Open comments focused on the need for equitable access rather than equal, with support adapted based on local needs.

## Table 39: Barriers to support (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Substance use should not be a barrier to young people accessing mental health treatment/CAMHS support/other services. Better integration of mental health and substance use-related support for children and young people is needed. | 100 | 0 | 0 |

Panellists unanimously agreed with statement 49, reflecting on how mental health and substance use issues often go hand in hand. In comments, panellists noted that substance use can be considered a form of self-medication, and prohibiting access to child and adolescent mental health support services on this basis increases the risk of substance-related harm.

## Table 40: Scope of guidance and training (stakeholder panel, n=42)

| 50. Guidance and/or training should be developed for those involved in substance use harm prevention, including information and guidance on: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Harm prevention activities | 100 | 0 | 0 |
| How to respond in situations of risky or problematic substance use | 100 | 0 | 0 |
| Child criminal exploitation in relation to substances | 100 | 0 | 0 |
| Online safety to address the availability and access to drugs via online channels and digital sources (social media, dark web) | 98 | 2 | 0 |
| How best to support and educate young people with protected characteristics, including additional support needs and different cultural and religious backgrounds | 95 | 0 | 5 |
| How to identify those at risk of substance use harm or affected by substance use of family members, including guidance on how to define different types of substance use, e.g. experimental, problematic or dependent use | 95 | 2 | 2 |

The panel showed strong consensus for the above areas to inform guidance and training for those involved in substance use harm prevention, agreeing that training and up-to-date guidance is essential. In the open comments, further additions were suggested:

- The changing drug market
- Innovative harm reduction approaches
- Sexual exploitation in relation to substances
- Available sources of support for children, young people and families

## 2.7. Harm reduction

All statements related to harm reduction achieved over 75% agreement and are therefore included in the full consensus approach.

### Table 41a: Harm reduction measures (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Harm reduction measures are an important aspect of substance use harm prevention. | 98 | 0 | 2 |

### Table 41b: Harm reduction measures (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Harm reduction measures are an important aspect of substance use harm prevention. | 89 | 4 | 7 |

This was the most popular statement of theme 7, across both the expert panel and the children and young people. In the panel's comments, they discussed how harm reduction measures needed to be age- and stage-appropriate and that interventions and risks can be very different from those for with adults who use substances. These comments were a recurring topic across all of the statements under theme 7.

In the children and young people's open comments, they reflected that people were always going to take drugs, so it was important to keep people safe and lower the risk of serious harm.

## Table 42a: Approaches to harm prevention (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| A balanced approach to substance use harm prevention, which reflects both harm reduction and abstinence-based approaches, is needed. | 93 | 2 | 5 |

## Table 42b: Approaches to harm prevention (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| A balanced approach which reflects both harm reduction and abstinence-based approaches, is needed. | 79 | 0 | 21 |

The expert panel perceived the combination of abstinence and harm reduction approaches to be important for children and young people. It was acknowledged that abstinence-only approaches could be unrealistic or counterproductive, but that both approaches need to be considered in the context of the young person as an individual.

Children and young people also reflected on the disadvantages of an abstinence-based approach, suggesting it was unrealistic to expect abstinence to work for everybody and that some young people would always rebel against things they are told not to do.

The evidence on abstinence-based approaches in children and young people is mixed and therefore supports the view that approaches should be balanced and based on the individual or the culture in which they live. The **Longitudinal Study of Adolescent Health** in the US (Sacks et al, 2014 revealed that young people who

attended schools with ‘zero tolerance’ policies were no more or less likely to be binge drinkers or to take drugs as young adults who did not.

Conversely, other studies found that harm minimisation was less effective than zero tolerance approaches in reducing alcohol problems in Australia (Epstein et al, 2021) and that zero-tolerance laws around alcohol limits for US drivers under the age of 21 had led to sharp reductions in youth binge drinking (Abboud et al, 2024). Eekhoudt, et al (2024) caution against an exclusive focus on abstinence for certain vulnerable populations of young people, which they argue can be not only unproductive, but harmful.

### Table 43: Safer consumption (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don’t know/Not answered (%) |
|---|---|---|---|
| Information/measures around safer consumption of drugs should be included in the approach to substance use harm prevention, with careful consideration of language and context. | 88 | 5 | 7 |
| There should be greater investment in and availability of safer consumption infrastructure (e.g. harm reduction information, drug safety testing, access to naloxone); this should be implemented in a controlled, evidence-based way to avoid unintended consequences. | 76 | 7 | 17 |

Including information and measures around safer consumption in the approach to substance use harm prevention achieved strong consensus among the panel, but it was noted that safe levels and types of substance use were different for young people as opposed to adults.

The statement regarding safer consumption infrastructure only marginally reached the threshold for inclusion in the consensus approach. As with other statements in this section, panellists advocated for implementing only age-and-stage-appropriate safe consumption infrastructure. This was particularly relevant to comments about

naloxone (a medicine to reverse opioid-related overdoses), which cautioned against normalising it in children and young people and instead advocated for access for those living with substance use in their family.

Panellists did agree, however, that drug testing/checking services were an appropriate harm reduction measure for young people and should be considered.

### Table 44a: Substance use first aid (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| First aid courses which equip children and young people to respond to an emergency situation involving substance use should be developed and delivered as part of a prevention strategy. | 93 | 5 | 2 |

### Table 44b: Substance use first aid (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| First aid courses which equip children and young people to respond to emergency situations involving substance use should be developed and delivered. | 86 | 0 | 15 |

Provision of substance use first aid courses was strongly supported by the panel, although it was again noted that this should be age and stage appropriate. The potential skills and attitudes gained through this training were seen as an effective way of reducing harm and stigma.

Panellists also reported that the young people they work with were highly supportive of first aid courses for substance use. This aligned with our feedback from young people throughout the whole Delphi process. Young people believed it was important

for others to know how to help their friends or others if they were in dangerous or emergency situations.

## 2.8. Early identification and intervention

Most statements under the theme of early identification and intervention qualified for inclusion in the consensus approach.

### Table 45: Early identification principles (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Early identification and intervention are key components of a prevention approach; addressing behaviours and risk factors at an early stage is key in preventing substance use harm. | 98 | 2 | 0 |

### Table 46: Early identification settings and services (stakeholder panel, n=42)

| The following settings and services are key for early identification of risky or problematic substance use and intervention support. | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Home | 98 | 0 | 2 |
| School | 93 | 2 | 5 |
| Outreach services | 86 | 0 | 14 |
| Detached work | 74 | 2 | 24 |

The panel strongly supported the principles of early identification and intervention. Panellists also supported early identification and intervention support taking place through home, school, and outreach services. Less consensus was achieved on the role of detached work in early identification of problematic substance use and

intervention support. This was, however, due to a larger number of panellists selecting “don’t know” rather than high scores for disagree or strongly disagree. Furthermore, open comments revealed that many panellists were unsure about the meaning of “detached work”.

The importance of detached youth work is also supported by the literature. Detached youth work is a form of youth work that occurs outdoors in public spaces such as streets and parks, where young people naturally gather. A **longitudinal, qualitative research study** (Deuchar et al, 2017) found that detached youth work in Glasgow was able to reach and build relationships with a diverse range of young people, enabling them to address issues such as violence, drugs and alcohol. Stead et al (2017) also found that it was feasible to deliver alcohol brief interventions to young people in community-based youth work settings in Scotland. Young people were positive about conversations with project staff about alcohol, provided there was a trusting relationship in place. The settings also allowed identification and intervention delivery to be opportunistic, with the young people themselves frequently initiating conversations about alcohol. This allowed a different approach from primary healthcare settings.

### Table 47a: Trauma-informed practice (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don’t know/Not answered (%) |
|---|---|---|---|
| Trauma informed practice is key to supporting those at risk of substance use harm. Consistent, reliable, non-judgemental relationships and safe spaces are key within interventions. | 95 | 2 | 2 |

## Table 47b: Trauma-informed practice (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Trauma informed practice is key to supporting those at risk of substance use harm. Consistent, reliable, non-judgemental relationships and safe spaces are key within interventions. | 93 | 0 | 7 |

The use of trauma-informed practice received strong approval from both the panel and the children and young people. In open comments from both groups, trusting relationships were described as an important part of this, and panellists commented that building trusting relationships with young people is often a longer process than with adults.

## Table 48: Access to services (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Steps taken to improve access to services (e.g. low threshold access, flexible appointments, local locations and reimbursement of travel costs) should be scrutinised as part of routine governance of the services. | 95 | 2 | 2 |
| Young people should be able to access services appropriate to their developmental stage, individual needs and circumstances rather than according to their chronological age. | 95 | 0 | 5 |

Both of these statements received strong support from the panel. Panellists suggested further considerations around barriers to accessing services and how these might be assessed:

- Ease of referral and intake procedures.
- Tracking appointment availability and whether flexible scheduling is meeting demand.
- Geographic distribution of services and whether they are meeting the needs of different areas (especially in rural regions).
- Accessing reimbursement of travel costs e.g. complicated claim processes.
- Impact of poor transport systems.
- Robust requirements for health impact assessment.

### Table 49a: Punitive approaches to substance use harm prevention (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Punitive approaches alone are not effective; a more humane and trauma informed approach to addressing substance use should be adopted. | 98 | 2 | 0 |
| The decriminalisation of drug use should be considered and researched further. | 69 | 7 | 24 |

While nearly two-thirds of the panel (45 out of 70, 65%) agreed that decriminalisation of drug use should be considered and researched further, this statement did not reach the threshold for inclusion in the consensus approach. Many indicated support for substance use being treated as a health issue rather than a criminal one, and supported avoiding the wider impacts of giving criminal records to young people. Panellists also, however, considered the issue of decriminalisation to be highly

contentious and politically divisive, and felt its inclusion in the consensus approach risked distracting from its primary objectives. Others raised concerns about the practical implications of decriminalisation and potential inconsistencies with existing legislation. However, this is an area that needs to be further developed.

### Table 49b: Punitive approaches to substance use harm prevention (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The decriminalisation of drug use should be considered and researched further. | 57 | 11 | 32 |

While panellists strongly supported moving the emphasis away from punitive approaches, a consensus was not reached on further consideration of the decriminalisation of drug use.

A large number of the open comments indicated support for substance use being treated as a health issue rather than a criminal one. Many also supported avoiding giving criminal records to young people for substance use to prevent the long-term impacts on their lives, and to reduce the prison population.

For many panellists, the motivation for excluding decriminalisation centred on a belief that such a contentious issue had the potential to distract from this strategy's objective: harm prevention.

Some panellists mentioned thinking that decriminalisation of drugs could be an ineffective policy and increase issues with, and rates of, substance use, citing an example of alcohol in Scotland. There is mixed literature on whether the decriminalisation of substances results in increased use. For example, Wu et al (2023) found an increase in adolescent cannabis use in Washington State after decriminalisation. This effect was also found by Schwartz et al (2024) in adolescents in South Africa admitted to hospitals with mental health illnesses. This contrasts with

other studies, which have found no statistically significant changes in cannabis use in young people post-decriminalisation (Cil et al, 2023)

Previous research has also found that decriminalisation can change cultural perceptions of substances. Studies in the US have found that the perception that cannabis is harmful has decreased dramatically among US adolescents and young adults (Keyes et al, 2016; Miech, Johnston & O'Malley, 2017).

Among children and young people, the issue of decriminalisation was quite contentious, and their comments reflected the same views of the expert panel. They raised some of the possible benefits to harm reduction: it would reduce stigma and punishment for substance use, along with people being more aware of what they were taking. The children and young people also showed concerns about decriminalisation increasing the usage of drugs. Some of them expressed that decriminalisation could perhaps be applied for certain illegal drugs that might be used medically, such as cannabis, but not to all drugs.

### Table 50: Researching prevention and early intervention (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The Scottish Government should identify prevention and early intervention research priorities and gaps for academia and research funders | 83 | 7 | 10 |

Despite achieving a consensus for inclusion in the final approach, the panel had mixed views on this statement. Those in support felt that developing prevention strategies was important, particularly among vulnerable populations and linked to the social determinants of health. Others felt that the Scottish Government was not the correct organisation to identify research priorities or gaps. Others felt that there would not be the budgets available for this work and that the government should prioritise evaluations of research interventions.

## 2.9. Place and community

The statements under the theme of place and community, all met the 75% threshold for inclusion in the full consensus approach.

### Table 51a: Local context (stakeholder panel, n=42)

| Local context should be considered in substance use harm prevention approaches/strategies, including: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The unique needs of rural and remote communities | 95 | 0 | 5 |
| The presence, availability, and ease of access to substances | 95 | 0 | 5 |
| The presence, availability, and ease of access to harm reduction, treatment, and support services | 95 | 0 | 5 |
| Ways to address substance use (including hidden use) in affluent areas | 93 | 2 | 5 |

### Table 51b: Local context (children and young people, n=28)

| When designing substance use harm prevention approaches, we need to think about different context and circumstances. This includes: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| How to deal with substance use in affluent (i.e. well off) areas | 86 | 0 | 14 |
| The needs of people living in rural and remote areas (i.e. not in big cities and urban areas like Edinburgh and Glasgow, but rather the countryside (Scottish Borders, Aberdeenshire) or islands (Shetland, Orkney) | 82 | 0 | 18 |
| How easy it is to get substances in different places | 79 | 7 | 14 |
| How easy it is to access help and support to stop using substances. | 71 | 11 | 18 |

The panel strongly supported the consideration of local context and culture, reflecting on how this can play a crucial role in shaping effective harm prevention approaches and strategies. One panellist cautioned against sweeping assumptions based on categories such as rural areas, advocating instead for approaches local to specific areas.

### Table 52: Community-based approaches (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| A targeted prevention strategy and funding should be developed for places experiencing disproportionate levels of substance-related harm. | 93 | 5 | 2 |
| Social and community support has a key role to play in minimising substance use harms by promoting protective factors. | 98 | 2 | 0 |

Although the panel strongly supported having a targeted prevention strategy and funding for places experiencing disproportionate levels of substance-related harm, the open comments were mixed. Some highlighted the need to target areas which face unique social, economic and environmental challenges that exacerbate substance use and related harms. One panellist suggested that targeted prevention could take the form of diversionary activities, such as groups and clubs, including sport.

The role of social and community support received the strongest approval from panellists, who highlighted the importance of positive relationships and reiterated the value of diversionary activities. Some drew positive comparisons with the Planet Youth model and its focus on community support and access to leisure activities as key protective factors. The research on this is mixed, Tome et al (2023) suggested that leisure activities can serve as a protective factor for adolescent wellbeing and life satisfaction, but can also be associated with an increase in substance use and other risky behaviours, particularly alcohol use.

## Table 53: Place-based approaches (stakeholder panel, n=42)

| Place based approaches for targeted prevention and early intervention can include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Supported accommodation | 90 | 2 | 7 |
| Clubs | 88 | 2 | 10 |
| Festivals | 83 | 5 | 12 |
| Parks / green spaces | 81 | 5 | 14 |

## Table 54: Environmental design (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Place based approaches should consider evidence based environmental design to reduce the risk of substance harms e.g. designing adequate ventilation and cooling off areas in night clubs | 88 | 2 | 10 |

All the possible places for targeted prevention and early intervention were agreed for inclusion in the full consensus approach. Onepanellist questioned the evidence base for these approaches, while other panellists suggested other places for inclusion:

- Major events (e.g. concerts, sports events)
- Other outdoor spaces – beaches, woodland
- Street work
- Youth organisations
- Entertainment and hospitality venues

Panellists generally supported considering evidence-based environmental design. Suggestions included:

- Drug testing facilities.
- Minimum standard of training in drug harm reduction for nightclub staff.
- Safe spaces in the nighttime economy, for protection following excessive use.

Issues were raised around applying these approaches, with questions on whether this would involve reducing the number of outlets selling legal substances in an area, or by making licences dependent on providing environmental design to reduce the risk of substance harms.

### Table 55: Online environments (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| All prevention, early intervention and harm reduction interventions should consider the online / digital environment. | 93 | 5 | 2 |

This statement received strong support. The online environment was described as an 'essential part of day-to-day life' for children and young people and a key way to access information, which meant that it could be a risk factor for young people.

Young people engage well in online or digital support, so online environments can also offer protective factors. One panellist cited a survey in their local authority (1,600 young people and 394 parents) which found that young people and their parents both wanted early intervention prevention messaging of substances via digital methods.

## 2.10. Protective factors

Every statement under theme 10 (Protective factors) surpassed the 75% threshold for inclusion in the full consensus approach.

## Table 56a: Protective factors (stakeholder panel, n=42)

| The following protective factors should be considered as part of substance use harm prevention approaches/strategies: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Access to safe, stable housing | 98 | 0 | 2 |
| Access to extra-curricular activities/youth groups | 98 | 0 | 2 |
| Access to community facilities/activities/resources | 98 | 0 | 2 |
| Access to a trusted adult | 98 | 0 | 2 |
| Access to digital and online communities | 98 | 0 | 2 |
| Access to leisure activity | 95 | 0 | 5 |
| Access to mental health support | 95 | 0 | 5 |
| Positive family relationships | 95 | 2 | 2 |
| Access to green space/nature/outdoors | 93 | 2 | 5 |

The expert panel strongly agreed with the individual protective factors, listed in the above statement. Further factors were suggested by the panel for possible inclusion:

- Access to peer support
- Access to affordable public transport
- Closing attainment gap for further education
- Access to work experience placements
- Access to music and arts
- Access to adequate financial means

## Table 56b: Protective factors (children and young people, n=28)

| Some aspects of life can help protect children and young people from substance use harm. This includes: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Access to safe, stable housing | 93 | 0 | 7 |
| Positive family relationships | 93 | 0 | 7 |
| Access to community facilities/activities/resources | 93 | 0 | 7 |
| Access to green space/nature/outdoors | 93 | 0 | 7 |
| Access to mental health support | 93 | 0 | 7 |
| Access to leisure activity (like sports & games) | 89 | 4 | 7 |
| Access to a trusted adult (like a teacher, youth worker or parent) | 89 | 4 | 7 |
| Access to extra-curricular activities/youth groups | 85 | 4 | 11 |
| Access to digital and online communities | 82 | 4 | 15 |

Children and young people also strongly agreed with the list of individual protective factors. A safe home environment was a particularly popular factor across both the survey responses and the open comments. Several young people raised a lack of leisure activities available for young people, including the shutting of youth clubs, which could potentially have protected them from risk.

## Table 57a: Licensing and restrictions (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| New restrictions around the advertising, sales and availability of legal substances (e.g. alcohol and vaping/e-cigarettes) should be introduced. | 90 | 0 | 10 |

## Table 57b: Licensing and restrictions (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| New restrictions around the advertising, sales and availability of legal substances (e.g. alcohol and vaping/e-cigarettes) should be introduced. | 75 | 11 | 14 |

The panel strongly supported new restrictions on the advertising, sales, and availability of legal substances, with open comments particularly supporting restrictions on advertising. Digital advertising was also mentioned, with issues around social media and implicit advertising.

The children and young people felt strongly that new restrictions should be placed on the advertising, sales, and availability of legal substances; the Children's Parliament group that participated in the study reached consensus that this issue was their highest priority. Vape marketing and sales were frequently mentioned in Rounds 2 and 3, with children and young people criticising them for being too colourful, appealing, and visible to young people.

## Table 58: Licensing forums (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Licensing forums should represent a diverse range of voices, including local communities and lived/living experiences, and young people. | 81 | 5 | 14 |

This statement received less support than the others in this section. Many panellists noted the limitations in the functioning and influence of licensing forums and a pronounced inconsistency across Scotland, with some areas having no licensing forums at all.

In the open comments of this statement, panellists additionally chose to raise issues relating to licensing boards, including:

- Issues with the composition of licensing boards.
- The role of the Portman Group.
- Licensing boards should have a key role and reporting duty within this strategy.
- Local licensing boards should have more autonomy over issues at a localised level, using local data.

## 2.11. Risk factors

All statements under the theme of risk factors met the 75% threshold for inclusion in the consensus approach.

### Table 59a: Risk factors (stakeholder panel, n=42)

| Risk factors/indicators for substance use-related harm should be recognised in a harm prevention strategy. Risk factors include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Experience of trauma | 100 | 0 | 0 |
| Mental health | 100 | 0 | 0 |
| Frequent A&E/GP attendance in relation to substance use | 100 | 0 | 0 |
| Experience of homelessness | 100 | 0 | 0 |
| Living in a deprived area/experiencing poverty | 98 | 0 | 2 |
| Parental/familial/intergenerational problematic substance use | 98 | 2 | 0 |
| Parental drug-related death | 98 | 2 | 0 |
| Disengagement from school (including truanting) | 98 | 2 | 0 |

| Risk factors/indicators for substance use-related harm should be recognised in a harm prevention strategy. Risk factors include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Polysubstance use (using multiple substances at the same time) | 95 | 2 | 2 |
| Experience of the justice system | 95 | 2 | 2 |
| Peer influence | 93 | 2 | 5 |
| Neurodiversity | 93 | 2 | 5 |
| Care experience | 93 | 2 | 5 |
| Poor academic performance / academic pressure | 90 | 2 | 7 |
| Leisure activities (including festivals and sport) | 83 | 7 | 10 |
| Protected characteristics | 81 | 2 | 17 |

## Table 59b: Risk factors (children and young people, n=28)

| Some experiences or characteristics can make young people at greater risk of substance use harm. These include: | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Experience of trauma | 89 | 0 | 11 |
| Poor mental health | 89 | 0 | 11 |
| Using multiple substances at once | 89 | 0 | 11 |
| Living in a deprived area/experiencing poverty | 86 | 4 | 11 |
| Experience of homelessness | 86 | 4 | 11 |
| Having parents or family who use substances | 82 | 0 | 18 |
| Peer influence | 82 | 4 | 14 |
| Care experience | 79 | 7 | 15 |
| Poor academic performance/academic pressure | 75 | 14 | 11 |
| Leisure activities (including festivals and sport) | 71 | 8 | 22 |
| Disengagement from school (including truancy) | 71 | 14 | 15 |
| Experience of the justice system (e.g. having been accused or convicted of a crime) | 68 | 15 | 18 |
| Protected characteristics (such as identifying as LGBTQ+, having a disability, being from an ethnic minority background) | 64 | 18 | 18 |

The panel agreed strongly across the risk factors listed in the above statement. The levels of agreement across the list of individual risk factors in children and young people were generally lower. Still, their comments broadly agreed with the view that some barriers and challenges put young people at increased risk of using substances.

Some panellists noted that these risk factors should be linked with policy and availability of services, rather than framing them in a way that blamed or assigned responsibility on the individual and their lack of resilience. Examples were given of how to reframe these factors:

- Lack of access to core service provision due to homelessness.
- Waiting lists for mental health services.
- Waiting lists for neurodiversity assessments.
- Normalisation, marketing and availability of substances in different cultural/leisure settings.
- Distribution of wealth/economic inequality.
- Prejudice against minorities and barriers to accessing services.
- Discrimination and stigma.

### Table 60: Defining and addressing risk factors (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Defining and addressing multiple risk factors should form part of a prevention strategy for substance use and related harms. | 98 | 0 | 2 |

This statement received strong approval, with comments mentioning the intersectionality of risk factors and the adaptation of interventions to risk factors. One panellist stated that it is also beneficial for children, young people, and their families to understand risk factors themselves and this could help reduce the stigma surrounding substance use.

## Table 61a: Defining and addressing risk factors (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Substance use harm prevention is related to mental health problems, self-harm and suicidality. Opportunities for overlap with other public health strategies or approaches should be explored. | 98 | 0 | 2 |

## Table 61b: Defining and addressing risk factors (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Substance use harm is related to mental health problems, self-harm and suicidal thoughts. Opportunities for overlap with other public health strategies or approaches should be explored. | 89 | 0 | 11 |

Open comments on this statement reflected earlier discussions about child and adolescent mental health services. Panellists agreed that there were well-evidenced links between substance use and mental health and that this could justify overlapping strategies for substance use, mental health, and suicide prevention.

Children and young people also agreed that there was a relationship between substance use harm, mental health problems, self-harm, and suicide. Their comments reflected the notion of substance use as a form of self-medicating for mental health problems, such as stress, anxiety or depression.

## 2.12. Contributing factors

Statements within theme 12 (Contributing factors) earned considerable support from the panel, each achieving over 75% agreement.

### Table 62a: Social determinants and culture (stakeholder panel, n=42)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| The social determinants of health should be a key focus of a prevention strategy for substance use and related harms. These include living and working conditions such as income in the home, experiences at school, safety in the neighbourhood and access to services. | 95 | 0 | 5 |
| Addressing cultural acceptance of alcohol and vaping should be part of a prevention strategy for substance use and related harms. Learning can be drawn from measures/approaches used to address cultural acceptance of tobacco. | 83 | 5 | 12 |

### Table 62b: Social determinants and culture (children and young people, n=28)

| Statement | Total Agree (%) | Total Disagree (%) | Don't know/Not answered (%) |
|---|---|---|---|
| Improving families' living and working conditions (e.g. addressing poverty, improving experiences at school and community safety) will help to protect young people from substance use harms. | 93 | 0 | 7 |
| Changing how society views alcohol and vaping will help to protect young people from substance use harms. We can learn from the strategies used to change how people view smoking. | 75 | 14 | 11 |

Panellists strongly agreed that the social determinants of health play a crucial role in health outcomes, including their risk of harms.

Children and young people also agreed that improving the social determinants of health would help protect young people from substance use harms. They reflected on the importance of a safe, loving environment and how this would improve mental health, relationships, and therefore lower the chances of engaging in risky substance use behaviour.

One panellist raised that, alongside the social determinants of health, the strategy needs to consider the Commercial Determinants of Health, as set out by The Lancet (2023) and the World Health Organization (WHO, 2024).

Panellists also agreed that it is important to try and change how society views alcohol and vaping, agreeing that vaping become a culturally significant behaviour among children and young people. Children and young people strongly agreed that it was important to change the culture around alcohol and vaping.

# 3. Limitations

A key limitation of the Delphi method is its reliance on expert opinion rather than empirical data and evidence. While expert insights can be valuable, they are inherently subjective and can be influenced by personal experiences and perspectives. This subjectivity can introduce bias and result in conclusions that are not fully supported by objective evidence, potentially undermining the validity of the findings.

To mitigate this risk, the selection of the expert panel involved careful consideration to ensure an adequate level of expertise and diversity in roles, organisations, backgrounds, policy areas and locations across Scotland. However, there was no rigorous assessment of the level of expertise or qualifications held by each panel member.

Another challenge was the level of attrition throughout the lengthy process. Despite concerted efforts to sustain engagement, the size of the panel decreased at each stage, with 90 panellists in Round 1, 60 in Round 2, and finally 42 in Round 3. This is a level of 33% for Round 1 and 30% for Round 2, which is on the higher end of an expected Delphi method attrition rate; Bardecki et al 2023 estimate this to range from 20% to 30% between rounds. Reasons for withdrawal included busy schedules, competing priorities and panellists changing jobs or organisations.

Finally, in order to ensure an appropriate level of engagement with children and young people in the process, it was necessary to deviate moderately from the traditional application of the Delphi method. Adapting the concepts to make them suitable for children and young people may have led to subtle differences in interpretation. However, due to the involvement of expert youth facilitators, we believe these differences and the overall impact on the findings to be minimal. Furthermore, including the voice of young people has added value to the findings overall.

# 4. Conclusions

Between 2023 and 2025, TLB and PHS have undertaken a 3-stage Delphi process exploring how best to prevent substance use harm among children and young people in Scotland. The people who participated in the expert panel included public health officials, academics and educators, youth workers, and individuals working in health, mental health, recovery, addiction services, local authorities, education services, social work, third sector, Alcohol and Drug Partnerships, Health and Social Care Partnerships, Children and Family Services and NHS boards. Children and young people who participated were from Young Scot, YouthLink Scotland, Fast Forward, the Time 4 Us service within Transform Forth Valley and Children's Parliament.

The Delphi process has led to the development of a consensus approach which advocates for a comprehensive, evidence-based approach that incorporates prevention, early identification and intervention, and harm reduction measures. The consensus approach also reflects the need for both universal and targeted prevention measures, the role of community and environmental factors in substance use harm prevention and the importance of relationship-based, trauma-informed practice.

The panel agreed on the need for a whole systems approach that fosters collaboration across different sectors and groups. It also recognised the need to involve children and young people in the development and implementation of prevention strategies and approaches.

PHS will seek to align these findings to inform the ambition of the Population Health Framework. Additionally, PHS seeks to align these findings to wider prevention activity including the Public Health Approach to Learning (PHAL).

# Appendix: Information about youth organisations involved

Throughout the Delphi process, a number of third sector services were commissioned to support the involvement of children and young people:

- Children's Parliament is a charity dedicated to the realisation of children's human rights in Scotland. This is delivered through rights-based practice which enables children to share their ideas and experiences so that they can influence positive change. More information on Children's Parliament is available at **www.childrensparliament.org.uk/**
- Fast Forward is an Edinburgh-based youth work organisation which supports children and young people to make informed decisions about their health and wellbeing. More information on Fast Forward is available at **https://fastforward.org.uk/**
- Time 4 Us Children & Family service within Transform Forth Valley works across Forth Valley providing support to children and families who have been impacted by substance use. More information on the Time 4 Us service is available on Transform Forth Valley's website: **https://transformfv.org.uk/**
- Young Scot is the national youth information and citizenship charity for 11–26-year-olds in Scotland. More information on Young Scot is available at **https://young.scot/**
- YouthLink Scotland is the national agency for youth work and the collective voice for the youth work sector in Scotland. More information on YouthLink Scotland is available at **www.youthlink.scot/**

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