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Translation and transferability of approaches and intervention programmes

Cross country report: WP7

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Introduction

This report is the cross-country report of Work Package 7 (WP) of the EPPIC project (www.eppic-project.eu). This WP set out to investigate the extent to which policy approaches and interventions identified in partner countries are seen to be transferable/ translatable between different policy systems, different cultures and different (national, local) contexts and to identify factors facilitating or impeding transfer/ translation of best practice. On the basis of the findings, criteria for assessing the potential of measures, interventions, tools to transfer/ translate across contexts will be proposed. The focus of the work outlined in this report is at the level of interventions for the specific target group, however, Rein and Schon (1993) argue that the overall policy approach frames how interventions at the level of practice are developed and furthermore, that the different levels interact and impact on each other.

The literature is littered with a vast array of overlapping terms, furthermore, the terminology used has evolved over time as conceptual ideas have developed. This report will begin with a brief overview of the key ideas and terms (see Box 1 for definitions of key terms). The methods will then be outlined, followed by a report of the findings and conclusions.

We know from the literature that there has been a move away from thinking about policy (or knowledge) 'transfer' or 'diffusion' as straightforward, technical and mechanistic. The emphasis is now on "translation" (Prince, 2009, p.173) and "variation, difference and distinction" (Newburn, 2010, p. 346). Stone (2012) notes that within the US literature 'diffusion' is the predominant term and framework, whilst European scholars tend to use 'transfer', and whilst the approaches do have similarities, "transfer studies tend to prioritise proactive knowledge utilisation or 'lesson-drawing' from policy developed elsewhere" (p.485).

The concept of policy 'diffusion' has its origins in the US as a way of explaining policy innovation and adoption within the United States. It was described as "the process by which an innovation is communicated through certain channels over time among members of a social system" (Berry and Berry, 1999, p. 171). Stone (2012) criticises the underpinning

notion that policy is 'contagious' and diffusion is inevitable, with scant attention to the role of choice, pointing to examples of 'best practice' that are ignored. Other key criticisms of the diffusion studies' literature are its failure to recognise that policy or practice may be altered during the process of adoption and playing insufficient attention to the role of political interests (Stone, 2012).

Box 1: Definition of key terms used in policy studies literature

Diffusion: 'the process by which an innovation is communicated through certain channels over time among members of a social system' (Berry and Berry, 1999, p. 171).

Transfer: 'knowledge about how policies, administrative arrangements, institutions and ideas in one political setting (past or present) is used in the development of policies, administrative arrangements, institutions and ideas in another political setting' (Dolowitz & Marsh, 2000, p.5).

Translation: "policy translation can be understood as multiple and variable processes incorporating (i) diffusion/transfer; (ii) assemblage/bricolage; (iii) mobilities/mutation; (iv) interpretation/localisation; and (v) trial and error" Stone (2017, p.56).

Convergence: "the tendency of societies to grow more alike, to develop similarities in structures, process and performances" (Kerr, (1983) p.3 cited by Bennett, 1991, p. 215)

Policy borrowing & selective borrowing: Steiner-Khamsi (2016, p. 383) uses metaphor: "Local actors reach out & grab the arm of the octopus that is closest to their particular policy agenda, and thereby attach (local) meaning to a (global) policy…Policy borrowing is never wholesale, but always selective."

The early 'transfer' literature was interested in the role of 'agency' in the transfer process. Analysis focused on the scope for choice in selection of policy ideas for transfer, the interpretation of circumstances, and (bounded) rationality in the replication, copying and adaptation of policy by decision makers (Stone, 2012). Stone (2017, p.58) argues that "the strength of the policy transfer literature has been to focus on decision-making dynamics

internal to political systems and to address the role of agency, and processes of learning, in transfer processes".

As Stone (2012) notes, from this literature it became apparent that there could be convergence around broad policy objectives and principles whilst leaving room for divergence in relation to the instruments adopted, type of legislation or institutional means of policy control/delivery. Stone identified five different but overlapping modalities of transfer (2012, pp.485-486), transfer can occur at:

- broad level of policy ideals or goals
- institutions such as higher education,
- regulatory, administrative or judicial tools
- transfer of ideas and ideologies
- personnel

Furthermore, it is possible to learn from more than one place at a time which leads to selective borrowing which has been described as:

> "Local actors reach out and grab the arm of the octopus that is closest to their particular policy agenda, and thereby attach (local) meaning to a (global) policy… Policy borrowing is never wholesale, but always selective" (Steiner-Khamsi, 2016, p. 383).

The translation literature highlights the *complexities of context* and the need for interpretation (see Stone, 2012). A key concept that has emerged is that of 'selective borrowing' which leads to hybrids and adaptive innovation to make the intervention better fit local conditions (Stone, 2012, p.486). A variety of terms are used including divergence, hybridisation, mutation, adaptation. However, Hulme (2005) argues that policies and practices are often not simply 'transferable' as they have arisen from the specific legal, educational and social systems of their 'host state' and are neither ideologically nor culturally proximate (p.423).

Interventions and approaches may be transferred/ translated between:

- Sectors (youth justice, CJS, substance use, health, education, social care)

- Setting (prison, probation, community-based health care, school, hospital etc)
- Target groups (age, gender, ethnicity, type of substance, 'at risk' etc)
- Geography/spatial level (countries, local, regional etc).

Within the EPPIC project we were keen to identify examples of interventions that had been transferred/translated. In WP4 we described a number of interventions in each of the partner countries. Two of these interventions had been transferred/translated (FreD) and CANDIS:

- **FreD Goes Net** – Polish adaptation of the German project "Fred - Early intervention in first-time drug offenders" by "Landschaftsverband Westfalen-Lippe". This consists of a short intervention (one-on-one interview and an eight-hour group course divided into 2 or 4 sessions); it aims to encourage young drug consumers (illicit or legal drugs) to reflect on, and possibly change, their consumption behaviour in order to prevent escalation. Developed in Germany, it led to a major research project (2007-2010) that set out to transfer it to other countries (including Poland). It was successfully transferred/translated into 11 of 12 European countries (Wirth and Rometsch, 2010).
- **CANDIS** - Polish adaptation of a German project. It is a cannabis-specific intervention combining CBT, MET and problem-solving training for people age 16+ with Cannabis Use Disorder (CUD; ICD-10). It was developed in Germany (Hoch et al, 2012; Hoch et al, 2014) and then transferred/translated to Poland. A comparison of pre-test and post-test results in a group of patients participating in the "Candis" programme, suggests amelioration of mental health, especially a reduction in the symptoms of anxiety disorders. Participation in the programme also contributes to improvement of social and individual resources (Wieczorek, Dąbrowska and Sierosławski, 2018).

Beyond these programmes, a literature search confirmed that, with the exception of schools- based programmes, there were few initiatives aimed at drug experienced young people, particularly those in touch with the criminal justice systems and these did not appear to have been transferred/ translated across countries (Moskalewicz *et al*, 2017; Herold and Frank, 2018). Two of the work packages (WP4 and WP5) collected data on

relevant interventions in the partner countries, and WP7 built on that to explore factors that appear to facilitate or hinder transfer/translation, particularly in relation to the innovative projects/interventions identified and examined in WP4 and WP5.

Data and methods

The WP leader, Rachel Herring (Middlesex) provided partners with a draft conceptual framework and questions for a workshop with key informants exploring issues around transferability and replication of interventions and approaches. A discussion paper was presented at an EPPIC project meeting (January 2019) and following this meeting, revised questions, structured templates for data recording and guidelines on running the workshop were circulated to partners for comment. The questions were based on the research literature and the findings of WP4 and WP5 of the EPPIC project. They aimed to further our understanding of the issues including key considerations when assessing whether an intervention has the potential to be replicated, barriers and facilitators of transfer/translation. Structured templates were used to ensure consistency across the countries and to facilitate cross –country comparison. Partners were asked to suggest interventions identified and examined in WP4 and WP5 that could be used as 'real world' examples for discussion about the potential for transfer/translation at the workshops. The final questions, intervention examples and structured templates were agreed by all partners (see Appendices 1 and 2) and the finalised workshop guidelines circulated.

The plan was for the country advisory group members to be invited to participate in the workshop on the basis that they would be people who make decisions about which projects get implemented and would ensure representation from across all sectors (i.e. youth justice, drugs, health etc) to allow us to examine how different sectors deal with transferability issues. However, it was recognised that, because of variability in the composition of the advisory groups, it might be necessary for additional people to be invited and/or supplementary telephone interviews to be conducted.

Workshops were held with country advisory group members in Austria, Italy and Poland; in the UK the workshop was held with staff from a project partner (a non-statutory sector service provider) and additional telephone interviews were conducted with four people

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working in other organisations providing services to drug experienced young people in contact with the criminal justice system (three organisations). Considerable difficulties were experienced in convening a workshop (in person or virtual) in Denmark and Germany; so in Germany information was collected via an email exchange and in Denmark responses to an email survey (the workshop questions) were obtained. Information was obtained from 44 respondents (Austria 5; Denmark 6; Germany 4; Italy 7; Poland 9; UK 13). In Austria the country report was circulated to all those who had been invited to attend the workshop (n=13) for comment and agreement.

Respondents came from a wide range of professional backgrounds and settings and included practitioners and policy makers working at local, regional and national levels. Background information about EPPIC project was provided and the purpose of the workshop was explained. First, from a list provided, individuals were asked to rank in order of priority the top five most important factors they considered when contemplating replicating an intervention. This was followed by group work. Firstly, exploring how respondents went about setting up new projects and whether they looked at what was done elsewhere. Secondly, using 'real world' examples of interventions to consider whether they could be replicated (or not) in their own context and, if it was thought to be transferable, then whether adaptations would be necessary. Structured templates were used to record the answers, notes were made and /or the discussions audio recorded. The individual telephone interviews used the same materials which were provided to the respondent prior to the interview, but there was, of course, no element of group discussion. Written or oral consent was obtained and with permission they were audio-recorded. Each partner wrote a short report of the findings of the workshop and interviews.

In the countries where it was requested, the EPPIC project was approved by specific Ethical Committees (Middlesex University Ethics Committee, UK) or by a data protection institution (Danish Data Protection Agency, in Denmark). In all countries confidentiality and anonymity was guaranteed according to current European and national laws.

Findings

This section draws on the country reports to report the findings from the workshops and additional data collection.

Replicating an intervention: what are the factors to consider?

From the literature and the results of WP 4 and 5 an initial list was drawn up of principles or factors that have been identified as key considerations when contemplating replicating an intervention (see Box 2). The workshops allowed for further exploration of these principles and their application in the 'real world'. Each respondent was asked to rank in order of priority 1-5 (1 as highest priority) the factors they took into account when assessing whether an intervention could be replicated within their work context[1]. The German respondents provided a consensus list of their top five priorities. Respondents were also given the opportunity to add additional factors and to comment on the wording of the factors. The results for the ranking exercise are set out in Table 1.

Box 2: Factors to consider when replicating an intervention

- Setting intervention delivered in
- Language used in materials (terminology & translation)
- Content and visual presentation of materials (up to date, relevant)
- Cultural context (appropriateness & adaptation)
- Compatibility of policy frameworks
- Compatibility of systems (health, legal, welfare, education)
- Geography e.g. transport links, urban area, rural area
- Strength of evidence base
- Resources required (staff, space, funding)
- Underpinning principles e.g. harm reduction, strengths based, abstinence
- Who delivers the intervention (e.g. professionals, volunteers, peers, specialist or generic workers)
- Ethical considerations
- User involvement in design and or/delivery
- Target group for the intervention

1 The Austrian team experienced resistance from the respondents to the idea of rating "key factors" in a "priority list". Therefore, they decided to select several issues from the "*list of factors*" for discussion: compatibility of systems; voluntariness and peer counselling, attenuated custody, and individual characteristics of clients such as age, gender, and ethnicity. Thus, there is no results of the ranking exercise to report.

The challenges of ranking

Some respondents found this ranking exercise a challenge as they were forced to make decisions about factors that they regarded as either of equal importance or inextricably linked. As one Polish respondent commented:

> *I had the feeling that you asked us to do some almost 'mission impossible', because it was just extremely difficult to say what is more important, or the strength of evidence or ethics. (...) Next, the cultural context and compatibility of the existing policy framework is very important, because you can also have the best programme, but if something does not comply with our regulations, there is simply no chance to implement such a programme. The same is true for cultural compatibility, the programme works great somewhere else and it won't work here, because there is such a big cultural difference.* (PL_R1)

One UK respondent argued that underpinning principles (i.e. harm reduction, strengths-based approach) and ethical considerations went 'hand in hand' and so they ranked them as joint second in order of priority. However, other respondents noted the value of having to focus on the 'deal breakers'. For example, within the UK workshop, there was a consensus that any proposed intervention must share the same underlying principles and ethos of the service they worked in (i.e. strengths-based and harm reduction) and one that did not, (e.g. abstinence oriented), would not warrant further attention.

Table 1: Factors considered important when replicating an intervention by country

Factor	Demark (N=6) N & (Ranks)[1]	Germany[2]	Italy (N=7) N & (Ranks)[1]	Poland(N=9) N & (Ranks)[1]	UK (N=13) N & (Ranks)[1]
Setting intervention delivered in	3 (2;2;5)		2 (2;3)	3 (3;3;3)	0
Language used in materials	2 (5;5)		4 (1;2;5;5)	1 (5)	8 (2;3;4;5;5;5;5)
Content and visual presentation of materials	1 (2)		0	0	6 (1;1;2;2;2;4)
Cultural context	2 (3;4)	3rd	2 (1;2)	3 (2;2;3)	8 (2;3;3;3;4;4;4;5)
Compatibility of policy frameworks	1 (4)		5 (1;1;1;3;3)	6 (2;2;3;4;5;5)	3 (4;5;5)
Compatibility of systems	0		4 (2;3;3;4)	6 (1;1;3;3;4;5)	0
Geography	0		0	0	0
Strength of evidence base	3 (1;3;5)	2nd	3 (4;5;5;)	6 (1;1;1;2;2;4)	6 (1;1;2;2;4;4)
Resources required	1 (4)	4th	5 (2;3;4;4;4)	6 (2;4;4;4;4;5)	3 (1;1;5)
Underpinning principles	3 (3;3;4)		3 (1;3;5)	3 (3;4;5)	11 (1;1;2;2;2; 3;3;4;4;5)
Who delivers the intervention	5 (2;3;4;4;5)		2 (5;5)	3 (3;4;5)	5 (1;3;3;5;5)
Ethical considerations	4 (1;1;2;4)		0	3 (1;2;2)	3 (1;2;3)
User involvement in design & or/delivery	3 (1;2;5)	5th	2 (2;4)	2 (4;5)	4 (1;2;3;3)
Target group for the intervention	2 (1;1)	1st	3 (1;2;4)	5 (1;1;1;1;2)	7 (1;1;2;3;3;4;4)

[1]= number of respondents who included the factor in their top 5. Ranks assigned by individual respondents.

[2] Germany provided a consensus list of the top 5 factors in order of priority.

- Underpinning principles – UK, Denmark, Italy & Poland (but not in German top 5)
- Compatibility of systems and compatibility of policy frameworks: key for Italy, Poland & Austria but not Denmark, UK & Germany
- Ethical considerations and who delivers the intervention were key in Denmark
- User involvement flagged up, with greater priority given by UK & Danish respondents
- Content & visual presentation of materials – important for UK
- Geography not a priority but issues around access/cost of transport were raised in work shops

'Priority' factors: shared priorities

Four factors were given priority across the partner countries (see Box 3).

Box 3: Shared priorities

- Target group for the intervention
- Strength of the evidence base
- Cultural context
- Resources required

One factor that was identified across all the partner countries as a priority was 'target group for the intervention', with German respondents giving it highest priority (1st) and individual respondents in other countries ranking it highly (with 12 of 17 respondents ranking it as 1 or 2).

'Strength of evidence base' was identified as a critical factor by all partners, with Polish respondents giving it the highest priority (see Table 1) and ranked second by the German respondents. The 'cultural context' was also viewed as important, with the majority of UK respondents (8/13) prioritising it and it was ranked third by the Germans.

Another key factor was 'resources required', one UK respondent reporting that 'resources' would always be the starting point when considering whether a project could be replicated or not. Whilst resources were not always ranked highly, it was, however, chosen by the majority of Italians (5/7), Polish (6/9) and was ranked fourth by the Germans. Furthermore, it was a discussion point in the Polish, Italian and UK workshops.

Notable differences between countries

There were notable differences between countries. For example, in Poland, Italy and Austria 'compatibility of systems' and 'compatibility of policy frameworks' were identified as priority factors, whilst in Denmark, Germany and the UK they were not. In Denmark, UK and Germany, no one listed 'compatibility of systems' as a priority consideration. In Poland

'compatibility of systems' was chosen by 6 of 9 respondents. In Austria, discussions were focused on 'compatibility of systems' and, in particular, the relationship between administrative systems of criminal justice and health care and the implications for transfer of interventions.

In Italy 'compatibility of policy frameworks' was given the highest priority with the most '1' scores (3) and five of seven people put it in their top 5 and in Poland 'compatibility of policy frameworks' was chosen by 6 of 9 respondents. Only one of the six Danish respondents listed 'compatibility of policy frameworks', whilst in the UK, three of the 13 respondents listed it but as a lower priority and it was a not a priority for the German respondents (see Table 1).

'Content and visual presentation of materials' (6/13) and 'language used in materials' (8/13) were seen as closely linked and important by the UK respondents. They argued that materials need to be 'young people friendly', visually appealing and accessible, particularly as many of the young people they work with have low literacy skills. 'Content and visual presentation of materials' was not listed by any respondents in Italy, Germany and Poland and by only person listed it in Denmark.

'Ethical considerations' were viewed as important in Denmark (4/6) and whilst fewer people listed it in the UK (3/13) and Poland (3/9), those that did ranked it highly. Eight of the ten people who listed 'ethical considerations' ranked it 1 or 2. However, nobody listed it in Italy and was not one of the '

In the UK the majority of respondents (11/13) identified 'underpinning principles' as a key factor. Moreover, as noted above, UK respondents argued that if an intervention did not share same the 'underpinning principles' of the service they worked in (i.e. strengths-based and harm reduction) then it would not be considered (i.e. abstinence-based intervention). Whilst respondents in Denmark, Italy and Poland also cited 'underpinning principles' as a factor, it did not make the German 'top 5' (see Table 1).

Factors not viewed as a priority

None of the respondents included 'geography' as one of their top 5 priorities but this may reflect the fact that respondents work in countries with well-developed infrastructures. However, geographical factors such as accessibility via public transport and cost of travel were raised in the workshops and there was a recognition that projects developed for an urban context may need adaption for rural areas or may not be appropriate.

'Compatibility of systems' was not identified as a priority factor by the by UK, Danish and respondents. None of the Italian and Polish respondents regarded 'content and visual presentation of materials' as a key factor and only one Danish respondent listed it. 'Ethical considerations' were not considered a priority by the Italian respondents and 'setting the intervention is delivered in' was not identified by UK respondents.

Other factors emerging from the data

Respondents suggested two additional factors that they thought should be considered - 'training of workers' (Italy) and 'Motivational Interviewing/positive outlook reflective practice aimed at client' (UK). Another UK respondent suggested a modification of the 'User involvement in design and/or delivery' principle to 'Involving people with lived and living experience in design, delivery and decision making', emphasising that for young people in particular, it was important to include those with living experience "not just those who had come through a hard time in the past" (UK_R1). This echoes the opinions of the young people and some professionals interviewed within the EPPIC project (see Rolando and Beccaria, 2018; Herold and Frank, 2018). However, in practice the involvement of young people in interventions was limited and most were unable to involve young people in the design and implementation of the intervention (Herold and Frank, 2018).

Explaining the differences

Differences in ranking of the factors may reflect professional backgrounds, distance from frontline delivery, experience of transfer/translation, cultural context and systems (i.e. legislation, policy frameworks, service delivery). For example, professionals in day-to-day contact with young people may prioritise content and visual presentation of materials based on their experiences, both positive and negative, whilst, a national policy maker may

prioritise compatibility with systems and policy frameworks. What these differences highlight is the need to consider interventions in the 'round' in order to make a comprehensive assessment that encompasses all aspects including whether an intervention 'fits' into current systems and structures (national, regional and local), interfaces with current interventions, down to the detail of the materials (language, content, mode of delivery etc).

Seeking inspiration and not 'reinventing the wheel': Setting up new projects

When planning a new project, respondents reported that they would look to see what else was being done elsewhere and they would use various strategies and approaches to finding out. Respondents were keen to avoid duplication, to learn from existing and previous projects and to prevent mistakes. Whilst internet searches were seen as a useful first step for identifying projects, respondents highlighted the value of 'word of mouth' and personal contacts within the field:

> *My experience shows that you must first ask familiar people whom you trust. (…) Because on the internet, we know well, various things are described in a wonderful way, and then it turns out to be a misunderstanding*. (PL_R2)

Formal and informal networks were also important for early scoping as they gave access to a broad, knowledgeable group of people. For example, one UK respondent reported that in the earlier stages of developing a project, they posted a request for information to a network (via email) and received a positive response which allowed them to identify projects of interest and to focus their ideas. Respondents also reported contacting experts directly. They also stressed the importance of making direct contact with project staff, speaking to them to benefit from their knowledge and experience of running a project and if possible visiting projects to see the 'reality'.

However, before staring the search, respondents felt it was necessary to develop search criteria to help focus and identify relevant projects. As one Polish respondent explained:

It is important to have criteria according to which we choose programmes developed in other centres or in the world that interest us. You have to have some criteria, because it is a waste of time to compare something that does not meet our standards, for example. (PL_R3)

Other respondents flagged up that they had exclusion criteria; as noted above, several UK respondents said they would exclude interventions that were abstinence based.

Implementing ready-made programmes, particularly those which have been evaluated was appealing as this was thought to save time and money. The CANDIS programme which was implemented in Poland is an example of the replication of an existing, evaluated programme. However, as respondents noted, a problem may be unique to a country or has specific conditions, and so it is necessary to devise a specific programme to address it. In Poland special programmes and policies were developed to respond to the specific issues of NPS in Poland, as one respondent explained:

When NPS appeared in Poland, there were no tested solutions in other countries. We had to create our own programmes and deal with the problem from scratch. (PL_R1)

For a number of practical reasons (e.g. visits more feasible, no need to translate materials) but also because of policy and legislative frameworks, respondents generally began by looking at local and national projects before they considered international projects. It should be noted that whilst cultural differences were one of the reasons that local and national projects were favoured over international ones, respondents argued that cultural differences existed within countries and it should not be assumed that a project in one part of a country would necessarily work in another part of the same country.

Whilst scientific reviews were not often undertaken, the importance of research was acknowledged. Knowledge from research literature was gleaned from various sources including networks and reports published by various institutions e.g. governmental, EMCDDA, NGOs. Respondents believed it was important to keep abreast of research developments and recognised that research not only provides the evidence base of 'what works' but also lessons around implementation, in particular challenges faced and possible responses to challenges.

Real world examples – considering transferability

Real world examples of interventions identified in WP4 and WP5 were used within the workshops and interviews to explore the potential for replication, adaptations required and barriers to replication.

Partners were asked to choose at least two interventions[2] to discuss and to provide reason for their choice.

Project over Muren (POM) from Denmark was discussed in Italy, Poland and Germany. POM is a pre-treatment drug initiative aimed at preparing inmates in custody in Copenhagen's Prisons to enter drug treatment programmes once they have received their sentence and are either released or transferred to their detention place. POM was chosen in Italy and Germany as, compared with current interventions in prisons, POM is very innovative, particularly, given the target group. In Poland, POM was chosen as there is a perceived need to modernise drug treatment in Polish prisons.

Spazio Blu (Blue Space), a 'multi-disciplinary integrated intervention' in Milan for young people with substance use related problems who have committed either penal or administrative offences, was discussed in the Italian workshop and also in Germany. Spazio Blu was born as a branch of a Public Addiction Unit; it became an independent service in order to better address the specific needs of the youth target. It aims to prevent the progression of consumption careers towards addiction by increasing awareness about substance use, through individual counselling, peer groups, parents' groups and the offer of alternative activities. The Italian research team was interested in the potential of extending Spazio Blu across the country. Indeed, they were curious as to why other local services had not already reproduced it.

The UK, Polish and Austrian[3] respondents discussed ***Project B*** (UK) which is a peer-based intervention which aims to keep young offenders purposefully occupied, 'upskill' them and provide an opportunity to 'give back' by supporting other young people, but also to keep

[2] The aim was to discuss two interventions and if time permitted to discuss a third.
[3] It was the third choice of Italy but there was insufficient time to discuss it.

them in education themselves. Project B was developed by people with past experience of the CJS and has strong links with the local community. It is currently delivered in one area in London and the UK team were interested in whether Project B would be regarded as a project that could be reproduced elsewhere in the UK. In Poland and Austria Project B was discussed as community- based interventions and support for drug experienced young offenders are rare in these countries.

The UK workshop discussed the Danish intervention ***Fundamentet (***The Foundation). The main aim of Fundamentet is to 'take a point of departure in the individual citizen' to create a space for change for the individual citizen by providing both practical help (e.g. with housing) and therapies (e.g. psychotherapy, occupational therapy), working with both 'here and now' and more long-term problems. Fundamentet was chosen as it adopts a holistic approach but is delivered with minimal recording and monitoring (i.e. paperwork, electronic records) which is in contrast to the UK where services are required to collect and report extensive information.

Challenges to replication

From the discussions of the interventions four main challenges to transfer were identified:

- Incompatibility of legal and regulatory frameworks
- Systems and structural differences
- Organisational factors
- Policy frameworks

Incompatibility of legal and regulatory frameworks

A key barrier was if an intervention was incompatible with legal and regulatory frameworks and thus a change in legislation would be required to enable an intervention to be replicated. For example, the Polish respondents suggested that POM would require legislative changes as in Poland no interventions are offered as long as people are in custody. In Italy, respondents argued that a main constraint was that national and local regulations in relation to harm reduction in the context of CJS were dated and weak, which made it difficult to implement interventions based on harm reduction principles.

Furthermore, Italian respondents suggested that the aims of the social and health professionals might be in contrast with the judge's or other justice system actors' view, more conditioned by a surrounding culture that has not yet fully accepted the harm reduction approach. Yet, somebody one respondent suggested that the problem is not just one of regulation but also the overly rigid interpretation of the legislation and a lack of courage to experiment with novel approaches. Whilst not unsurmountable, incompatibility of legal and regulatory frameworks does present a significant barrier.

Systems and structural differences

Systems and structural differences were identified as critical barriers. In Italy a lack of uniform policies and interventions and clear policy from the responsible government department - Department of Anti-Drug Policies (DPA)- was regarded as a key issue which led to wide variation and inconsistencies in service availability across the country and prevented the replication of interventions, not just international ones, but also those developed in Italy. Spazio Blu is well established (since 2005), part of the regional health system, and the Local Addiction Services have been encouraged to reproduce the model in other areas; however, it remains a unique service. Whilst lack of resources (money and staff) were identified as the main reason for this lack of replication, respondents argued that Spazio Blu should be rolled out across all regions and incentives offered as a part of a national policy. Given that the target group are likely to enter the adult prison system at considerable cost, the value (monetary and social) of such a preventative programme was thought to justify the expense of providing the service. This provides an interesting example of within country challenges to the replication of interventions.

Organisational factors

Other barriers were related to a variety of organisational factors. For example, the Polish respondents stated that another barrier to the implementation of POM was that co-operation between prison services and external organisations is not well developed.
The German respondents felt that POM could be replicated and would be welcomed by most professionals, although they did envisage resistance from some prison staff who believe abstinence is a pre-requisite of treatment. However, they did identify challenges,

linked to staffing and resources, arguing it would be crucial to engage prison guards, as one explained:

> *From the concept PPC (Positive Peer Culture), which I got to know in a German juvenile prison, I can point out the importance of cooperation between social workers and prison guards (which is given in POM). It is important that the guards also stand behind the project and support it. It is not always easy to convince the prison guards of "new" projects.* (G_R1)

In addition, they suggested that given the heavy workload of prison staff, additional specialist staff would be required and perhaps extra prison guards, which then raises the question of how POM could be financed.

UK respondents were very positive about the Danish intervention Fundamentet (The Foundation) but doubted it could be implemented in the UK. As Fundamentet is a voluntary organisation it not subject to the Public Administration Act, this frees it up to try out new approaches, means it can offer users anonymity and is not required to monitor service users. Whilst the UK respondents could see benefits of not having to keep records (e.g. may allow some people to access who otherwise would not), they could not envisage an organisation being exempt from keeping identifiable records of their service users. There were concerns about the lack of a 'paper trail', particularly, in relation to the assessment and management of risk and legal requirements around the safeguarding of vulnerable individuals (i.e. service user, child in their care etc). In addition, monitoring of service users and funding in the UK are inextricably linked which respondents felt was a major obstacle to replication of Fundamentet.

Policy frameworks

The discussions about Project B highlighted that the prevailing policy approach shapes the interventions which are developed and also whether an intervention is seen as transferable or not. Project B was viewed positively by the UK workshop respondents, in particular, that it enabled young people with lived and living experience not only to provide support to others but also to provide oversight (via the Board of Trustees). The focus on education, training and employment to create credible routes away from offending and into long-term

employment was seen as a strength. Furthermore, they were keen to contact Project B to learn more and explore the potential to replicate within their organisation.

Polish and Austrian respondents were more reticent about Project B, and whilst acknowledging the potential of peer led interventions, for both the individuals and the young people, they envisaged a number of challenges related to ensuring the peer navigators received appropriate training, supervision, support and integration into an organisation (e.g. contracts for paid and voluntary work, pay etc). These concerns related in part to 'quality control', that is ensuring that the peer navigators had the knowledge and skills required to undertake the role and that there were robust monitoring systems in place so that they did 'good' and certainly no harm. There was a concern about presuming that experience with CJS meant a young person would make a good peer navigator and that attention should be paid to selection criteria. As one Polish respondent observed:

> *Experience alone, just going through problems is not a sufficient condition for me, it is not a disposition or qualification to create a programme.* (PL_R3)

There was some unease about the possible negative impact on the lives of the peer navigators. Firstly, that the role might place too great a burden and responsibility on a young person and second, that it might limit their horizons and mean they cannot envisage their future without the support of Project B.

These differences may be in part because within country replication is (on the whole) more straightforward but also reflect that UK respondents appeared to be familiar and comfortable with peer led interventions. In the UK the development of peer led interventions is a key trend with wider policy frameworks (i.e. health, criminal justice system, drug services) (e.g. Parkin & McKeganey, 2009; Webster, 2017; Mather, Taylor & Parry, 2014; South *et al*, 2014). In addition, people with lived experience are identified as an integral part of the workforce of substance use services (HM Government, 2010; HM Government 2017). More broadly, UK respondents (along with the Danish) emphasised the importance of lived experience, user involvement in design and delivery and who delivers an intervention. The Austrian respondents noted that peer counselling and community-based support projects have not been common in Austria and that is probably a legacy of a social

welfare state as the major service provider which may have acted to hamper the development of such projects.

Box 4 provides a summary of the key findings from Work Package 7.

Box 4: Key findings

- Exchange of best practice was valued by respondents but simple transfer was not seen as viable.
- Participants argued that if interventions were to succeed they required 'translation' (i.e. adaptation to varying degrees) to fit different, often complex contexts and to respond to local needs.
- The main barriers to 'translation' between one country and another were thought to be:
  - incompatibility of legal and regulatory frameworks;
  - systems and structural differences
  - organisational factors
  - policy frameworks
- Within country transfer of the interventions whilst more straightforward could still face challenges (e.g. lack of resources, policy direction).
- In considering whether it might be possible to transfer/translate an intervention, there were differences as to what factors (e.g. setting, policy framework etc) were considered most important.
- Differences may reflect different professional backgrounds, disciplines, cultural context, experience of transfer/translation and systems e.g. legislation, policy framework.
- However, there was broad agreement that these factors were critical:
  - Target group for the intervention
  - Strength of the evidence base
  - Cultural context
  - Resources required
- Opportunities to share learning (virtually or in person and accessible up-to-date resources are required to aid decision making.

Conclusions

As already noted, there has been a move away in the literature from conceptualising policy transfer and diffusion as straight forward, rational, linear processes to thinking about "translation" (Prince, 2010, p.17), and "variation, difference and distinction" (Newburn, 2010, p.346). As Hulme (2005) argues policies and practices have often arisen from the specific legal, educational and social systems of their 'host state' and are neither ideologically nor culturally proximate, so are not simply 'transferable' (p.423). 'Translation' is characterised by "hybridity, synthesis, adaptation and 'localisation' (Stone, 2017, p55) rather than simple 'cloning' of an intact policy. Whilst the focus of this study was on interventions rather than policies, the results support the idea that interventions require 'translation' from one context to the other. Indeed, there seemed to be an expectation that interventions would need adaptation (to varying degrees) to respond to local needs and to ensure the materials were culturally appropriate.

The importance of interventions being age appropriate and culturally nuanced (e.g. materials using slang terms for drugs, colloquialisms, suitable images etc) was highlighted. It was noted that even within countries adaptation might be required to accommodate differences (e.g. slang terms for drugs, the specific group being worked with) and assumptions should not be made that what 'works', for example, in London, will necessarily work elsewhere in the UK without 'translation'. Moreover, UK respondents reported that even at the local level adaptation may be required to accommodate differences, for instance, what might work in North London may not necessarily work in South London without 'translation'. It is important to note that this need for 'translation' was not on the whole seen as a 'problem' rather as an opportunity to produce an intervention that was relevant for the young people it was being offered to.

Respondents believed there was value in exploring what interventions were offered elsewhere for drug experienced young people in contact with the CJS. Indeed, investigating what is done or has been tried elsewhere appeared to be a point of departure for developing new projects, responding to emerging issues (e.g. within local area, country) or just keeping abreast of work being done within the field. Beyond a broad aim of 'learning from others', the key reasons given were to avoid 'reinventing the wheel' and to learn from

experience, including 'what not to do' as well as 'what to do' and 'how to do it'. Respondents did not want to waste time or resources developing an intervention if one already existed and they also felt they could learn from where things had gone 'wrong' or not gone to plan. Thus, it was thought worthwhile to look at interventions and projects which may not have been a complete 'success' to see what lessons had been learned and if adaptation could potentially address the issues. Stone (2017) has argued that 'trial and error' is inherent in policy making and that 'translation' provides a conceptual framework to understand the learning that takes places.

A number of methods were employed to gather intelligence on evidence-based interventions. Written resources (e.g. reports, research papers, briefings on websites etc) were key sources. However, great value was placed on speaking to people involved in the development and/or delivery of an intervention and if practical visiting to see an intervention in operation. Being able to tap into 'expert' knowledge (e.g. experiential, research, policy, written, verbal) was seen as a critical resource and people drew on their professional networks, using technology (e.g. social media, email groups) to increase their reach (i.e. national and international). Organisations and professionals developing and delivering drug interventions to young people in contact with the CJS require accessible up-to-date resources to aid their decision-making and opportunities to share learning either virtually or in person (e.g. knowledge exchange events, study visits).

There were differences in what factors (e.g. compatibility of systems, cultural context) the respondents prioritised when considering whether an intervention could be translated from one context to another. These differences may reflect professional backgrounds, distance from frontline delivery, cultural context and systems (i.e. legislation, policy ideas about how to respond to youth crime and drug use). It was evident that there were a range of overlapping perspectives about what was important and assessing whether an intervention can potentially be 'translated' is complex and involves "fluid multi- actor processes of interpretation, mutation and assemblage" (Stone, 2017, p.67). This speaks to a need to include a wide range of actors, including young people with lived and living experience in 'translation' in the process in order that the intervention is relevant and engaging for service users (DARC, 2019)

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Critical barriers were believed to be incompatibility of systems and policy frameworks e.g. interventions that would require a legislative change or fundamental policy shift to allow them to be implemented. This is not to argue that they are always insurmountable but to acknowledge that the 'translation' of such interventions would require political will, the input of multiple-actors and may take a considerable time to achieve. For some respondents, the underpinning principles of the intervention were crucial (e.g. harm reduction, strengthens-based). If the intervention was not based on these principles, then it would not be considered for 'translation'.

Translation of interventions is a messy, non-linear process and undertaking comparison challenging, however as Newburn (2010, p. 350) argues:

"…in drawing our attention to the linkages between the universal and the particular, the global and the local, it reminds us of the importance of exploring comparative developments in all their messy variety, for it is here that we have the best chance of finding nuanced explanations of contemporary trends".

Although further work is required, from the EPPIC project it is possible to identify principles upon which interventions for drug experienced young people in contact with the criminal justice system can be assessed when considering transfer and translation (see Box 5). Underpinning the principles is a recognition that interventions will require translation and so that that interventions need to have an inbuilt flexibility that does not compromise the intervention.

Box 5: Principles for the transfer of interventions for drug experienced young people in contact with the criminal justice system

- Young person centred: strengths based, agency, holistic.
- Age appropriate: taking into account developmental age, literacy levels & educational attainment
- Culturally nuanced: language (e.g. colloquialisms, slang terms for drugs), images used in materials (which can be adapted to meet local needs, the dynamics of the cultural landscape)
- Localisation: meets the specificities of the local socio-economic and cultural context
- Flexibility: able to respond to changes e.g. drugs consumed, method of consumption, drug markets, drug terms etc
- Involvement of young people with lived and living experience (e.g. design, delivery, translation)
- Interface: with other interventions, programmes, systems

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APPENDIX 1: Workshop materials

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REPLICATING AN INTERVENTION: FACTORS TO CONSIDER

Each person to fill in individually please

The table below lists factors which have been identified as key factors that may be important when considering replicating an intervention.

1. What would you say in order of priority are the key **FIVE** factors that need to be considered when contemplating replicating an intervention?
   Please list in order of priority the top 5 considerations
2. If there any additional factors which you think should be taken into account, please add to the table in the boxes left blank for this purpose. Indicate if they rank in your top 5.

Factor	**Priority**
Setting intervention delivered in	
Language used in materials (terminology & translation)	
Content and visual presentation of materials (up to date, relevant)	
Cultural context (appropriateness & adaptation)	
Compatibility of policy frameworks	
Compatibility of systems (health, legal, welfare, education)	
Geography e.g. transport links, urban area, rural area	
Strength of evidence base	
Resources required (staff, space, funding)	
Underpinning principles e.g. harm reduction, strengths based	
Who delivers the intervention (e.g. professionals, volunteers, peers, specialist or generic workers)	
Ethical considerations	
User involvement in design and or/delivery	
Target group for the intervention	

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EPPIC - Exchanging Prevention practices on Polydrug use among youth In Criminal justice systems

WORKSHOP ON TRANSFERABILITY

Group work 1

Working as a group we would like you to discuss the questions and issues raised. We will start with three broad questions about setting up new projects. Then we will provide 'real world' examples of interventions and ask you to consider whether or not you think they could be replicated in your country. ***We expect that people within the group will have different opinions and we would like you to record these different opinions.*** Please note your answers on the work sheets provided.

Thank you.

Please note the feedback sheets have been amended for the appendix to avoid the blank pages

Setting up new projects

1. If you want to set up a new project do you look to see what is being done elsewhere? Yes? No? Sometimes?
YES *Explain reasons briefly*
NO *Explain reasons briefly*
SOMETIMES *Explain reasons briefly*

2. How would you go about finding out about other interventions? (i.e. speak to people, internet search, literature, look at guidelines
Brief details& reasons for approach

3. Do you consider interventions that are delivered: a) locally b) other parts of the country (national)

c) other countries (international)
a)Local interventions *Explain reasons briefly*
b) Interventions delivered in other parts of the country (national) *Explain reasons briefly*
c)Interventions delivered in other countries (international) *Explain reasons briefly*

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EPPIC - Exchanging Prevention practices on Polydrug use among youth In Criminal justice systems

INTERVENTION: EXAMPLE ONE

Name of intervention:

You will each be given a description of the intervention to read and then please work as a group to answer the following questions.

QU. 1 Would this project be something you could replicate in your country?
We realise that people within the group may have different opinions and would like to record both the YES and NO answers separately. Please make a note of how many people thought YES and how many thought NO.
YES please record answers in the **YES** box
NO please record answers in the **NO** box
How may YES? _____
How many N0? _____

*PTO for Boxes (**blank pages have been omitted from the appendix)***

Qu. 2 Could the project be transferred to your country without adaptation?
We realise that people within the group may have different opinions and would like to record both the YES and NO answers separately. Please make a note of how many people thought YES and how many thought NO.
YES please record answers in the **YES** box
NO please record answers in the **NO** box
How may YES? _____
How many N0? _____

*PTO for Boxes **(blank pages have been omitted from the appendix)***

APPENDIX 2: Intervention examples used in workshops

Fundamentet (The Foundation)

Denmark

MAIN AIM/OBJECTIVE

The main aim of Fundamentet is to 'take a point of departure in the individual citizen' to create a space for change for the individual citizen and to make sure that there is always an open door at Fundamentet.

There are **three main elements** focusing on different ways of creating opportunities for change.

- The 'treatment space' (Da.: behandlingsrummet),
- 'Help for citizens' (Da.: Borgerhjælpen)
- 'Space for change'(Da.: Forandringsrummet).

Two of these interventions aim at helping the user on an individual basis, the third one is based on social activities. The reason is to accommodate that some users are not ready to be integrated into social activities, but need individual therapy or counselling and help to navigate in the other welfare systems he or she is also enrolled in. Others are not ready to look inwards and go into e.g. therapy, but need to get out every day and see other people.

The idea with the '**Treatment space'** is to:

a. offer different kinds of physical and psychological counselling to citizens who do not have the means to attend regular treatment facilities but are in great need of help; and
b. that therapy can help facilitate change in ways that other kinds of interventions cannot.

There are more than 50 therapy sessions each week at Fundamentet, including psychotherapy, occupational therapy, and massage. It is free of charge and users can be anonymous if they prefer. Users do not need a referral from a General Practitioner. At the time of data collection (for EPPIC study) there were about 65 users enrolled in some form of therapy in 'The treatment space'

'Help for citizens' is a service where citizens can get practical help (e.g. help to move), but also ask for help to navigate in the public welfare systems they are enrolled in (have a staff

or volunteer from Fundamentet to participate in meetings with the municipality, the Prison Service, educational information, or the like).

The kind of help Fundamentet offers can be for a 'here and now'- problem or more long term help, e.g. to be sure there is always a person from Fundamentet that attends meetings with the user. Users can be anonymous, there is no waiting lists (only for therapeutic counselling), and no 'ordinary case management' – so no monitoring or record keeping. This is one of the important points where Fundamentet differs from most municipal social and prevention services. They do not have to monitor their clients and keep records. Help for citizens' take a point of departure in what the user wants. At the time of data collection (for EPPIC study)there were about 50-60 users using 'Help for citizens'.

'Space for change'(Da.: Forandringsrummet) is a course with a holistic approach that focus on helping users with complex problems, get the young person closer to get a job or in education, as well as increase quality of life, self-insight, decrease drug use, and secure a more stable economic situation. The point of departure is trust, openness and care for the young people. The initiative consist of different kinds of social activities, including fitness training, outings, common meals, etc. But also counselling with a social worker and getting a contact person. It is possible to participate in mindfulness training, learn to play a guitar, or other activities where the user interacts with other users and staff and/or volunteers. Most young people enrolled in the 'space for change' struggle with loneliness and the idea is to create a 'healthy community' that is not centred around drugs or being in groups where no one is in a job or enrolled in the education system. At the time of data collection (for EPPIC study) there were about 35 young people connected to 'space for change'.

TARGET GROUP DESCRIPTION

The target group at Fundamentet is very wide, however, according to the professionals*, the majority of users of the initiative are young people.*

Users at Fundamentet are voluntarily there. They have heard of Fundamentet, e.g. from others in their network, and show up because they want help to something in their life. Only a few (maximum 10 young people) are referred to by municipal services.

The target group have been in and out of welfare services most of their lives, resulting in that many of these young people have experiences of having numerous and constantly changing social workers, that they have told their story many times and often have had

experiences of not being listened to, understood or taken seriously. Because of their lack of secure and stable upbringings they have not learned 'basic social rules' or 'manners' which make them appear as non-co-operative and difficult to work with. While many of the participants in Fundamentet have used or use drugs, not all do. Not all have been in touch with the criminal justice system, but it is not uncommon that users have been in prison and are in supervision at the Prison Service or have an electronic tag.

WHERE DELIVERED

The intervention is housed in a 400 m2 venue in the outskirts of inner-city Aarhus. Opening hours are on weekdays between 9 am to 3 pm. The venue consists of a homely common area with couches and carpets, looking like a living room, of several rooms used for therapy and counselling, a kitchen and an open office space where the employees have their desk, computer and phone.

WHO DELIVERS THE INTERVENTION

There are 8 part time employees (30 hours/week) at Fundamentet, who are there during opening hours, and who are responsible for the different elements that the intervention consists of. Additionally, there are about 75 volunteers who are affiliated with Fundamentet and spend at least 1 hour a week providing counselling, different kinds of therapy, etc. All volunteers are educated and use their skill (for example social worker, physiotherapist, occupational therapist, psychologist, masseuse) in the work they voluntarily do at Fundamentet. Volunteers commit to work at Fundamentet a minimum ½ a year. During the volunteer period they will be offered supervision and can attend the lectures and workshops that Fundamentet organizes.

At the time of data collection (for EPPIC study), there were about 100 users of Fundamentet and 20-30 daily users

SHORT HISTORY OF THE INTERVENTION

Fundamentet was founded by Steffen Rasmussen and has existed since 2014 (Fundamentet.org; steffenrasmussen.dk). It defines itself as a 'socialphilosophical organization for vulnerable, exposed or despaired citizens who needs

help'. Furthermore, Fundamentet claims to be explicitly oriented towards rethinking existing social interventions.

FUNDING OF THE INTERVENTION

Fundamentet is a voluntary organisation consisting of members and a board and is funded by external funding and donations. Fundamentet have a 5 year funding scheme from Aarhus Municipality (100.000 € pr. year), but the rest of the 500.000 € budget comes from private funds and donations, especially from the business community.

The board is the main governing body in Fundamentet. All members can run for the board and be elected for a 2 year period. The chairman of the board is elected for a 3 year period. All can become a member of the organization as long as one subscribes to the by-laws. The minimum member fee is 3 € per month. there are around 300 members.

There are several important reasons for being a volunteer organization:

- Sets Fundamentet free to try out new and innovative approaches to social work;
- They can offer users anonymity and that they do not have to monitor any users.

By not being subjected to The Public Administration Act because they are a voluntary organization, means that they can decide a lot themselves about how to run the place (e.g. not monitoring). This is a deliberate chosen position, they want to be independent, decide their own target group, and have freedom of methods.

THEORETICAL BASIS OF THE INTERVENTION

The employees at Fundamentet do not work with a particular method or particular sets of methods. But the employees use their educational skills (e.g. social work) and the team of employees represent different kinds of educations. The volunteers use their education as well and their voluntary work is based on what their educational back ground is.

Fundamentet works with a set of values. The most important values are compassion, presence and empathy. The idea is to create a trustful relationship with the young person that shows up at Fundamentet, and make the user feel that he or she is listened to and taken seriously.

Many employees and volunteers grew up in homes with abuse, alcohol or drug misuse. so have a personal motivation for working there and have similar experiences to the users they help and can to act as role models. While the staff's background is not enough to be

employed or a volunteer at Fundamentet, it can support the way that Fundamentet wants to approach the users, create trust and understand their conditions, and work with them (slowly) on the users' own terms.

As any employee in welfare services in Denmark, staff and volunteers at Fundamentet have an obligation to report to social services. The two professionals also emphasize that the most important features when choosing new staff or volunteers is a genuine interest in the young people and that they share and can work with a point of departure in Fundamentet's basic values.

EVALUATION AND QUALITY STANDARDS

Fundamentet does not have to comply with particular quality standards since they are a voluntary organisation. They have, however, a cooperation agreement with Aarhus Municipality, who can make surprise inspections, because of the funding from the Municipality. They have not been subjected to inspection, but are also not worried about it, as they try to be as transparent an organization as possible.

Projekt Over Muren (POM)

Denmark

MAIN AIM / OBJECTIVE

POM (Dk:Projekt Over Muren , Eng:Project Over the Wall) is defined as a pre-treatment drug initiative aimed at preparing inmates in custody in Copenhagen's Prisons (Da.: Københavns Fængsler) to enter drug treatment programs once they have received their sentence and are either released or transferred to their detention place.

The long term and overall objective of POM is to prevent relapse into drug misuse as well as criminal behaviour. These aims are in congruence with the Danish Prison Service's (Da.: Kriminalforsorgen) aim of providing prison-based drug treatment.

In sum, the *overall* and official aims of POM is :

- to build and improve its participants' opportunities to live a crime-free and drug-free life,
- to reduce the amount of drugs in prison.

The *short term objectives of POM* is to:

- optimize treatment attendance and minimize dropout (referred to as process aims)
- that at least 50 % of POM's participants continue into community treatment services after release (referred to as result aims).
- 90 % continues in prison based drug treatment when sentenced (referred to as result aims).

Participation in POM is voluntary and the only requirement is that participants are "motivated to change". Thus, the aim is not to ensure that its participants become drug-free through participation in POM, but rather to support and strengthen their motivation to continue into regular treatment.

Treatment structure in POM:

As described in the accreditation report (2009), treatment in POM consists of:

- 'Basis program' (Da.: basis forløb) focusing on establishing a good relationship between participant and treatment provider; motivational work; and cognitive treatment.

- ‘Follow-up program’ (Da.: opfølgningsforløb) focusing on maintenance of motivation to receive treatment after release/when transferred to another prison unit.
- Contact is established to a drug treatment facility in- or outside CJS.

The flow in POM’s treatment structure begins with visitation. The following steps depend on whether the participant are expected to be released following from sentence; how long he will be waiting for a sentence, and if he is already sentenced and is thus receiving treatment according to the treatment guarantee (see below). In any case, future treatment possibilities will be mapped out, and in cases of release, there will be focus on establishing treatment contact outside the prison setting.

The following treatment elements are present in POM: -

Individual sessions focusing first on individual goals and subgoals in terms of change by means of MI (1-2 sessions). In the following 12 sessions once a week, focus is on pathways out of drug use, and other everyday life changes by means of MI and cognitive approaches (this has been increased from 6 sessions). Treatment manuals are available at www.kfkk.dk. In practice, use of manuals are adapted to meet the individual needs of the participant. - Focus on treatment possibilities under further imprisonment as well as bridging between CJS and life outside the prison, e.g. in terms of collaboration with municipalities and local treatment institutions. Contacts / collaborations are gathered in a ‘knowledge bank’. - Group sessions focusing on change, values, and personal resources. - Drug education, psychosocial education and communication education / conflict management. - NADA ear acupuncture. - Sports (if the participant is located in the Motivational unit).

TARGET GROUP DESCRIPTION

POM’s overall target group is all inmates in Copenhagen’s Prisons who are motivated to change their drug use patterns. It is therefore very broad. Three basic target groups are mentioned in the project description:

- Inmates with cannabis misuse who are motivated to cease or minimize their use.
- Inmates in maintenance treatment who are motivated to attain a more stable social situation, e.g. receive support in ceasing/minimizing any supplementary use of drugs.
- Inmates with drug misuse who are not prone to seek treatment (in order to constitute or reinforce any existing treatment motivation).

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However, since POM was initiated, there has been changes in the target group definition as it turns out that more than 50 % of POM's participants were not known to or familiar with the treatment system. Furthermore, POM data showed that this group was mainly below the age of 25, mainly cannabis users and from other ethnic backgrounds than Danish.
POM is the only drug treatment initiative with a specific focus on and approach towards imprisoned youth within the Danish Prison Service. POM offer drug and alcohol treatment.

WHERE DELIVERED

POM is located in the Copenhagen based prison, Vestre Fængsel. Whenever possible, for POM participants under 25 years of age, treatment and imprisonment take place at Vestre Fængsel's Motivational unit, where all POM participants are gathered in the same wing, and where POM workers collaborate closely with the prison guards.
There is a greater focus on sports and social activities, which some POM participants experience as highly valuable, also in relation to minimizing their drug use, because it allows them to focus on their body.
Individual treatment sessions usually takes place in the (small) prison cells. Group rooms for group sessions are also available. Young people under 25 are offered more treatment sessions, and they are subjects to a higher degree of cross-sectorial collaboration.
The prison (Vestre Fængsel) is the largest remand prison in Denmark, and currently, about 100 inmates are part of POM. This is app. 25 % of the total number of inmates. The prison is described as a place with…:" … a lot of coming and going. Many are only here for a short period of time…" On average, inmates spend 70 days in the prison, but time spent varies from a few days to several years. As another professional says, "it is a big house with a huge flow". This condition can make it difficult to follow the treatment plan. All inmates in the Motivational unit are male. Female inmates with drug problems, who are under the age of 25 are rare, and are according to professionals (informal interviews) in many instances too affected by other life circumstances (e.g. prostitution) to be in the same premises as the young male participants.

WHO DELIVERS THE INTERVENTION

Treatment is delivered by 'in house' professionals with different educational backgrounds and professional experiences. Treatment staff consists of social workers and social

pedagogues with special drug treatment training, and some have other relevant training, e.g. in relation to mental health / psychiatric issues. The Danish Prison Service. usually buys in treatment services from external organisations rather than delivered 'in house'. In house professionals have access to CJS information about their participants (e.g. previous drug treatment experiences) from the CJS monitoring systems which externals do not. .
Besides trained professionals, three student assistants are employed, two work as sports coach and one with project documentation.

SHORT HISTORY OF POM

In January 2007, the Danish drug treatment guarantee for inmates in prisons was passed (Frank & Kolind 2008). This meant that all inmates were entitled to receive psychosocial (not medically assisted) drug treatment if they had received their sentence and had more than three months left to serve. Following from this, POM was initiated in July 2007 as a collaborative treatment project between Copenhagen's Prisons funded by the Danish Ministry of Social Affairs and Copenhagen Municipality. In 2011, the original treatment guarantee was extended so that it also includes prisoners with short sentences and people in custody. In 2009, POM was accredited in first attempt by the Danish Prison Service's accreditation panel. It is thus no longer temporarily funded by the Special Pool for the Social Area (Da.: Satspuljen), but is a permanent initiative.

FUNDING

POM is now part of the permanent treatment services on offer in Copenhagen's Prisons and hence funded by the Prison Service

THEORETICAL BASIS OF THE INTERVENTION

Prochaska & DiClementes (1986) concept of change is fundamental in POM ('the wheel of change'). So is an emphasis on relationship formation/therapeutic alliance. Together with motivation for change and voluntariness, motivational interviewing (MI) (Miller & Rollnick, 2004) and cognitive therapy (Beck, 2007) are identified as the central methods in the accreditation report (2009). MI and cognitive therapy are emphasized as the central methods by professional.

EVALUATIONS AND QUALITY STANDARDS

POM was accredited in 2009, and thus evaluated by external evaluators in relation to the quality standards of the Danish Prison Service, regarding: Theory/model of change; ethics; target groups; methods/concrete approaches; duration/structure/intensity; individual planning and coordination; documentation and quality assurance; staff, corporation and working environment. In terms of ongoing evaluations, the most recent annual report is from 2016. The report builds on data collected systematically by POM. Quarterly reports are available at POM's homepage (http://www.koebenhavnsfaengsler.dk/). In January 2017, new evaluation forms were introduced in order to obtain more qualitative responses from participants regarding their experiences of participation in POM. The aim is to gain further knowledge on two of POM's five success criteria1 of which criteria four is that minimum 75% of participants have experienced positive treatment effect following the basis program, and criteria five is that at least 75% of participants who follow group sessions find them recommendable. Furthermore, there is project steering group meetings every 6th month, with the participation of POM's manager, two professionals, one external counsellor, one external researcher, and two representatives from the Prison Service. The aim of the steering group is primarily to provide external feedback from different stakeholder- and professional perspectives.

However, growing number of community based anonymous treatment initiatives makes it difficult for POM staff to evaluate and register how many of POM's participants are enrolled in drug treatment after they are released from prison.

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Multiple prevention intervention in an Attenuated Custody Section (ICATT)

Italy

MAIN AIM / OBJECTIVE

The main outcome of the intervention is to make possible to people to access alternative measures to the prison.

The more general aim is the prevention of reoffending and of progression of consumption careers by helping detainees to handle their anger and aggressiveness.

The specific aims are to evaluate individual needs, and to construct programs alternative to prison aimed at improving offenders' life-skills.

TARGET GROUP DESCRIPTION

Young adults and adults detained in special sections named "Attenuated custody for detainees with addition problems" (ICATT) who voluntary access to the program. 18-24 year-olds are about 1/3 of the total population. The average age is 35.

WHERE DELIVERED

ICATT are special Attenuated Custody Section, which, according to the law (DPR 309/90, art. 96), should be present in each region and can involve also external professionals from addiction and mental health services. They must provide prevention, harm reduction, rehabilitation and social reintegration services to alcohol/drug addicts who voluntary access to programs. For this reason, in these special sections, it is more difficult that drugs circulate than in ordinary prison environments.

The ICATT placed in Padoa serves three Regions (Veneto, Trenti-Alto Adige, Friuli Venezia Giulia so called Triveneto).

Number of persons hosted: max 50, almost always full.

WHOSE DELIVERS THE INTERVENTION

The staff team is composed by 3 psychologists/psychotherapists and 2 educators. Furthermore there are psychiatrics of the penitentiary as well as other health professionals of the prison who collaborate with the team.

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SHORT HISTORY OF THE INTERVENTION

ICATT was open in February 2014, for one-year-trial, then it became a regular service.

ICATT is a building within the Padoa prison, but it is separated from the rest of the prison, a sort of island, which is necessary in order to diversify the activities. Besides, to make it a place of care, it was necessary to crumble the total institution in favour of suitable spaces to permit to the detainees to develop a relation with the operators.

The challenge was to create a place of care inside the prison, a therapeutic context dedicated to detainees who use drugs. This first step allowed the team to work with a specific type of consumers, to provide them tools and skills in order to access alternative measures. Which means to provide therapy, to create capacity and to develop capacities to face the reality.

Then, a model based on evolutionary steps -low, medium and high- was developed. It includes three main elements: motivational, skills and capacity to manage emotions, and stress.

FUNDING

ICATT is funded by the Regional government, with 200.000,00 euros per year, which are used for human resources and activities (e.g. dog-assisted therapy and Rugby).

THEORETICAL BASIS OF THE INTERVENTION

"In the prison context, inmates affected by drug addiction need to comply with detention life, characterized by heavy emotional entailments and by the customs and culture of the correctional facility they must take on. Therefore, in order to adapt to this difficult environment, full of stressors and infightings, they have to develop ***their own coping strategy****, which often results in being dysfunctional because of their addiction. In this framework,* ***rehabilitation and specific therapeutic programs are strongly recommended to facilitate the reintegration of inmates into society as law abiding citizens, overcoming the concept of prison term as a punishment and enhancing a health-promoting approach to offenders' management in prison settings****. Time spent in prison offers an opportunity to influence the future lives of inmates, making a major contribution to improving health and well-being of these disadvantaged people, reducing substance abuse relapse as well as financial cost for the community and preventing future criminal behaviour. In particular,*

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animals appear to be increasingly incorporated into correctional programs in prison as part of vocational and social skills training and in the treatment of substance dependence" (Contalbrigo et al. 2017, p. 4)

The theoretical framework is the Attachment theory (see e.g. Cooper et al. 1998; Shivpuri 2006) to explain antisocial behaviour or drug consumption.

In this framework, drug consumption is seen as the last element in term of therapeutic and prevention actions. The main work is done on the factors that have led the patient to develop drug consumption, on his basic vulnerability, and then the crime. Therefore, in the first phase the focus is rather on the crime than on the drug consumption. The reason is that the crime is also a mirror of the capacity of the person to face the reality. In the last phase of the program the focus is also on the drug consumption and on the prevention of relapse.

Access to the program

The access to ICATT is voluntary. The prison operators of the area called Tri-Veneto inform the detainee about this possibility, but also the detainee can ask to have an interview for entering in ICATT.

There are some conditions for the admission:

1. problematic drug consumption (a history of consumption)
2. the crime committed has to be linked to drug consumption
3. low social and criminal perilousness
4. to have a conviction not more than 6 years, or no more of 6 year of remaining conviction.

These conditions are evaluated by the social-health operator of the prison who guests the detainee.

Then the ICATT team runs the filter interview: motivational evaluation, psycho-diagnostic evaluation with a test SCL90, a psycho-pathological scale.

After that there is a meeting of the two teams (from ICATT and prison) to make the entry in ICATT formal.

The clinical evaluation includes only the motivational evaluation, and the collection of the clinical history. The person enters in the structure with this evaluation and the SCL90, on the base of which it is decided how to intervene (in case of insomnia, depression ...).

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Intervention

1. Psycho-diagnostic **assessment** of skills with different scientific tests. On the base of this information a rehabilitation program is draft lasting 1-3 months.
2. In the meantime, the so called “low-evolutionary patients” access to a series of basic activities, such as
    a. Harm reduction interventions, addressed to inform newcomers about prevention measures, such as condoms and drug paraphernalia, and to test their use. Distribution of a specific kit at the release, including sterile syringes, paraphernalia and naloxone. In collaboration with the Arcigay association.
    b. Educational area: to develop skills about the meaning of the norms, the elaboration of the crime through laboratories and film club.
    c. Basic group on: emotions, assertiveness, management of anxiety.

After these basic activities most of patients move to medium/high evolutionary level and can access to a higher-level-program aimed at learning to manage stress and anxiety, as following described.

3. Intervention for “high evolutionary patients”:
    a. Harm reduction interventions aimed at learning how to behave, how to use the information they received (e.g. to manage a condom, a syringe …). This is a sort of test, after the cognitive reorganization, to verify the capacity to use the harm reduction measures and information, to put them in practice. Even if it can instigate a craving, they must apply the skills they have learned to face it.
    b. Meditation and mindfulness practices, to learn how to manage the anger and how to answer to specific stimulus in difficult situation. The intervention is run in collaboration with the University of Padoa, Faculty of social psychology. The focus is also on the meaning of the crime and its acceptance. It is very useful as prevention of relapse.
    c. Dog-assisted therapy in order to reduce anxiety and craving and to increase social competences. The relationship with the dog implies a capacity to manage with anxiety and emotions. There is a great interaction between dog and person. In collaboration with the Zooprophylactic Institute of the Venetians with a close collaboration between the vets and the team. There is an evaluation of

the development of capacities through different instrument that the team has elaborated.

4. There are also people who are not able to get the tools, they rest at low, medium evolutionary level – which is measured by some indicators. For these patients the main activity is:

    a. Rugby (form low and medium evolution). It works on the management of emotions.

If the professional team thinks that there is not an evolution process, it works on a more individual tailored-program.

The prevention of relapse is then an individual work, on the basis of the individual history, before accessing to an alternative measure. The program aimed at preventing the relapse is based on cognitive behavioural therapy (Marlatt & George 1984). It is centred on the identification of the trigger, that is the high-risk stimulus, considering both the vulnerability of the person and the characteristics of the context, the behavioural aspects and the capacity to face difficulties.

In this program the substance does not occupy a central role.

The whole program lasts around 12 months.

Drug consumption in the structure

Controls are performed with fast tests, even randomly, however it is not possible to state that ICATT is completely drug free. Anyway, consumption is very limited as people are selected and get privileges compared to other detainees (e.g. more spaces …). Patients are aware that the advantages are higher compared to sacrifices, especially because this path will bring them more rapidly to an alternative measure.

Among the about 120 patients guested by the structure since February 2014, there have been 1-2 expulsions. All in all, it seems that even anti-social patient can adapt to the programs provided.

EVALUATIONS AND QUALITY STANDARDS

1) Annual reports about ICATT

2) First evaluation of follow-up: the number of those who went back to prison because they committed a crime have been identified and are 3-4 in total.

3) A collection of data is ongoing including personal diaries, but data are not available, yet.

3) Dog-assisted therapy. Published a pilot study based on 22 drug addicted male inmates housed in an attenuated custody institute, 12 treated, 10 involved as control sample – i.e. following the standard rehabilitation program. One week before the beginning and one week after the end of the sessions, all the involved inmates were submitted to symptom checklist-90-revised and Kennedy axis V. Inmates involved in the dog-assisted-therapy significantly improved their social skills, reducing craving, anxiety and depression symptoms compared to the control group. (see Contalbrigo et al. 2017)

No external evaluation is available.

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Spazio blu (Blue space)

Italy

MAIN AIM / OBJECTIVE

Prevention of progression of consumption careers towards addiction by increased awareness about the use of substances and education to pleasure, i.e. on how to take pleasure by other activities.

It is an environment characterized by the absence of stigmatizing factors and by an high expertise in adolescent consumptions (Giove et al. 2012)

TARGET GROUP DESCRIPTION

Minors with substances consumption related problems reported for both penal and administrative offenses – the latter being a minority - and those directly reported by the court even though not having been tried. Young adult up to 25 years are also admitted if the offence occurred when they were minors. Once the penal procedure is concluded, young people can voluntary continue to frequent the service, until the age of 21 years. About 2/3 of the service clients are under a judiciary penal procedure, about 1/3 frequent it voluntarily, even they are not under the justice system.

In 2012 (Fiore 2013) 91% of the service clients were boys and 80% and aged 16-18. 69% were Italians, while among other countries the most represented were Morocco and Tunisia. Most of them have scholastic failures, 53% are Neet (not engaged in education, employment or training). The prevalent substance is cannabis (75%), followed by alcohol (11%), cocaine (8%), polyuse (5%). Offenses are in most cases drug-related (69%).

WHERE IT IS DELIVERED

Spazio blu (Blue space) is a service of the public health local unit (ASTT Santi Paolo e Carlo, Milan) and represents a unique experience in Italy. It is an external structure for alternative measures, which hosts about 300 users throughout the year. Its mission is to provide diagnosis, treatment and rehabilitation to minors with legal proceedings and problems of use of substances / alcohol. The professional team of Spazio Blu can be engaged by the Judge or by the Social services since by the time of the arrest.

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WHOSE DELIVERS THE INTERVENTION

The service head is a psychotherapist, then there are four psychologists/psychotherapists, one medical doctor, two professional educators, two social workers and one nurse. There is also a criminologist and 2-3 trainees under periodical internships.

SHORT HISTORY OF THE INTERVENTION

The service was born is 2005. Pilot interventions began already in 2000 –within the Addiction Department - funded by regional funds, contributions by foundations and funds dedicated to innovative actions. By 2005 it was recognised as a stable Unit within the Health Regional System. Since 2012 the collaboration with the public family counselling centre – the social service unit addressed to families with difficulties – was formalised. Protocols and common operative procedures have been agreed and signed – based on a period of spontaneous collaboration - with all the other institutions involved in the Justice System for minors; the minor Justice centre, U.S.S.M. (unit of social services dedicated to minors), CPA (First reception centres), IPM (Juvenile detention centres), as well as with the Minor Court, the Prosecutor's office and the Prefecture.

FUNDING

Before 2005 the service was funded by regional funds, contributions by foundations and funds dedicated to innovative actions, which means that funds were related to specific projects and time. By 2005 Spazio Blu was recognised as a stable Unit within the Health Regional System and receives stable funding.

THEORETICAL BASIS OF THE INTERVENTION

The ideology of the service based on the importance of early taking on responsibility of minor offenders before their substance use develops in addiction. The use of substances is framed in an evolution perspective. The assumption is that use of substance relates to emotional needs also dealing with the personal relationships. Therefore, it is important that minors have the opportunity to increase awareness about their abilities and about the opportunities provided by the external environments to get pleasure from activities other than taking drugs, related to cultural fruition, physical activities, socialisation...

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There is no a main/unique theory of reference, as each professional applies his/her own intervention model, which however has to be integrated with the others, that is, methodologies must be consistent. There are standardised procedures for the initial multi-dimensional evaluation, however choices – e.g. if to use or not specific diagnostic tests – are to be proposed and discussed within the treatment team.

TREATMENT MODEL/APPROACH

The treatment approach is called 'multi-disciplinary integrated intervention'. Each case is assigned to a case-manager, who works in collaboration with a multi-professional team and in collaboration with other professionals from the other involved institutions. There are periodical inter-institutional meetings in order to make the psycho-educational treatment provided by the service consistent with other possible paths, such as those related to professional training and placement.

The first meeting with the minor is led by the social worker and the educator, also aimed at an administrative evaluation. Then there is the intervention of a medical doctor if there are health issues.

Many kinds of interventions are provided (Giove et al. 2014):

- Counselling
- Brief psycho-therapy
- Sanitary monitoring
- Social intervention
- Educational tutoring
- Group activities
- Family counselling

Even though individual psychotherapy is provided, group therapy is the favoured form of intervention. The group therapy is usually more accepted by young people than individual treatment. The group offers to the young patient the possibility to enter into a communication process in which he can represent himself (Giove et al. 2013). For this reason, the group activities are in some cases prevail on and strengthen the individual interventions.

Groups are made of 8-15 young people – where those with under penal procedure can be mixed with others - and entail about 10 meetings, even though the number can vary based

on the group characteristics. They are psycho-educative groups based on active participations. For instance, minors are stimulated to work on their personal stories, rather than being informed about substances, although some specific forms addressed e.g. to get information about risks related to driving under the effect of substances, or about infective diseases, are provided. Psycho-pedagogical groups are run by psychologists and educators together, aimed at experimenting and discussing within the group different kinds of situation, aimed at making the minors to discover the pleasure of cultural activities (cinema, exhibitions…) and social activities (e.g. barbeques). Spending time with their peers, they also learn how to manage their emotions. Sometimes young adults/minors who have been at Spazio Blu in the past are invited to tell about their experiences.

Groups are also accompanied to visit the other territorial services, for instance the family consulting centre, the centre for sexually transmitted diseases, and other local agencies for socialization, free time, job orientation… The aim is to increase the young people's knowledge and use of local resources, not focusing only on the substance problem, so that they can approach other paths beyond that of Spazio Blu.

In the case of penal procedure and sentence/probation, usually the process is 1,5-2 years.

Parents are also involved in the process. Besides individual counselling, once a week the educator and the psychologist meet the parents' groups (8-10 parents for 6-8 meetings). The aim is to increase their parental competences about use of substances and acquire more awareness about personal parental skills, by exchanging experiences with peers and learning more information (Giove et al. 2014).

EVALUATION AND QUALITY STANDARDS

Systematically collected data are available only from the last 6 years. A statistical analysis is being conducted with a detailed analysis of the medical reports. The aim is also to evaluate the correlation between type of penal procedure, type of treatment and clinical initial/final observations.

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Project B

UK

MAIN AIM/OBJECTIVE

The aim is to keep the young offenders purposefully occupied, 'upskill' them and provide an opportunity to 'give back', by offering support to other young people, but also to keep them in education themselves – thereby reducing their risk of reoffending. A further aim is to make services more accessible for young people by providing support through peer navigators.

The mission statement of the charity is: '…to support those on the margins of society. Supporting them to gain personal, social health education to lead purposeful, fulfilled lives to influence change for the benefit of their community. We aim to ensure that engagement participation is an inclusive holistic by ensuring the most excluded are inspired, motivated, we believe the best strategy for supporting the immediate and long-term wellbeing of the most vulnerable people is through a holistic, life-course approach.'

The approach taken is highly participative and engaging, involving young offenders in consultation processes to understand why they are using drugs, and what support they need. Providing training to young people so they can communicate and feel confident to talk to commissioners on what they can offer in the community to help address the issues. Service users can be a part of the Board of Trustees for a year.

Young adult offenders are trained to deliver mini group programmes to other young people to start discussions around their service needs and offering advocacy for government programmes (e.g. Child and Adolescent Mental health Services [CAMHS]).

TARGET GROUP DESCRIPTION

As an organisation, Project B is primarily service user led, with half of the board of trustees made up of service users or ex-offenders.

Two main groups are targeted by Project B for intervention. Peer support navigators are young adult offenders who have been through the criminal justice system and have similar life experiences to younger people using the service. Navigators are volunteers (16-21) who go through a training programme, gain qualifications and 'shadowing' experience. Once this is completed they can undertake paid sessional work.

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Project B also encourage and promote attendance at colleges or training for further skills or alternative employment opportunities (e.g. apprenticeships). Navigators receive accredited qualifications in peer mentoring and youth and community work. Navigators work with service users aged between 13 and 25 years who have been involved with the CJS and have additional substance misuse problems. There is a particular focus on ensuring local people are available to offer local information and support.

WHERE DELIVERED

Navigators are trained on site at the YOS offices in a London borough, they can either volunteer to become part of the training programme or may be identified by the Project B team via their involvement in YOS and invited to join.

Group sessions led by peer navigators are delivered through schools and community organisations. 24

WHO DELIVERS THE INTERVENTION

Peer navigators are trained by one or more of the four paid staff in the organisation in aspects of mental health, trauma, personal wellbeing, speech and language and substance misuse. Young adult ex-offenders are trained to become navigators and once complete they are employed to provide support to young people in the CJS in accessing local services. Peer navigators are supported by qualified staff who are mainly ex-service users themselves.

SHORT HISTORY OF THE INTERVENTION

Project B was founded by an ex-offender and two colleagues in 2016 as a charity after being approached by the local authority to set up an intervention programme for young people involved in the CJS. The intention was to create a service that can act as a bridge between the CJS and referral services such as CAMHS or substance misuse services where usually young people are expected to navigate these services alone. The board of trustees is made up of 50% service-users and 50% representatives from criminal justice, youth offending, mental health or substance misuse backgrounds.

The current process of selecting peer navigators arose from a consultation with young service users who reported that they wanted to be mentored by others with similar, and relatively recent, experiences of the CJS to themselves.

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Substance misuse educational programmes were developed in collaboration with young people who had experience of misuse and criminal activity. This led to a meeting with local commissioners, the head of the Youth Offending Service, school authorities and the police where young people shared their views and influenced the delivery of a substance misuse programme for young people in YOS.

Future visions of the service are to create a similar support network within prisons so that those who are most vulnerable, and that are often missed or unrecognised, will be able to access peer support navigators who will also be able to speak on behalf of the prison population to authorities. These navigators would be able to identify and communicate issues across the prison to the authorities (e.g. prison governor) and can be available to offer direct support to other vulnerable prisoners where needed.

FUNDING

The project is currently being funded as part of a three year pilot by the Local Authority (began in 2016).

THEORETICAL BASIS OF THE INTERVENTION

The approach focuses on a number of key factors that are thought to influence a young person's ability to develop necessary life skills that will enable them to meet challenges and respond positively in their everyday lives. The programme is built on a PSHE perspective with a holistic, life-course approach to encouraging and promoting greater resilience, engagement, leadership and transformation that has impact on not just the individual's life but also those around them.

EVALUATION AND QUALITY STANDARDS

Project B has been self-evaluated. There has been no external evaluation to date but possibilities are being considered.

Project A

UK

MAIN AIM/OBJECTIVE

Project A operates with the objective of ensuring young people have the necessary information to keep themselves safe and to avoid risky behaviour. The package is designed to ensure young people received 'the basics' in terms of keeping themselves safe, in an integrated way that covers a range of interlinked risk behaviours. The programme aims to support young people to be more resilient and to develop effective coping skills to deal with issues they face in life. The main objective of the programme is to empower young people to remain safe and avoid risk.

TARGET GROUP DESCRIPTION

Primarily the programme is aimed towards young people (male and female) aged 11 to 18 years who are in contact with the Criminal Justice System (CJS) and are considered 'high risk' and subject to the Intensive Supervision and Surveillance Programme (ISSP). The ISSP is a community based programme for the most persistent and serious young offenders and is an intensive programme of supervision and surveillance aimed at managing potential risks posed by these young people and that their needs are met and continually reassessed in order to reduce or prevent their re-offending. Within the youth offending services, the service staff also provides training to Youth Offending Services (YOSs) to deliver Project A themselves and they deliver specific substance misuse interventions directly to young people within the YOS.

In addition, prevention/early intervention programmes are delivered to local schools to young people identified by teachers or school authorities who are thought to be at particular risk of becoming involved in alcohol/substance misuse or criminal activity. This arm of the programme has been accredited by the Feeling Safe Foundation.

A third strand of the programme is the Protective Behaviours mentoring programme that has recently been piloted. This programme focuses on teaching mentoring skills to a range of potential groups including young people (aged 14 years and up) and those who have been released from offending institutions (aged 21 years and up). There has also been interest from groups working with young people within or just about to leave the care

system to produce a targeted mentoring intervention to help them adjust to independent living.

WHERE DELIVERED

Outside of the schools initiative which is delivered in the classroom, the programme is delivered through a West Midlands YOS within the community. Young people are directed to the YOS via police directives or court orders and they receive the programme on planned visits with case workers.

WHO DELIVERS THE INTERVENTION

The intervention is currently being delivered by case workers within the YOS to young people referred through the CJS. School based delivery of the intervention is given by trained Project A staff.

SHORT HISTORY OF THE INITIATIVE

Project A was developed for delivery through school groups focusing on a range of potentially risky behaviours and how young people can keep themselves safe through the Protective Behaviours approach (explained below). The resources were created through consultation with experts, young people and professionals and through collating some of the best materials currently in existence. These consultations were combined with academic research leading to an awareness that young people often don't appreciate the risk involved in some of their actions which could make them vulnerable. The programme consists of five sessions with materials and resources built around the concept of resilience that can be broken down in a series of shorter sessions run over a longer timeframe. The programme has not yet been adapted to work with young people in the CJS and just recently been introduced to the YOS in the local area. It is expected that some modifications may happen over time once the programme is in full use and feedback from practitioners and young people has been collected.

FUNDING

The project is currently funded by a Local Authority.

THEORETICAL BASIS OF INTERVENTION

The programme works broadly on the principle of promoting greater awareness among young people of the consequences of their behaviour and understanding how to change that behaviour to avoid risk. The main theoretical influence comes from the Protective Behaviours approach initially described by Peg West in the 1970s. This approach identifies strategies that young people can use when they find themselves in situations that make them feel unsafe and works towards building a support network that they can use to ask for help or advice when they feel they need it. One of the aims of the Protective Behaviours approach is to empower young people to develop their own problem solving skills and to avoid risk. The second aim of the programme, as described by the Project A director is to develop young people's empathic understanding which feeds into the peer mentoring aspect of the programme.

Two underpinning principles of the 'Protective Behaviours' approach have been utilised throughout the Project A package:

- 'we all have the right to feel safe all the time'
- 'we can talk with someone about anything even if it's awful or small'

A young person, through self-discovery facilitated by participation and practice in activities based around developing key skills and understanding, will learn and understand the concepts of actions and consequences, safety and risk avoidance/minimisation and 'own' them.

The approach aims to support young people to be more resilient and develop coping skills to deal with the issues life may present them with, ultimately leading to the main aim of Project A; empowering young people's safety and avoidance of risk.

The delivery team are qualified counsellors and use a therapeutic approach to working with the young people in the programme. They offer a range of therapeutic interventions including motivational interviewing, CBT, psychodynamic therapy and transactional analysis.

EVALUATION AND QUALITY STANDARDS

A pre and-post programme assessment and evaluation (for each individual client) has been developed, in conjunction with a behaviour change psychologist. Project 12 has been running since September 2016 and has not as yet been evaluated as a whole project.

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Schweizer Haus Hadersdorf (SHH)

Austria

MAIN AIM/OBJECTIVE

Schweizer Haus Hadersdorf (SHH) is a non-profit organization for inpatient (residential) and outpatient (ambulant) therapy for drug and alcohol problems. The aim is to help people to move towards being free from drugs and support them in re-socialization. SHH works through counselling, medical treatment and short- and medium-term therapy. Schweizer Haus Hadersdorf offers four kinds of services:

1. In-patient care for up to 45 patients
2. All-day out-patient care
3. Out-patient individual counselling
4. Extended in-patient therapy in an autonomous residence

TARGET GROUP

In Austria the application of alternatives to punishment, especially suspension of sentence in the context of the principle of "therapy instead of punishment", is regulated by law. Convicts can be allocated to SHH with AUSTRIA - WP5, 2nd national report EPPIC 8 a sentence according to §39 SMG (suspension of sentence). The prison sentence will be delayed for a maximum of 2 years if that person takes part in the therapy programme offered by SHH and other providers. At the end of a successful therapy, the prison sentence will be turned into a suspended sentence. Approximately 80% of residents come to SHH in this way. Often, people contact SHH and ask for admission before the trial in order to influence the judgment. Other clients are allocated by the Vienna City Council. Those have not been officially in touch with the criminal justice system, but experience shows that they have been in contact with crime at some point.

WHERE DELIVERED?

This institution is located in an old residential villa in the 14th district in the periphery of the city of Vienna. People live in small communities in shared apartments. On the property there are opportunities to work in mechanic workshops and practice sports. On weekends

excursions are organised, otherwise clients are only allowed to leave the property with a special permit from the management.

WHO DELIVERS THE INTERVENTION?

All forms of intervention at Schweizer Haus Hadersdorf are offered by certified professionals.

SHORT HISTORY OF THE INITIATIVE

The history of the building, where Schweizer Haus Hadersdorf (SHH) is now located, goes back to the early years of the 19th century. The lordly Gerngross family, later the most famous warehouse-company in Austria, resided in the villa from the 1850s until their deportation or flight to Switzerland. During the Second World War the building was used by the German air force, before it was opened in 1947 as an orphanage by the "Hilfswerk der Evanglischen Kirchen der Schweiz" (social services of the Evangelic Churches in Switzerland). From 1971 the property was used as a convention centre by the Vienna Evangelic Church Community. In 1997 the place was turned into a residential care facility for therapy and reintegration of people with drug-addiction. Then, in 1998, the property known as "Schweizer Haus Hadersdorf" became an institution for residential and ambulant drug therapy. As a low-threshold institution SHH also accepted people in need of help from other institutions in the country, and for a long time served as the only place in Austria to offer substitution-therapy in stationary care.

FUNDING

Today, Schweizer Haus Hadersdorf is a non-profit organization. It is registered as a psychiatric hospital according to §5 (WrKAG) of the Vienna Hospital Code. According to §16 SMG (drug law), funding for all institutions and organisations offering services for persons with drug addiction may receive a subsidy by the Austrian government. However, the subsidy has to be in coordination with subsidies by other public authorities. Subsidies may be used exclusively for the erecting and operation of organisations.

THEORETICAL BASIS OF THE INTERVENTION

Medical treatment, therapy, social work and professional education are offered all the time. The therapeutic concept of SHH starts with 2 – 6 months residency in the house, followed by a 6 months period of "decentralised living" with an offer to use the medical facilities on a daily basis (Tagesklinik). The particular concept of intervention is based on four pillars: 5. Combination of milieu-therapy and psycho-therapy 6. Maintenance of connection with the social environment (family) (proximity to the city of Vienna) 7. Short residential care with an emphasis on self-responsibility 8. Possible opioid-substitution in all phases of treatment Innovative concepts of care have been developed from the very beginning at this facility. For many years SHH was the only institution in Europe that offered substitution in a stationary setting beyond the system of correctional services. This form of therapy has become a standard form of drug treatment. Today, the principle of abstinence from drugs is considered out of date and has been replaced by a systemic approach: The most recent concept of intervention integrates psychological and psychotherapeutic drug-treatment and forms of social learning in terms of coping strategies for healthy living. In general, opioid-substitution is an important stabilizer for individuals and will be applied with care. Most importantly, individual capacities and competences obtained during the therapy shall be strengthened with all resources and expertise available in the house. Here it is important to find a good balance between excessive demand (overextension) and boredom (mental underload). In addition to regular therapy, either individually or in group sessions, the training of everyday competences, health promotion and general encouragement for better quality of life are crucial elements of treatment at SHH. This particular approach of milieu- and social therapy facilitates working and living independently. Therefore, the objective is not only to achieve complete abstinence or stability of drug consumption, but also to give support in experiencing everyday life and to practice a daily routine with low-risk drug consumption. Treatment at SHH is aimed at both abstention from drugs and leading a self-responsible life without any massive conflict with societal norms. Next to the cognitive reflection of addiction as a disease, this approach fosters gradual implementation and realization of leaned coping strategies in the life of clients. This social training together with therapeutic work is integrated into the overall framework at SHH.

EVALUATION AND QUALITY STANDARDS

The quality of service is guaranteed through a permanent assessment by the Ministry of Justice. According to §15 SMG (drug law) SHH must report the performance and progress of clients to the Federal Ministry of Justice. All institutions and associations offering services in the programme “therapy instead of punishment” must subscribe to the regulations around the provision of suitably qualified staff, monitoring and reporting of activities and must work towards abstinence from drug addiction and towards social reintegration of the client and can be subject to inspections.