West Midlands Violence Reduction Unit Evaluation

The Project Level Evaluation: Teachable Moments Literature Review and Process Evaluation

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March 2021

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Executive Summary

Background

The two projects involved in this section of the evaluation are Teachable Moments in A&E and Teachable Moments in Custody. Both are delivered by St Giles Trust as part of a suite of interventions commissioned through the WMVRU.

The Teachable Moments in A&E service aims to support children and young people presenting to Coventry and Wolverhampton hospitals' Accident and Emergency (A&E) Departments and the Major Trauma Centre (MTC) as a result of youth violence, exploitation, gang and/or county line related activities.

The Teachable Moments in Custody service aims to offer timely and tailored support to young people under 25 years old that come into police custody. These young people are affected by criminal activities (e.g., gangs, carrying weapons and violence) during the "reachable moment". St Giles Youth Workers work in partnership with West Midlands Police (WMP) and operate within the existing infrastructure offering practical, emotional, and 1-2-1 mentoring to young people and their families in custody and on release back into the community.

The aim of the evaluation was to examine how (and how efficiently) the teachable moment projects have evolved, and the relationship between this and the impact – particularly in light of the restraints placed upon them as a result of the Covid-19 pandemic. This aim was to aid the continued development of the services, and identify any barriers to success.
The evaluation team carried out 14 semi-structured interviews with staff, stakeholders and parents of clients involved in the two projects, as well as a narrative literature review. Two case studies received directly from St Giles were also incorporated.

The narrative literature review was undertaken to address a number of questions about the police custody intervention that cannot be answered through the collection of new empirical data at this point. The literature review sought to explore the following questions:

- How important is the messenger? What impact does having someone with lived experience deliver the messages have on the overall outcomes (i.e. engagement, sustained involvement)
- How important is the timing of the intervention?

The review involved a detailed review of over 40 journal articles and reports centring on teachable moment methodologies, brief interventions, mentoring initiatives and the impact of 'lived experience', police custody environments, and youth violence and its associated risk factors. Several of the sources addressed A&E initiatives, particularly those focusing on teachable moment methodologies and brief interventions. The literature was then used to augment the findings from the interview data.

Key Findings

Findings from detailed qualitative analysis identify the following as key to the Teachable Moments in A&E:

- Multi-agency collaboration and communication
- Building trust and confidence through the cultural competency and 'lived experience' of its staff team and a relational approach
- Taking a whole-family approach

The project has been challenged by low levels of sustained engagement, the availability of support for young people transitioning from child to adult services, and the overall profile of the project in terms of awareness within the hospitals.

Similarly, findings from detailed qualitative analysis identify the following as key to the Teachable Moments in Custody:

- Credibility of the staff team built on their lived experience and cultural competency and contextual awareness
- Offering longer term support, without a pre-determined duration and
- The passion and dedication of the staff team.

The project has faced challenges through the pandemic because of the lack of available 'alternative' opportunities for young people and the difficulties of maintaining a high level of communication with clients and their families.

Combining these findings and augmenting them with the narrative literature review, the key overall findings include:

- The 14 semi-structured interviews carried out with staff, stakeholders and parents involved in the two projects revealed numerous benefits, and some innovative approaches. The benefits mainly revolved around perceived behavioural changes in clients and new multi-agency working relationships. Caseworkers and parents reported seeing changes in the way young people speak and interact with their families and social networks; their willingness to speak about the traumas they have experienced; their desire to return home at night instead of attending house parties; the seriousness with which they attempt school work or consider enrolling at college; and even their attentiveness towards their sleep routine, among other benefits. These changes were usually attributed to the establishment of a relationship between young people and supportive and patient caseworkers/ peer mentors with lived experience.
- The more innovative procedural aspects of the initiatives included the establishment of new working relationships between St Giles caseworkers and NHS staff. This involved the use of NHS computer systems to upload information about interventions on a case-by-case basis, which could be used to link together other social services involved with an injured patient. Nurses, in particular, became more comfortable sharing information with caseworkers as part of this initiative. NHS staff, more broadly, became more aware of the lived experience of young people

and the terminology they used by attending joint training sessions with St Giles caseworkers. Separately, within police custody suites, custody officers routinely referred young arrestees to youth workers, and their enhanced awareness of the work of St Giles reportedly led to the swifter release of arrestees (who had agreed to participate in a mentoring programme) on at least one occasion.

- The interviews indicated that the projects ran efficiently and effectively during the pandemic, as judged by the participants, due in no small part to the enthusiasm and relatability of the St Giles caseworkers. There does not seem to be any real variation across stakeholder groups (in terms of perceptions).
- Stakeholders felt generally positive about the initiatives in general, the specific processes between staff and clients, and the processes used to link the relevant agencies in particular. The vetting required to co-locate a caseworker within police custody reportedly took a long period of time, but such experiences are not unusual when going through a vetting process.
- The pandemic affected the types of interactions and recreational activities that caseworkers would ordinarily engage in. Clients in lockdown were required to remain at home, which wasn't beneficial for their mental health or their motivation to engage in schoolwork or progress to college. However, St Giles reportedly kept processes alive by working with clients virtually and even provided some clients with laptops for use at home.
- Due to awaiting the Data Sharing Agreement (DSA: as noted elsewhere in this report), we were unable to request populated Monthly Performance Reporting (MPR) framework forms populated to carry out data review and analysis. However, following a review of the empty MPR templates, it would appear that to clearly identify teachable moments the forms require some amendments. At present, biographical data (age, gender, criminal history etc.) and intervention data (number of support sessions and types of assistance provided etc.) seem to be counted separately. The forms also seem to count only the number of instances without explaining how the completion or success was reached (and for whom) i.e. what is the threshold that must be passed before a box is ticked (or a zero turned into a one) etc. Tying intervention types to particular people, places and times, would enable examination of the causes and effects at an individual level (or identify potential teachable moments or their potency from case to case).
- The VRU Monitoring Template document connects some biographical data (such as age, gender, ethnicity and reason for referral) with free-text comments that can be made at 3, 6, 9 and 12 month follow-ups. It is not as detailed as the MPR form and we have not seen the types of comments routinely entered by caseworkers. However, if the data entered addresses all of the categories contained in the MPR form, and outlines additional information such as the point in time that particular conversations or assistance took place (e.g conversations about drug use or knife carrying), whether and to what extent a client learned something from a caseworker

following particular meetings, and outlined crime/hospital/ self-report data pertaining to violence at 3, 6, 9 and 12 month points, then it may be more conducive to identifying teachable moments (that could then be tested through experimentation). This is a point we wish to examine when the DSA is in place.

- We considered the 2019 Review carried out by JH Consulting. However, we did not find any substantive evidence to support the reachable/teachable moment claim made by JH. The consultants appeared to rely on figures showing a drop in participation from initial contact in hospital (highest point - 32 participants) to ongoing support after 6 weeks (lowest period of engagement - 10 participants) to deduce that initial contact in hospital was therefore a reachable/ teachable moment. It could be argued that this difference says little about teachable moments, and that the authors have possibly conflated the idea of a reachable moment (which is considered to be an opportunity to interact with someone who is otherwise hard to reach) with a teachable moment (which involves behavioural/ cognitive change). It is not clear that the outcomes following hospital contact were more potent than latter engagements. Comparisons could be made with control groups or other interventions that start, for instance, after hospital A&E. In addition, it is unclear how the JH Review measured some of the 'positive signs', like an improved ability to manage risk (29 participants). What specific thresholds were met, what did they entail, and who did they benefit most (characteristics, risk factors etc.)?
- At a population level, we remain unclear about whether and to what extent various kinds of interventions/ assistance interconnect and produce client outcomes, especially those outcomes related to violence. It is unclear, for example, how 'gang exit' and 'reduced risk of radicalisation' is attempted from a process perspective.
- The narrative emanating from the academic literature is that negative connotations could be associated with external visitors, such as youth workers, in custody settings if they are seen to participate in or acquiesce to the 'pains of police detention'. This may affect the willingness of young people to engage with caseworkers and undermine the reputation of external agencies. It may also become difficult to recruit volunteer caseworkers to operate in this environment.
- It appears unlikely that an opportunity to modify violent behaviours or cognition through a right message - right messenger - right time approach can be capitalised upon at 'first contact' regardless of where that takes place, due largely to the absence of a pre-existing relationship and mutual trust. Rather, teachable moments in A&E and police custody might be better suited to teaching young people about the availability and promise of mentoring initiatives etc. (with behavioural modification occurring later, during an intensive intervention).
- Awareness raising of an intervention, and an invitation to join one, could usefully continue to take place within A&E settings. There is the potential to attract young people, and to enhance inter-agency collaboration between healthcare services and youth workers in the community (the co-location of caseworkers and healthcare

staff, and the information sharing between them, was one of the more novel aspects of these initiatives). The same might not apply to the police custody suite due to the negative connotations often associated with adults who operate in that environment (as expressed in the academic literature).

- Cooperation between mentors, custody officers and A&E nurses were key levers facilitating delivery. The smoothness of inter-agency working, facilitated in part by how contactable St Giles reportedly were, indicates that the interventions were relatively effective at realising new forms of multi-agency cooperation.
- The lived experience of the mentors appeared to be a key lever facilitating delivery of the programmes but practical limitations included the long vetting process for police custody, and St Giles caseworkers only working on weekdays.
- The Covid pandemic affected caseworkers in a myriad of ways. For example, the recreational activities that are routinely used for diversion (towards health-promoting activities and positive friendship groups) such as football, rugby, basketball, martial arts and boxing were no longer available. To overcome some of these issues, caseworkers utilised video calls, text messages, and even provided some clients with laptops.
- Short-term VRU funding issues meant that some caseworkers had already sought out alternative employment. Unstable funding can fuel a view amongst clients that supportive adults will abandon them eventually.

<u>Recommendations</u>

1. To examine teachable moments fully would likely require additional categories of data to be collected, including the duration of meetings, activities undertaken and things addressed in each (using the list of activities) etc. to help identify methods, effects and teachable moments. For example, it would be helpful to know that drug use was discussed in a specific week and in a particular way, and knife carrying addressed at a different time and way etc (measured against longer term self-report and police/ hospital data etc.). Caseworkers could perhaps be asked to comment on whether they could identify teachable moments within each interaction and what they thought it looked like, and to ask clients (at some point) where they think learning took place and why
2. The monthly reporting templates could attempt to measure self-reports of violence in an effort to establish how frequently clients experience or commit violence acts (that don't come to the attention of healthcare or the police) on a daily, weekly or monthly basis, and whether this reduced during particular interventions/ forms of assistance. There is no mention either of knife carrying, and whether this is being addressed. Neither is there an attempt, at least within the monthly reporting form, to record awareness levels or performance of healthcare or police staff partners, and how this affects outcomes. Data of this kind is arguably important in teachable moment methodologies.

3. In order to determine whether police custody or hospital A&E is more likely than any other setting or point in time to be a teachable moment, or to lead to one, and under what particular circumstances, a robust research method would need to draw comparisons. For example, a Randomised Controlled Trial – or method employing similar principles but with practical considerations balanced. As noted above, we reviewed an experiment that was carried out using the police custody participants, whereby offending rates were compared against a matched sample, indicating a reduction in violence among the treatment group. A more advanced design should take account og differing levels of engagement, the techniques used by mentors, external variables, or potential disproportionalities by race or ethnicity etc.
4. The decision-making processes of partner agencies could be clarified and reflected in the monthly reporting template and other documents/ case studies. It should be clear exactly how A&E staff and police custody officers screen people for referral: What thresholds do they use exactly? Who is excluded and why? Is decision-making potentially biased? These kinds of questions should be asked and answered as a matter of course.
5. A reasonable amount of time needed to complete vetting of St Giles caseworkers should be discussed with police partners and factored into the intervention. The intervention team should avoid reaching a point where it considers reconfiguring an intervention because of vetting issue.
6. In order to make 'first contact' with eligible young people in A&E and police custody settings, caseworkers should ideally be available on weekdays, weekends and weeknights as young people can enter these environments 24-hours a day.
7. Longer and more secure funding streams appear to be needed in order to avoid the possibility of leaving young participants feeling abandoned (by purportedly supportive adults) if funding is suddenly cut. The academic literature indicates that projects can end up doing more harm than good to a young person by enrolling them onto a programme that then fails them. Caseworkers and parents reportedly feared such an eventuality, which is not conducive to trust and confidence-building.
8. The St Giles ethos that caseworkers will never terminally close a case - and instead remain open to the possibility that a young person may reach out for support and present them with an organic teachable moment at some undetermined point in the future - appears to be one of the most novel aspects of these projects. With further evaluation and examination, it could potentially be promoted as best practice nationally and internationally.

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1. Background Information

1.1 The West Midlands Violence Reduction Unit (VRU)

The projects involved in this evaluation are part of a suite of interventions commissioned through the West Midlands Violence Reduction Unit (WMVRU).
The West Midlands Violence Reduction Unit (WMVRU) was launched in 2019 having secured funding from the Home Office, supplemented locally through the re-purposing of previously allocated grants from the Police and Crime Commissioner and Local Authorities. The WMVRU takes a public health approach to violence reduction focussing on understanding health, social care, and economic needs as well as identifying the risk and protective factors that can support individual and community level interventions; and developing a whole-system approach to tackle complex problems using evidence-based practice.

1.2 Commissioning

Teachable Moment in A&E and Teachable Moments in Custody were commissioned through the Violence Reduction Unit from March 2020. The Teachable Moments in A&E project was an existing service, which was established in May 2019.

1.3 St Giles

St Giles is a national charity that uses expertise and real-life past experiences to empower people who are not getting the help they need. They focus on supporting people who are held back by poverty, exploited, abused, dealing with addiction or mental health problems, caught up in crime or a combination of these issues and others.

St Giles aim to show people there is a way to build a better future – for themselves and those they care about -and help them create this through support, advice and training.

1.3.1 Teachable Moments in A&E

The service aims to support children and young people presenting to Coventry and Wolverhampton hospitals' Emergency Departments (ED) and the Major Trauma Centre (MTC) as a result of youth violence, exploitation, gang and/or county line related activities.

The specialist casework support is intended to engage these young clients and help them to move away from crime and negative activity to develop networks of support that lead to more stable and more positive lifestyles.

The service is provided by a team of skilled and experienced caseworkers, including four full-time staff based across University Hospital Coventry and New Cross Hospital Wolverhampton and one part-time worker based in the community.

Support is provided for young people (and their families) on site in the hospitals and continues after discharge, working with other partners in the community with the aim of

enabling young people to engage or re-engage with services that can benefit them. (St Giles Trust, 2020)

1.3.2 Teachable Moments in Custody

The aim of the Teachable Moments in Custody service is to offer timely and tailored support to young people (YP) under 25 years old that come into police custody who are affected by criminal activities, gangs, and related issues such as carrying weapons and violence during the "reachable moment". St Giles Youth Workers work in partnership with West Midlands Police (WMP) and operates within the existing infrastructure offering practical, emotional and 1-2-1 mentoring to YP and their families in custody and on release back into the community.

St Giles aim to to help each young person to identify and realise alternative aspirations and goals to support them to establish lifestyles that move them away from criminal activities, gang involvement, violence and negative life choices.

2. Evaluation Aims and Methodology

2.1 Evaluation Aims

The aim of the evaluation was to examine how (and how efficiently) the teachable moment projects have evolved, and the relationship between this and the impact – particularly in light of the restraints placed upon them as a result of the Covid-19 pandemic. This aim was to aid the continued development of the services, and identify any barriers to success.

The principles of the 'teachable moment' are centred on three key elements: getting the right message, delivered by the right 'messenger' at the right time. The original intent of the model offered by St Giles through Teachable Moments in Custody is for the message to be *delivered* by a Peer Mentor (an individual with lived experience of offending behaviour) at the point of a young person's arrest – specifically in the custody suite whilst he or she is awaiting interview.

There has been a significant challenge to the model in that Peer Mentors have not been granted access to the custody suite. This means that the 'right time' element of the model has been 'flexed'. Instead, Peer Mentors are picking up referrals onto the programme after the young person has been bailed/released from the custody suite.

In order to assess the longer term viability of this adapted model, the VRU we were interested in finding an answer to the following questions:

- How important is the messenger? What impact does having someone with lived experience deliver the messages have on the overall outcomes (i.e. engagement, sustained involvement)
- How important is the timing? What proximity to the point of arrest does an initial intervention have to be in order to be effective (i.e. does it matter that the Peer Mentor cannot attend the custody suite, if he/she engages with the young person immediately after release?)

The answer to these questions will give the VRU a steer as to a) whether access to the custody suite to allow for an immediate 'teachable moment' and b) whether the 'peer mentor' element are both critical to the success of the programme; and if so, to what extent.

The impact of Covid-19 and changes to delivery and timescales of the evaluation meant that these questions were explored within the current research period. A narrative literature review was therefore conducted to provide answers to these questions. As the evaluation progressed, it was clear that these questions had relevance for both settings.

2.2 Methodology

Due to the Covid-19 social distancing restrictions, all interviews were conducted via the video conferencing platform Zoom or through telephone calls. Interviews were digitally recorded with the participant's permission.

2.2.1 Data Collection

A. Literature review

A narrative literature review was undertaken to address a number of questions about the police custody intervention involved a detailed review of over 40 journal articles and reports centring on teachable moment methodologies, brief interventions, mentoring initiatives and the impact of 'lived experience', police custody environments, and youth violence and its associated risk factors. Several of the sources addressed A&E initiatives, particularly those focusing on teachable moment methodologies and brief interventions.

The literature was then used to augment the findings from the interview data.

B. Interview Data

<u>St Giles Trust: Teachable moments in A&E</u>

Five semi-structured interviews were conducted with project stakeholders, using a topic guide which covered: role of the interviewee; delivery of the project; gains to the client; and outcomes. Participants included a manager from St Giles, A&E Nurse, Police Officer, and two parents of young people who had been involved in the project. Attempts were made to interview young people who had benefited from the project, however none agreed to be interviewed. In order to ensure that young people's perspectives were included, case studies of young people's involvement in the project were sought from St Giles staff.

Interviewee
Stakeholder 1: A&E Nurse
Stakeholder 2: Police Officer
Stakeholder 3: Manager at St Giles
Stakeholder 4: Parent of child
Stakeholder 5: Parent of child

St Giles Trust: Teachable moments in Custody

Semi-structured interviews were conducted with nine stakeholders by either telephone or video call. Questions focused on understanding the role of interviewee, the delivery process, factors which contributed to successes, challenges faced, and the impact and outcomes achieved by the project. Of the nine interviewees, three were parents of clients, two were involved through the police, two were the St Giles caseworkers themselves, a St Giles manager, and a youth worker within the Horizon team (which focuses on child exploitation)

Interviewee Number	**Organisation**
1	Client Parent
2	Client Parent
3	St Giles (Manager)
4	Client Parent
5	Horizon Hub
6	St Giles (Caseworker)
7	Police
8	Police
9	St Giles (Caseworker)

Audio recordings from the one to one interviews were written up (not verbatim) and analysed using a process of thematic analysis. The first step of analysis was familiarisation with the data via transcription of the recordings to a Microsoft Word document and reading the transcripts thoroughly. Working through the transcripts, the data was coded inductively (i.e. the codes and themes emerged from the data itself rather than applying a pre-existing structure to the data). The iterative process of analysis allowed the coded data to form themes and sub-themes drawn from the data.

2.3 Ethics

The process evaluation forms part of the wider WMVRU Evaluation. Ethics Approval was granted by the University of Wolverhampton's Ethics Committee in January 2020.

3. Key Findings

3.1 Service Delivery: Teachable Moments in A&E

In the A&E model, St Giles sent three caseworkers to a hospital in Coventry and two to a hospital in Wolverhampton. Their aim was to support children and young people presenting to the respective Emergency Departments (ED) and the Major Trauma Centre (MTC) as a result of youth violence, exploitation, gang and/or county line related activities. The caseworkers sought to engage these young clients within a 'teachable moment' and help them to move away from crime and negative activity by helping to develop networks of support that lead to more stable and more positive lifestyles.

The caseworkers maintained a presence in an office within the hospitals and initially sought to raise awareness of their work. An A&E nurse acted as a 'liaison person' to act as the link between the St Giles team, NHS staff and patients. The nurse guided them around the hospital, introduced them to relevant services across the organisation, and facilitated their participation in monthly training events so that they could raise awareness of their work and vice versa (Stakeholder 1). As an A&E nurse explained: '*we provide training together which is really useful and raises their profile but also gives them the snapshot of people who they can support*' (Stakeholder 1). Participation in the training sessions was also an opportunity for the caseworkers to inform NHS staff about St Giles and to provide some insight into the lives of at-risk children. One caseworker explained that: "*We show them the sort of language that the kids are going to be using when they're in there, you know, the language they use might not be understood by the medical staff whereas we may because we work with them all the time*' (Stakeholder 3). Attendance at monthly training sessions and the use of posters was considered to be integral, in part because of frequent staff changes within hospital settings: '*… people forget and staff change quickly…within a few months, so you need to absolutely be very visible*' (Stakeholder 1). St Giles' caseworkers were cognisant of this fact and worked hard '*to do the networking, to get known to the clinical staff*' (Stakeholder 3).

When young people were admitted with injuries from stabbings or assaults, the caseworkers were phoned or emailed. The A&E nurse reported that the caseworkers were very accessible by phone, adding that '*people [NHS staff] need to know that if you ring them they are going to answer because people soon get fed up if they ring and you do not answer, but they are accessible, they've all got mobiles*' (Stakeholder 1). Upon receiving the clinical referral, caseworkers would visit the individual in the A&E department. In one of the two hospitals (Coventry), referrals were also made from across hospital departments, enabling young people with less obvious signs of involvement in youth violence and exploitation to be identified and approached.

When meeting patients, caseworkers didn't use a formal script, attempting only to discuss their general health and wellbeing, their current relationship with other support services and risk factors in a relatively casual manner. One caseworker explained that **'***We talk to them – very casual, it's a very casual service.'*

Caseworkers were required to refer to one of the NHS electronic systems, where they could find relevant information around social care involvement or any other practitioners

involved, and insert information about their interactions with patients (Stakeholder 1). The nurse showed them how to use this system, and would also review data entries to ensure that all safeguarding processes and statutory referrals were completed (Stakeholder 1). In some cases where a social worker was contacted, the nurse facilitated a meeting between the caseworkers and the social worker; she stated that '*I bring everything together I guess*' (Stakeholder 1).

The caseworkers would subsequently make a referral to a community caseworker who would make contact with the child after they had been discharged from hospital. One parent described this process as follows:

> "It was just not long after the surgery and he we had [the case worker] and her colleague come out to speak to myself and then spending time with [the victim] to just explain what they do and I had a session with them and then [the caseworker] went and spoke to J privately because he was in a real state and a huge amount of pain and also quite traumatised by the whole thing" (Stakeholder 4).

In another case, where a child was discharged from hospital and taken to a police station for questioning, a caseworker liaised with the child's family to keep them apprised of what was happening, linking in with the police and the child's solicitor (Case Study LK – note we have referred to the case studies where relevant, but not in full to protect anonymity). Some referrals reportedly came through a police officer who explained and offered participation to some young people (Stakeholder 2).

3.1.1 Young People's Journeys

Stakeholder 3 explained the referral process in A&E:

> *"We've got the caseworkers on site that receive clinical referrals from medical staff… they're on site, they get a phone call, they go down and try to make engagement with the individual that's been stabbed in the form of an assault, domestic violence or anything like that. So anything that the clinical staff feel our remit is covered by, we go down and try and make engagement with team. We talk to them – very casual, it's a very casual service."* (Stakeholder 3).

Other young people had a different referral pathway. For instance, Stakeholder 4 was in Police custody when he was referred to St Giles.

Stakeholder 1 had not worked with young people directly, but facilitated collaboration and contact between NHS and St Giles, as well as she supported NHS staff who were directly involved in provision of healthcare services to young people. She explained how most of the young people who present themselves in the NHS are mostly in need of urgent medical assisted as a first:

> *"They are here for a medical intervention usually and then they are assessed and sent home if you like, so we do not have young people that are on the unit for many weeks." (Stakeholder 1)*

However, many of those young individuals are referred to various statutory and non-statutory services, including St Giles to proceed with more in-depth work with young person, something that is outside the remit of the NHS:

> *"Many young people who are presented themselves (at the emergency department) will be referred to St Giles. We need organisations that meet the needs of the children, whether it is about communication or accessibility, how they presents. I do not know because we do not do a lot of engagements on the wards. It would be most of the follow-up work, work on the outside that would happened that this young person or child left this organisation (NHS)." (Stakeholder 1)*

At the beginning of the project St Giles Trust provided a presence onsite to facilitate initial contact. Initial intervention usually covered current risk assessment, general health and wellbeing, current relationship with other services/support available. In that sense St Giles provides a more holistic approach to supporting young people, often impossible to be done within the acute NHS services:

> *"I think that a lot of conversations that St Giles case workers have with young people are difficult conversations, and I think that they are probably conversations that medics and medical practitioners find challenging, so I think that the way they communicate with young people around exploitation and criminal exploitation, all of that is difficult, but they have knowledge, so they know who to engage, how to question, how to challenge, and I think, as I have said, that we in medicine we wouldn't be able to do that, we know how to deal with stab wounds, gunshot wound, and those conversations (that St Giles has) probably would be avoided or, or questions would not be asked, but I think the way they communicate with young people is great!" (Stakeholder 1)*

Stakeholder 3 explained that from the first referral in hospital the project works with young people for up to 6 weeks, but then refers on to the community caseworker who supports after discharge from hospital with support in a mentoring role. Cases are then closed following a risk assessment.

For young people referred through West Midlands Police are often just released from the custody, and their journey is sometimes more complex:

> *"It is hard to say what a typical journey of young person is, but what it may look like from the outside…after the referral one of their (St Giles) caseworkers will make contact with a young person. So that will be after they've been released from the custody environment and then we will take it from there. (Stakeholder 2)*

The complex situation that the young people find themselves after being released from the custody requires complex solutions that St Giles provides:

"But ordinarily, that would be a follow up meeting at their home address or in a mutually convenient location. And then the caseworker will start to understand some of the requirements that a young person, starts to perhaps understand their needs and perhaps some of the triggers such as these, resulted in the police's attention and then we would of course, looking at alternatives, kind of a positive diversion to support them such as sports or physical activity or even kind of an exit strategy or looking at their potential employment or work on their qualifications and have so they become more employable." (Stakeholder 2)

Stakeholder 3 noted that even when cases are closed sometimes young people get back in contact for support later on:

"Even though we close cases, do they still have our numbers and they will give us a break if they get into major crisis again, because they know that they've worked with us, they know we're not linked to the police, So they trust us. And that is why we get so much engagement, I think." (Stakeholder 3)

3.2 Service Delivery: Teachable Moments in Custody

The original intent of the police custody model was for a message to be delivered to young people under the age of 25 by a peer mentor (an individual with lived experience of offending behaviour) at the point of a young person's arrest – specifically in the custody suite whilst he or she was awaiting interview. The peer mentor or caseworker from St Giles would be physically present within custody in order to make first contact during the 'teachable moment'.

There was reportedly a reluctance among some existing volunteers to work in the custody setting initially. It wasn't what pre-existing volunteers had signed up for, and the idea of sitting in a custody suite all day was thought to minimise the amount of outreach work they could do in the community (Interviewee 3). As a result, a new member of staff was reportedly recruited who was more amenable to it. However, the vetting process required in order to permit the caseworker to work within the police station reportedly delayed the implementation of the process substantially. Then, once vetting had been secured, national restrictions relating to the pandemic prevented the caseworker from being able to work safely within the custody suite. Due to the prevailing uncertainty around the end-dates of lockdown, the intervention proceeded with a modified referral process.

Rather than engage with a young person within the custody setting, the modified process involved a custody sergeant or other member of staff speaking with the young person, telling them about the initiative and asking for consent to refer them to the programme on a voluntary basis. If the child was under sixteen years of age, this conversation would take place in the presence of the Appropriate Adult or parent. If consent was provided, the custody officer sent an email to a case manager at St. Giles, containing the contact details of the young person (or parent or guardian), and providing some contextual information about why the young person was arrested (Interviewee 3, 7). It would then be assigned to a caseworker would attempt to make first contact with the young person, parent or guardian by phone within 48 hours to explain the process and seek their agreement to continue with

the service (Interviewee 3). First contact usually covered a risk assessment, general health and wellbeing, and current relationship with other services/support available. Contacting young people, AAs and parents by phone was acknowledged as a problem because if 'they don't recognise a number, they don't accept the call' (Interviewee 3). Ordinarily (pre-Covid) they 'would normally just go out and see them face to face in their home' (Interviewee 3). This would be followed up with up to three phone calls and two letters to ascertain if further support is required. If the young person did not engage, no further action was taken although data would continue to be held for the lifespan of the project to facilitate timely and informed intervention if the young person came to St Giles' attention again.

3.3 Teachable Moments in A&E Success factors

Five key success factors are discussed below: Multi-agency collaboration; Staff with experience of the criminal justice system; Relational approach; Communication and collaboration; Working with family members. We then discuss suggested improvements.

3.3.1 Multi-agency collaboration

The A&E nurse was extremely positive about the service and collaboration with St Giles, and how different this was from her usual way of working:

> *"I am very proud how they (St Giles) have work in here (hospital) and how the relationship formed with them. I have been nurse for 38 years and I never worked so closely with an organisation that isn't in 'health'. So, it is challenging, like oh gosh they are 'not health' and I will share information with them, but I think we worked really well." (Stakeholder 1)*

The collaboration between the NHS and St Giles was described as unique and supportive. The stakeholder was grateful that she could work with the St Giles and felt that the support when working with young people and children was mutual:

> *"It is quite unique (the project) and I am glad I have been privileged to work alongside. I think we developed an excellent working relationship, and you know, I feel confident that they would support me as well if, you know I needed some support, I would always support them and they would support me I am sure!' (Stakeholder 1)*

Another key collaborative relationship in the Teachable Moments project was strong collaboration with West Midlands Police. Stakeholder 2 is a Police Officer working with St Giles project:

> *"So I've got a Police Officer who basically works with St. Giles. So he leads on what's called the Teachable Moments and is in constant conversations with young people (…) and explain them what the offer is and who St Giles are, you know." (Stakeholder 2)*

This close collaboration could be difficult to explain to young people who were suspicious of the Police. The fact that St Giles worked with the Police but were operationally independent was important to young people who did not trust the Police:

> *"We always [get] asked at first 'are you the Feds?', meaning the Police. 'No, we're not the Feds'. Once they establish you're not linked to the Police or any statutory service in any way, that's when you get the engagement." (Stakeholder 3)*

3.3.2 Staff with experience of the criminal justice system

It was highlighted that St Giles provide a unique services based on the knowledge of complex lives that young people have and the connection that the organisation has with other services:

> *"What St Giles brings is a unique selling point, a lot of their case workers have what we call experience, so they know maybe the failings of the system that these young people have been exposed to" (Stakeholder 2)*

Stakeholder 3 explained that employing staff with experience of the criminal justice system was a deliberate strategy:

> *"A lot of our case have been through the criminal justice system, which means they know what that individual's going through, like themselves could have been arrested, they know the anxiety, they know how it works, the stress of going to court… and I think that has a lot to do with the engagement" (Stakeholder 3)*

Stakeholder 5 also identified this as a benefit that improved the service St Giles was providing:

> *"He takes it better from them, doesn't sound or feel like nagging. He listens and understands them. I absolutely love that the youth worker has been through life, he hasn't had a perfect lifestyle and rosy life. Not someone reading off a script - do this, do that - it'll be fine. But it won't because you haven't experienced it."*

3.3.3 Relational approach

Stakeholder 5 had noticed that the St Giles caseworker was able to communicate effectively with her son:

> *"Also he speaks on his level, like he's talking to his friends. Very casual, sat on a couch, making it clear though that he had been in trouble. Not overly structured or formulaic. What are your fears and aspirations etc?"*

Stakeholder 3 talked about how young people trusted St Giles because they were not a statutory or uniformed service, and this theme was picked up by Stakeholder 4 who found that her son trusted St Giles staff:

"So she's had some sessions with him where she's sat down and gone through various things and then just around Christmas time, and that seemed to really go well, actually … Joseph really opened up to her and talked to a lot more than he was opening up to us. So that was great in that. We felt he definitely felt that she was somebody he could relate to and somebody who they're not going to judge, and speak a similar kind of language because they speak a bit differently don't they, young people? The fact that they were of a similar age and the case workers was not seen as an authority figure like a teacher was thought to be a bonus in gaining trust."

The role of having someone to talk to who was not part of officialdom or a parent was valued by the young people:

"He needed someone to talk to and didn't necessarily want to talk to us, his friends are not necessarily the right people to be talking to, so it is good to have somebody that came in, that was supportive. Yeah, I think he definitely found it helpful." (Stakeholder 4).

Stakeholder 5 also noted that her son found it easier to communicate with St Giles workers than her:

"When he needed someone to talk to - that's the most important for me. Having a teenage son I didn't know what to expect. Boys don't talk as much or come to Mum and Dad. Youth worthier was a point of contact, when his headspace wasn't good, and the process was all new, he was able to contact the St Giles youth worker, who could also work alongside schools to smooth things. They were there for him mentally and that helped a hell of a lot."

The St Giles worker got to know Stakeholder 5's son, working with his strengths and interests to engage him:

"Back to the start, youth worker got to know K, his interests, way drives him, discuss wrongs and rights, then put a plan together. Asked about hobbies and started doing basketball, got him involved in a group. Used contacts to get him into music, get him involved in stuff. Whatever K was interested in they tried to help."

3.3.4 Communication and collaboration

St Giles staff were given access to the relevant NHS electronic case recording system in order to ensure good communication between stakeholders and rapid referrals:

"We worked closely with our electronic recording system, so we spoken (with St Giles) about the need for them recording on that, so they started doing that now, so that sort of allows easy communication and information sharing." (Stakeholder 1)

Collaborations between stakeholders was facilitated by the interviewee who had good insights into how the NHS work and in which department young people in need of help may occur:

> *"I knew where young people would present themselves, in which units, I was so much involved in introducing them to relevant services across the organisation and then trying to raise their (St Giles) profile if you like, so I was making sure that the organisation are aware of the service. I was guiding them around making sure that they could have access to our paediatric care, they used one of our electronic systems, so I was guiding them through that, showing them where they can find relevant information (…) so they could know how is coming through our doors, and now we can look out for the people who may fit the criteria and email St Giles team about them…about those young persons with the information that may be relevant." (Stakeholder 1)*

Embedding St Giles into the day-to-day life of the hospital was highlighted as important in the development of good collaboration:

> *"Just trying to get them (St Giles) embedded as quickly as we could, because it is a huge organisation (NHS) and you could spend years to find you way around, but because I got I guess some internal knowledge of where this young people may present themselves, for example they my show up in Eye Department, they may go to Day Surgery to have something fractured to repair (…) so Emergency Department really incorporated them for their meetings, so we are just trying to get those avenues open to them." (Stakeholder 1)*

Also, raising St Giles profile among hospital staff and young people was pointed out as important in enhancing collaboration and knowledge about available services. For example, joined training was provided by the NHS and St Giles that focused on available services in order to raise awareness among staff about St Giles work and encourage NHS staff to contact them if needed assistance:

> *"They (St Giles) also support training. So, we provide training together which is really useful and raises their profile but also gives them the snapshot of people who they can support." (Stakeholder 1)*

Stakeholder 3 gave an example of how this training for hospital staff was useful:

> *"We show them sort of the language that the kids are going to be using when they're in there, you know, the language they use might not be understood by the medical staff whereas we may because we work with them all the time. So we just sort of do a quick presentation on what we do how we can help them and how we can take some work off them. Because if you can imagine when they come in they're quite volatile, they're quite agitated and they will be agitated by people in uniform, but when we walk in we see it totally different, we can diffuse the situation."*

In addition, good collaboration between stakeholders required flexibility and frequent communication:

> *"You need to be very accessible as well, so people (NHS staff) need to know that if you ring them (St Giles) they going to answer because people soon get fed up if they ring and you do not answer, but they are accessible, they've all got mobiles and posters are displayed around the organisation." (Stakeholder 1)*

St Giles was described as accessible and flexible in the ways in which they provide their services.

> *"(A)nd St Giles has a such a fantastic relationship with statutory bodies and the police, but also with the people themselves." (Stakeholder 2)*

The strong relationship and collaboration with other services was seen as important as it assists in addressing young people's needs in a holistic manner:

> *"What is important is to help these young people collectively, so we can look at what problems are occurring, what strategist we can have to work on that" (Stakeholder 2)*

Sharing information between different agencies was also crucial to safeguarding the welfare of young people. Good collaboration between various services and St Giles was pointed out as crucial to ensure effective safeguarding arrangements:

> *"I work very closely with St Giles organisation, very closely, so if they receive a referral from our organisation I will ….that, that child, all of these children, are safeguarded properly. I will share all of the information around social care involvement or any other practitioners that maybe involved, and you know share all of the relevant information with St Giles about those young people, and also if I will see young people on our unit that I think they would meet their (St Giles) criteria and lease them quite heavily with the social care. So, if I am talking with social work about a care for a young person who came here and they smelled strongly of cannabis, I check with social care if they are involved, and if they are they will give me a bigger picture, so I can now sort of link St Giles and the social worker together so they can support and have a meeting to look at how perhaps this child could be engaged …I bring everything together I guess." (Stakeholder 1)*

3.3.5 Working with family members

Stakeholder 3 explained how St Giles did not just work with the young person themselves, but worked with the whole family to identify and address issues:

> *"Once you start the engagement, things start to expand and grow in the sense of what is the issue. So then when you start working with the individual, then probably start with the whole family. And within that family, that could be six siblings, but then have issues so then expands. But you working with the victim of the violence,*

the family and discipline so that it in so you could end up getting one caseworker getting engaged, but then two caseworkers working on what's going on within the family situation. So what we would do then is we would work with the family. We ask them what they want to do" (Stakeholder 3).

The mother of one of the young people who had been involved with the programme explained how this worked:

"It was just not long after the surgery and he we had [case worker] and her colleague come out to speak to myself and then spending time with J to just explain what they do and I had a session with them and then [caseworker] went and spoke to J privately because he was in a real state and a huge amount of pain and also quite traumatised by the whole thing." (Stakeholder 4)

3.3.6 Suggested improvements

Currently St Giles staff only work weekdays, and attempts to change this had been shelved due to the pandemic:

"I think initially when they started; the talk was that they would do sort of early shift, late shift and then weekends …which that never happened for one reason, or another. I do not understand that probably fully and Covid of course…so they have been removed from the organisation obviously when lockdown came…but I think weekend work (post-Covid) would be beneficial." (Stakeholder 1)

Stakeholder 1 highlighted how moving to a seven day per week would be a better fit for when young people present at A&E:

"So, I guess visibility and seven day service would be fabulous. It is hard to say when this young people present, so for example when something happens in the weekends and they (St Giles) are not necessary here …it can be in the evening, week, afternoon, it can be overnight, so you know we will never cover 24/7 a week that would be a huge ask, but that would be ultimate I guess. That would be a wish … somebody is here all the time (lough)". (Stakeholder 1)

The vast majority of young people that St Giles could work with present at hospitals unexpectedly, therefore St Giles' more frequent presence could lead to assisting more individuals. Additionally, a number of young people receive rapid assistance by the NHS and often are not formally admitted:

"They (St Giles) would take a referral of people that would probably not be admitted to the…to the hospital, so you have to catch them when they are in ED an if you are not here seven days a week, if you do not going to catch them they will be gone so you missed the moment (teachable moment in hospital)when they are there, when they are within ward being stitched up, so if they are not here …sometimes you can catch them afterwards, but you need them, you need them in front of you to help them." (Stakeholder 1)

Furthermore, more frequent meetings and better information sharing practices were identified as possible improvements, although they were limited due to capacity. Issues with capacity and workload had been exacerbated by the pandemic, and the resulting increase in NHS workloads and hospital admissions:

> *"I think better information sharing would help. I mean we meet regularly and have discussions, and I guess we could do that more, but I guess it is just my capacity and their capacity. Meetings every week would be useful to get through cases, to ensure that we are sharing information appropriately, but having capacity in my dairy would be challenging to do that every week." (Stakeholder 1)*

3.4 Teachable Moments in A&E – Challenges

3.4.1 Transitions

Transitions between children's and adult focused support was identified as an issue by Stakeholder 2, and young people sometimes lost access to some service provision when turning 18:

> *"For example when the young person becomes 18 they lose a lot of the support that they had before. So, they are uniquely aware of the challenges that the young people face and they are strongly linked. So, they are connected to children services, social workers, they are heavily involved with ourselves (the police)." (Stakeholder 2)*

3.4.2 Project profile

Others discussed challenges relating to publicising the project within the hospitals. Continuously raising the profile of St Giles was seen as particularly important, as staff at the NHS rotate frequently:

> *"I think you need to be visible in an organisation like this (NHS), so they (St Giles) need to be in the area as much as possible because people forget and staff change quickly, especially in the medical staff move quickly…within few months, so you need to absolutely be very visible." (Stakeholder 1)*

Stakeholder 3 also raised the challenge of continually needing to publicise the project:

> *"I think when you first go into a hospital and you're a new project, it's a massive challenge. So they've agreed to take this project on board. And it's like, do they really know what the project is involved with? So in Wolverhampton for example, we've been allocated an office and then it's up to us then to do the networking, to get known to the clinical staff. As you know, in hospitals, they're big places, staff change, the rotation of staff, et cetera. So the challenge for me, I suppose, is to make sure that everyone knows about our service. And what I've incorporated into both sites is that we attend a monthly training session, which is statutory for medical staff to ensure that they know about St Giles. So what I've incorporated in is we go, we have*

to talk to them and we show them some videos of what St Giles actually do."

3.4.3 COVID-19

Challenges related to the current pandemic were the difficulties most commonly raised. Stakeholder 3 had noticed an increase in referrals relating to domestic violence and assaults between siblings and family members which were attributed to people being "under the same roof locked in". The need for social distancing had also made face to face meetings difficult because at various times it had not been possible to enter private homes, or to meet in an office. However, the project had adapted to this reality:

> *"The case worker would go find an appropriate area like a park or somewhere where they can go to sit with and have a coffee just to catch up with conversation. And that's the way forward we're going at this moment with all the families"* (Stakeholder 3).

For ongoing cases, practitioners had utilised WhatsApp to do video calls to check in with young people, as well as text messages. However, this also limited the engagement that could be had with the young people on the project, as Stakeholder 4 acknowledged:

> *"like I say, it's difficult because I'm sure, things would have been different if a lot of it did not have to be sort of remote just over the phone."*

Stakeholder 4 had noticed that the pandemic had set her son back, and the isolation of lockdown had a detrimental impact:

> *"Obviously, we've gone back into lockdown again and back into not being at school, and so that's not been the best situation for J, having only just gone back again, having had an extra chunk of time off then."*

3.4.4 Lack of engagement

A large number of the young people that were referred to St Giles by Police engaged with the project well. Only those who were strongly involved in criminal activities were reluctant:

> *"So, I think it's fair to say that the ones that haven't engaged really well are the ones that are really, really heavily entrenched in criminal activities?" (Stakeholder 2)*

Other stakeholders identified that where there was coercion or some form of exploitation it was more difficult to engage young people:

> *"We've had this where if you've got a young girl and she's with a man, that man won't leave her side. So to us then we know straightaway something's going on. It could be sex exploitation. It could be grooming. So these are the situations we have where we can't pull them apart. You have that reachable, teachable moment when they're feeling very vulnerable within the A & E department. But if you have a young man sitting by the side of my school talk and will not leave the room. That is when it's*

difficult you can speak to the young girl but if she doesn't want to engage with you because she's being influence there's nothing we can do" (Stakeholder 3).

In these situations the team would discreetly give the young person something with St Giles' contact number on it, such as a pen or other object, to allow the young person to contact them later if they were in trouble.

3.5 Teachable Moments In Custody: Success Factors

There were a number of factors which were cited by a number of interviewees as having contributed to and explaining the success of the project.

3.5.1 Perceived Credibility

Stakeholders of all types placed a great deal of emphasis on the fact that caseworkers were perceived by clients as having a credibility based on their lived experience. This credibility was seen as a fundamental in achieving engagement from clients, particularly when first making contact.

"They've got a lived experience, haven't they? They've been there. They've done that. They understand it inside out. So they can reach that young person, probably better."
(Interviewee 5, Horizon)

"the thing that makes it more successful is people like myself that's got lived experience. Because if you haven't been in that position in life before, how could you ever help a young person that is in that position… What we do have with our lived experience, we've got, we've got automatically we've got something in common straightaway with the young person… when they look at someone that's actually been through those real things in life. And now they've changed and they're doing something different, even a young person, their little hearts will melt and they'll look up."
(Interviewee 9, St Giles Caseworker)

This lived experience was in some cases understood as experience of criminal activity and the criminal justice system.

St Giles are *"more relatable… a lot of their staff have lived experience, to use their term… Potentially, they may have done the same crime that this young person has been involved in and potentially served a lengthy custodial service for a similar type of crime and they can talk about the damage. Talk about what it's really like being in jail."*
(Interviewee 7, Police)

In other cases, however, the lived experience was understood more broadly as experience of the kind of environment and situations in which clients found themselves situated. For

example, one of the caseworkers spoke about being perceived as more credible by clients who were having difficulties within the educational system, because he himself had had those some difficulties.

> *A lot of a lot of my clients, they, some of them, like they listen very well, where I can talk to them and tell them like, from just experiences, you know, like, I've been there, I've gone myself, I was excluded from school, and I had to go to a pupil referral unit. They call it ELC now.*
> *(Interviewee 6, St Giles Caseworker)*

Both of the caseworkers interviewed were very conscious that their language and demeanour was a way of signalling who they were, and so important as a way of expressing their lived experience.

> *I just talk the same way they all talk, it's like me talking to - a lot of the clients, what I've seen, its like, I'm communicating with my nephews, or my little brothers and stuff like that. And I feel like, okay, that's how they respond, they respond better to that form of communication, when they identify something relatable. It might be just my choice of clothing for that day, it can be my, my choice of phrases, you know, how I put sentences together. Now, some clients, I don't even talk formal with them, I just talk straight slang with them.*
> *(Interviewee 6, St Giles Caseworker)*

A common issue raised by both caseworkers and partner organisations was the prevalence of misconceptions about who the caseworkers represented. Clients often had a tendency to interpret them, at least initially, as essentially an extension of the police or the social work team. In that context, their manner of speech and demeanour, as well as talking directly about their life experiences was an important and quick part of the process of distinguishing them from other organisations, statutory services in particular, which had the risk of preventing engagement.

3.5.2 Contextual Knowledge

In addition to the value that the caseworker's lived experience provided in terms of how clients engaged with them, it was also described as an asset because of the additional knowledge it gave caseworkers about clients and the world they lived. One caseworker for example said that he was typically able to gain a good understanding of any given client and their situation and do so quickly because he had first-hand experience with those kind of situations from his own life.

> *"So some clients, like they're further down that road than others, some clients ain't even down that road, they're just having other type of issues. So it's just, I've got to gauge it myself… I've got to look at it and say, Okay, my experience tells me that you're this, you know, like this is your type of background. All right, you've got older brothers that are in prison. That's your type and I can see how it's gonna come together. Each person is, everyone's different."*
> *(Interviewee 6, St Giles Caseworker)*

Caseworkers are, "*looking on their lived experience as 'how do we what can we do? What does this mean?' So you know, our professionalism and our, and our knowledge of that lifestyle is an asset."*
(Interviewee 3, St Giles Manager)

Caseworkers contrasted this with workers from partner organisations, in particular statutory services, who often struggled to understand the situation of clients, or did so only after a lengthy process. Even in cases where partners in statutory services did understand the literal facts of a client's situation, they often struggled to understand the terms in which the client interpreted them, which could hinder engagement.

A lot of the time, people (from other organisations) have told me information. And I've tried and tested it - a lot of the times those informations and it's like, it's far from the truth. Okay. Like it's far from the client's truth.
(Interviewee 6, St Giles Caseworker)

In other areas, the lived experience of caseworkers gave them detailed knowledge of various process which were relevant to client's situations. One interviewee mentioned gang affiliation and a number of interviewees spoke about being able to give guidance related to the criminal justice system. For example, one caseworker spoke about being able to explain to clients the process and implication after they had been convicted.

I help clients to "understand the whole like, criminal record block, the whole record side of things like convictions, how they work, when they're spent, when they're unspent, like I got to prepare them, tell them, getting to understand Okay, that you might get charged and put on a youth order or this happens or you've got a nine-months probation, this happened to you, cool but now you've got to understand that situation. Your life's not over mate, understand that if you got two years on probation, a year's probation, you've got now on your record, cool, but your life's not over. There's going to be a time where you don't have to disclose this. And it's just getting them to understand certain things like they think it's gonna hinder them for life and this and that, and I'm telling them this government's changed their rules on a lot of things, and there's a lot of opportunities and second chances you can get."
(Interviewee 6, St Giles Caseworker)

The process and proceedings within court itself was another area, where caseworkers had domain-specific knowledge, which they were able to support the client using. In these cases, the value was not necessarily that caseworkers were the only available people with that knowledge, but they may be the only available person with that knowledge *who is able to effectively communicate with the client.*

I'm not a solicitor or anything, but I've got an experience that I went through with, like, the criminal justice system and stuff like that. So it's giving advice on that… some clients the first time they get arrested - I've been there before, you know, like, what are the thoughts going through your head? What's going to

happen next?
(Interviewee 6, St Giles Caseworker)

Communication in these cases can often break down, even when clients are trying to engage, which is not always the case. Particularly in situations such as court, where clients are unfamiliar with their surroundings and may be nervous, they can have difficulty understanding even their own solicitor.

if I explained to them something basic English, they wouldn't understand it. But if I explained it to them in basic slang, they would understand it. So what I tried to do is bridge that together.
(Interviewee 6, St Giles Caseworker)

In many cases though, the knowledge which caseworkers were described as bringing was not explicit and domain-specific, but rather a broader, sometimes implicit understanding of how to interact with the client.

You know, what they're saying is one thing, what they're looking like is another but what is it that they're not actually saying and that's where these caseworkers are just absolutely pivotal? Because they've lived that they know what those unspoken, unspoken words mean?
(Interviewee 3, St Giles Manager)

"because I grew up in London, multicultural, you know, like, I grew up with so many different communities. And I feel like that's conditioned me in my work… How would I approach them and that's something that's conditioned me from my local communities in London, that's how I just bring that same experience. So when I'm talking to parents, that's actually helped me talk to them… (and) those experiences helped me now like when I'm working with young people… and that's helped me communicate with also. How I do it is – I don't know how to put a word on it, man, but it's just different. Everyone's, everyone's cultural needs, you've got a kind of understanding. And I feel like because I've come from a multicultural background that's helped me understand different approaches in young, some young people."
(Interviewee 6, St Giles Caseworker)

3.5.3 Length of Relationship With Client

The project was compared favourably by a number of interviewees to other programmes due to the fact that the relationship between caseworker and client did not have any pre-specified duration. This was seen as having a number of benefits. Demonstrating commitment over the long-term was described as encouraging engagement from clients. It also allowed clients to dictate the intensity of engagement, fitting the support more seamlessly in with the rest of their life.

one of our advantages is that we're not, you know - often we get asked 'how long do I have to work with you? How many sessions do I have to see you?'

because they've learned that from other projects and other services, and when we say 'this is voluntary - you can, you can, you know, go now, you don't have to stay'. You know, we work to their needs. So that ultimately means that, you know, sometimes they'll work intensively for a few weeks, then then they'll have a period of stability. And then, you know, it might be that something has happened within the community within their friendship groups, and they come back. So there's lots of variations of that engagement really, for us, which is, you know, it's brilliant, because it means that they've got that trusting relationship." (Interviewee 3, St Giles Manager)

"Do you know what, this should be for every professional – how can anyone put a time limit on a child?"
(Interviewee 9, St Giles Caseworker)

This model linked with the implicit model of Teachable Moments that the caseworkers held. Caseworkers understood teachable moments as arising, at least in part, from the client themselves, rather than just from the external situation. Given this, a longer relationship was often required because it was sometimes necessary to wait for the client themself to be ready.

One of the caseworkers interviewed said it was simply unrealistic to expect short programmes of fixed lengths to lead to long-term changes in clients who are living in unchanged circumstances, and such programmes often lacked even a coherent theory of change for how this could happen.

I asked the probation officer, what they want to do with their clients, you know, what's the, what's your aim? Because then, sometimes they're there for only a short period of time. So I don't really understand that. Sometimes, like, okay, you got him to do a knife awareness programme, cool, six weeks later, or whatever, eight weeks later, he's gonna be finished with whatever programme you had in mind. What's next? Because I tell you something, making the young person watch a knife programme, and then he goes back to listening to drill music. It's the same thing, you know, like you just, there's no remedy there. Because he's not, do you understand, you haven't fixed the problem with anything. You've shown him something. He's done it because he's had to do it, but I don't think he's understood.
(Interviewee 6, St Giles Caseworker)

3.5.4 Dedication and Passion

All of the stakeholders interviewed spoke of the personal passion and dedication shown by the two caseworkers, Larry and Zak, as individuals – and suggested that this had an impact on clients over and above many of the structural features of the programme.

"the right people delivering the project is ultimate… those guys - their heart, their passion, their commitment, you know, there's no, not many projects out there that would have the high numbers that they have and, and, and have as much

commitment for each and every one of them"
(Interviewee 3, St Giles Manager)

The caseworkers "are really unique and how they work with young people is really, really effective"
(Interviewee 8, Police)

A similar point was reiterated by one of the caseworkers, who said that he was only able to engage because he was so personally passionate.

"These kids, they can tell someone that's a fake. You know, they can tell a fraud. These kids are looking at you and saying 'oh he's just in it for the money.' And you know, I mean, they can tell someone that's passionate to help them"
(Interviewee 9, St Giles Caseworker)

Whilst the glowing description of the caseworkers by stakeholders paints this particular project in a very positive light, it complicates any implications that we can draw from the structure of this project to a broader context.

3.6 Teachable Moments in Custody - Challenges

3.6.1 Offering Alternatives Lifestyles

Key part of the project is offering an alternative lifestyle to young people – this was done through through offering alternative life plans (including careers) but also alternative activities, in order to engage them in healthy activities and also form social groups based around positive behaviours.
In this context, the lack of opportunities for young people was mentioned as important.

"There's no, there's very little by way of job opportunities, you know, to say to someone who is earning 1000 pounds a day - this is again their words, but you know, feasible - don't do that. You've got to have something else to be able to offer them and a legitimate career, you know, with with no anxiety, no fear, and earning your money knowing that it's never going to get taken off you, you're not going to die from it, you're not going to go to prison from it. That's great. But that doesn't exist right now."
(Interviewee 3, St Giles Manager)
what are we expecting these young people to do? They've got nothing, their families have got nothing. They're living in poverty, they need money. And they're, they're actually using their head quite entrepreneurially, aren't they by saying, I'm going to go and earn, this is what I'm going to do. This is how I'm going to do it. And they probably are doing a really good job at earning that money. And they probably are, you know, leading themselves up to tears in the in the urban street gangs, and they're probably getting themselves to the point they want to be
(Interviewee 5, Horizon)
"At one stage, we just said, let's get you, you know, some work in McDonald's, Co Op, whatever it is. Because I think they've never earned legitimate money,

they don't know how good it feels when you've earned something in that way. And, and yeah, we're struggling to kind of give them that as an opportunity." (Interviewee 3, St Giles Manager)

"they like the adrenaline rush, and they're doing crime and all of it because they haven't got nothing else in place. So how can we blame them? You know, they haven't gotten nothing else in place. And this is where it's about putting these things in place. I mean, growing up, I always have to look, when I was a child, it was youth clubs all over the place. You know, like, boys Brigade, there was everything going on, you know, like, you could never get food growing up… You could go here there and everywhere, there's a youth club there, a football tournament there, a rugby tournament there. It's not like that "
(Interviewee 9, St Giles Caseworker)

suggesting college where you've got to do you want to be a bricklayer, and they like that they want construction, but they've got to do functional skills, you know, the hated school, they didn't, they didn't achieve in school.
(Interviewee 3, St Giles Manager)

This lack of availability was described as predating, but exacerbated by, the pandemic.

I've got 16 and 17 year olds, though, you know, last year would have done their GCSE this year wouldn't will not be doing GCSEs they haven't had an education. They're not coming out with the qualification. Sorry, that will get them halfway. (Interviewee 3, St Giles Manager)

this year's worse than last year, because the colleges are currently shut. So they're not even going into see the open days and getting that buzzer of your college life and the autonomy that sits with college
(Interviewee 3, St Giles Manager)

The pandemic and the associated government restrictions have severely limited the available activities which caseworkers can engage clients in.

"The problem we've had is that the services that we would rely on for diversion are not there - gyms, football clubs, rugby clubs, basketball, boxing, they're - you know, to divert a young person out of this lifestyle, we've got to offer them a carrot that's worthy. And that usually is a hobby or an interest, moving them into, you know, a new peer group, taking them out of their community." (Interviewee 3, St Giles Manager)

The challenge of the pandemic - "it's definitely about the positive activities of football, boxing, martial arts, all that type of things, and that group work stuff, you know, whether you when people can come out of their situation for a short period of time and do something positive, something different, something burn, something to burn off that adrenalin, and take their mind away from what's going on. So I think that it's been really difficult"
(Interviewee 5, Horizon)

The pandemic has even like, with what's opened as well for young people that, young people want to go gym, they can't go gym. It's easy to say to someone to work in their house and work in their garden, what out in their garden but they

lose motivation very quickly.
(Interviewee 6, St Giles Caseworker)

Caseworkers offered alternative hobbies where possible – music, art, physical training – as part of the support.
Had to cancel "going to the cinema and stuff" (Interviewee 1, parent of client) due to the pandemic

"we work with very little money, obviously, you know, it'd be great if out of my 60, I could get all 60, a gym membership and the CSCs card and their provisional driving licence… we have to often go outside to see where we can we can get money for these young people"
(Interviewee 3, St Giles Manager)

In some case however, some of the specific support that they could support related to the pandemic was used as a way to engage with clients.

"We were able to supply – because we've got access to this great fund - So we were able to supply you know laptops for people to learn with, sports activities for them to be doing at home, that we could be using as our engagement tools. So actually, what I felt was going to be the you know, the death of his was was probably a saving for us in that sense."
(Interviewee 3, St Giles Manager)

3.6.2 Communicating With Clients During a Pandemic

An initial worry for St Giles was that with restrictions of face to face interaction due to the pandemic, they would struggle to engage with young people.
Broadly this was less of an issue than expected, and case workers and clients were able to adapt fairly well to working through virtual means to a much larger degree. In some senses, this even brought advantages – it meant that staff could work with more clients, and in the case of some clients they actually preferred responding to texts.

"When the first national lockdown hit, we had to then go home-based, which meant that our contact was over the telephone, Whatsapp and we thought genuinely, we did think that was going to be the end of it, because these are hard to reach young people that are not answering the phone to anybody. But actually, it was the opposite. It worked brilliantly. And we still had engagement"
(Interviewee 3, St Giles Manager)
"we have had success with remote working with our young people. And actually some of them prefer that because they've got so many other professionals knocking on the front door. And that texting and WhatsApp pin is refreshing"
(Interviewee 3, St Giles Manager)
His hands are tied slightly, you know, because of the lockdown and can't meet up in a normal situation. You probably have a one to one meetings with my daughter. And, you know, maybe that would help a bit more
(Interviewee 8, Client's parent)
I think it's working quite well over the phone. So I think some young people engage better over the phone
(Interviewee 5, Horizon)

"There's that type of person that when you go and visit them, they'll have a conversation with you. But they won't speak to you over the phone. So it's just a different, it's a different approach for that as well."
(Interviewee 6, St Giles Caseworker)
So it's like, okay, speaking to that person now. They might, I'm trying to jump on the phone with them and speak to them on the phone. They're not, there's not so much you get out of it, but you put the phone down and you start texting them – you're having a full blown conversation with them.
(Interviewee 6, St Giles Caseworker)
Initially when first lockdown hit they had to go to doing stuff over Microsoft teams stuff like that and it did prove quite challenging, but they adapted really well. … Everyone's adapted really well, everyone's been really open to the changes.
(Interviewee 8, Police)

In terms of making initial contact however, this was sometimes a challenge.

"some of the barriers we have is that because we will be given a phone number, and that might be a moment appropriate adult. So immediately, you know, that that could be the problem that they don't recognise a number, they don't accept the call. And it can take them a little bit of time or might be working… It was initially an issue for us, because as I say, we would normally just go out and see them face to face in their home"
(Interviewee 3, St Giles Manager)

3.7 Summary

The evaluation of the two Teachable Moments projects has taken place in the context of ongoing restrictions necessitated by the Covid-19 pandemic during its first year of delivery.

Findings from detailed qualitative analysis identify the following as key to the Teachable Moments in A&E success:

- Multi-agency collaboration and communication
- Building trust and confidence through the cultural competency and 'lived experience' of its staff team and a relational approach
- Taking a whole-family approach

The project has been challenged by low levels of engagement, the availability of support for young people transitioning from child to adult services and the overall profile of the project in terms of awareness within the hospitals.

Similarly, findings from detailed qualitative analysis identify the following as key to the Teachable Moments in Custody success:

- Credibility of the staff team built on their lived experience and cultural competency and contextual awareness
- Offering longer term support, without a pre-determined duration and
- The passion and dedication of the staff team.

The project has faced challenges, particularly through the pandemic because of the lack of available ‘alternative’ opportunities for young people and the difficulties of maintaining a high level of communication with clients and their families.

4. Augmenting the findings with the literature review

The narrative literature review, which was undertaken to address a number of questions about the police custody intervention (see conclusion), involved a detailed review of over 40 journal articles and reports centring on teachable moment methodologies, brief interventions, mentoring initiatives and the impact of 'lived experience', police custody environments, and youth violence and its associated risk factors. Several of the sources addressed A&E initiatives, particularly those focusing on teachable moment methodologies and brief interventions.

4.1 Teachable Moments

A 'teachable moment' can be described, broadly, as an elusive opportunity for instruction and learning with a view to cognitive or behavioural change. Although relatively new to criminal justice settings, the term has long featured in the professional language of teachers. In the classroom, the 'teachable moment' is recognised as a powerful and authentic opportunity that happens when someone who needs to learn something 'is ready to learn it right then' (Glasswell and Parr, 2009, p. 352). The opportunity can materialise just at the edge of where a student is developing, often when they are unable to solve a problem, making them more receptive to instruction. Although a teachable moment can be 'barely noticeable', a teacher who has an intimate understanding of what their student knows and is capable of doing, can use the opportunity to provide feedback about where the student currently stands in relation to their learning goals, provide information about how the student might best move forward, and, ideally, follow the child's lead in order to move them forward and produce learning (Glasswell and Parr, 2009, p. 352). Other classroom based conditions that are considered conducive to teachable moments include catching a student cheating or fighting in the school yard (Bertram Gallant, 2017).

4.2 Identifying the Right Place

4.2.1 Hospital A&E

In recent years, the idea of teachable moments has featured with increasing prominence in public health contexts. A visit to an Accident and Emergency Department (A&E) is often characterised as a teachable moment for the simple reason that people may be more receptive to thinking about positive or health-promoting behaviour change when one or more unhealthy behaviours has contributed directly to a life-threatening medical emergency (Bernstein et al 2007, 2010, 2015; Dohnke et al 2012). The life-threatening nature of the experience is thought to act as a rare and powerful catalyst for a reflective and receptive state of mind, particularly towards changing potentially contributory behaviours such as smoking, alcohol misuse, knife carrying and resorting to violence to resolve conflicts. The aim of many teachable moment initiatives is to draw a patient's attention to the connection between potentially contributory behaviours and their medical emergency to such an extent that the person becomes sufficiently motivated to begin a process of modifying relevant behaviours in order to prevent repeat events. If they can, and if a degree of learning and behavioural modification can be realised, the results could be significant;

smoking, drug abuse, alcohol misuse and violence are considered to be some of the leading causes of preventable deaths and non-fatal injuries among adults and children around the world (Krug et al, 2002; Gomez et al. 2012; Donovan et al 2015).

Within the academic literature, teachable moment initiatives in healthcare settings appear to be dominated by what are known as brief interventions (BIs). They are usually short sessions lasting no more than three hours (some are as short as five minutes) involving some kind of structured advice or psychological or motivational interviewing (Newbury-Birch et al., 2016). Brief structured advice generally seeks to raise awareness of risks of future reinjury, generalised health-promoting behaviours and local community assets that may be able to help reduce the risk of future reinjury, whereas motivational interviewing or some other form of counselling takes a more individualised approach to address drivers and risks of reinjury or recidivism for the purposes of developing a change plan that a person can follow.

Unlike brief structured advice, which can amount to little more than handing out leaflets, motivational interview generally involves discussing a typical day in the life of the participant and the sequence leading up to the medical emergency or detention, partly in order to establish context for the interviewer. The motivational interview can incorporate conversations focusing variously on the participant's awareness and motivational levels, their understanding of general norms, their outcome expectancies and the challenges of change, among other issues. Questions can include 'do you see any connection between this (distressing) situation and potentially contributory behavioural problems?'; 'do you think you are more or less likely than other people of your age and gender to be seriously injured?; 'on a scale from 1 to 10, how ready are you to change your (problematic) behaviours?'; and 'can you compile a list of pros and cons, and put the biggest ones at the top?' (see De Vos et al., 1996; Bernstein et al., 2007; Cunningham et al 2009; Dohnke et al 2012; Donovan et al, 2015; Brice and Boyle, 2020). The interview process should be non-judgmental and promote self-reflection, intrinsic motivation and sense of responsibility and self-efficacy (Woodin and O'Leary, 2010; Neville et al, 2014; Bernstein et al. 2015).

The final steps normally involve providing the participant with brief personalised feedback on norms specific to age and sex, generating a menu of options, and establishing some kind of collaborative and customised 'change plan' outlining coping strategies and a small number of achievable next steps that the person can follow (Bernstein et al, 2010; Blow et al, 2017). The interviewer may also make further referral appointments directly (by phone or email). The interviewer is normally a specialist who has undertaken extensive training in the interview algorithm. Training may include role plays using scripted case scenarios, marking recordings of practice interviews and training sessions on matters of ethics, cultural competence, conflict resolution and active listening among other techniques (Becker et al, 2004; Bernstein et al, 2007; Donovan et al, 2015; Brice and Boyle, 2020).

Several interventions that use BIs, including motivational interviewing techniques, have demonstrated statistically significant reductions and efficacies in improving health outcomes. Usually located in primary health care settings, promising results have been reported following interventions that focus on smoking cessation (Dohnke et al 2012; Bernstein et al, 2015), alcohol misuse (Bernstein et al, 2007; Chariot et al, 2014), drug abuse

(Blow et al, 2017) and non-fatal violent injury recidivism (Becker et al, 2004; Cunningham et al, 2009, Gomez et al, 2012; Neville et al 2014; Brice and Boyle, 2020). Since timing is important in teachable moment methodologies, the intervention usually starts within a 2 hour window of hospitalisation, often in the waiting area, a private room or at the patient's bedside (before or between consultations and treatments). For example, a violence-prevention counselling session of 45 mins to 2 hours duration given to adolescent victims of violent assault admitted to a trauma centre as part of the Boston Violence Prevention Project (VPP) reported subsequent reductions in violent behaviour (De Vos et al., 1996). Similarly, in emergency departments in Flint, Michigan (USA), a brief intervention which sought to raise awareness of the link between alcohol abuse and aggression (known as SafERteens) reportedly resulted in reductions in alcohol consumption and injury (Cunningham et al., 2009). Others have reported reductions of up to 100% in rates of injury resulting from violence, making an apparently strong case for the use of teachable moment methodologies, particularly in hospital A&Es, as a means of reducing violence-related trauma (Gomez et al 2012).

However, these studies have been challenged across an array of metrics. The quality of the evaluations and the outcomes measured tend to vary greatly. For example, self-reports (of violent or addictive behaviours) are a common metric of success, yet various studies have shown that while changes in attitudes to problematic behaviours and service utilisation may be considerable, rates of violent revictimization and arrest can be much lower. One systematic review of hospital-based randomised controlled trials in the US, for example, found that 75% reported attitudinal change and 66.7% reported service utilisation following BIs, but only 33.3% reported reductions in violent revictimization or arrest (Brice and Boyle, 2020 p. 494). In other words, participants frequently tell interviewers and evaluators that their attitudes towards problematic behaviours have changed but modifications are not necessarily reflected in actual behaviours. A major challenge for evaluators is that many instances of violence are neither self-reported within academic studies nor recorded or collated by schools, hospitals and criminal justice agencies, making substantiation a challenge. Another obstacle is the prevalence of reporting bias which involves participants embellishing their responses in order to 'look good' to an interviewer (a social acceptability thesis) (Olds et al, 1998; Bernstein et al., 2007).

Other studies have shown that although the positive effects of intervention may appear strong in the clinical setting (and even at the 3 month mark), the efficacy of brief interventions tends to attenuate over time, sometimes to the point of non-significance at the 12 month point (Bernstein et al., 2007, 2010, 2015; Cunningham et al 2009). Similarly, reductions in retaliations and gunshot victimisation have been reported following several focussed-deterrence initiatives in the US, where law enforcement is threatened, however these gains tend to attenuate relatively quickly due in part to the absence of deeper social change (Butts et al, 2015).

A&E-based initiatives that report successes in getting people to engage with initiatives at the outset, often report that considerably fewer are still engaging later. One study by Donovan et al. (2015) focusing on patients with drug problems discharged from six emergency departments in the US, found that slightly more than half of the relevant sample engaged in a 20-minute follow-up telephone call with a trained counsellor within

approximately three days of discharge (but fewer engaged in a second call between days four and seven). Other studies have shown that follow-up 'booster' sessions (used to re-engage participants) have a minimal effect on attendance and attrition rates at post-release appointments within community settings, partly because contacting and engaging transient people and high-risk mobile young people, who may have limited phone access or unstable housing, is intrinsically difficult (Donovan et al 2015; McGovern et al 2020). This means that it is usually difficult to discern the extent to which the 'lesson' conveyed by the brief intervention during the purported teachable moment has been 'learned' (Donovan et al, 2015).

Self-reported changes in risk perceptions, continued intentions to change, and positive feelings towards a programme, as measured against a pre-intervention baseline, do not necessarily translate to health-promoting behaviour modifications. Nor is there substantive evidence that proves that successes, however marginal, in one area means that, with some tailoring or tweaking, the same kind of success can be seriously expected in other settings.

The sequelae of alcohol-related violence and knife-carrying among children may differ considerably within and between places, communities and cultures. What exactly should be taught, when, how and to whom, and whether it is likely to be learned, remains largely shrouded in ambiguity. Major variations may be hidden within vague reported outcomes. As Lipsey (2009, p. 125) cautions: 'simple comparisons of summary effect sizes can be very misleading.' Rather than reporting positive effects, it is arguably more instructive to identify the factors and general principles that characterise 'what works' to reduce recidivism (ibid, p. 126). However, only a small proportion of the literature appears to contain working models for behaviour-changing effects, and fewer still appear to have been rigorously tested (Dohnke et al 2012). There is also a considerable mix of interventions focusing on children and adults, making it difficult to isolate the experiences and challenges that might be unique specifically to children (Bernstein et al, 2010).

Although teachable moment initiatives, by their very definition, connote brief interventions within a short 'window of opportunity', they rarely end within the hospital A&E or at the location of greatest distress. Some form up follow-up often takes place, such as 'booster' phone calls, to see whether participants followed the advice given, attended the referral to community services or treatment facility, or took the next steps in the change plan created during the brief intervention, and if they haven't, to discuss barriers to change and prompt them to complete actions and attend referrals (Bernstein et al. 2007; Bernstein et al, 2010). Booster calls with nurses, trained counsellors or other support staff are frequently used in alcohol and drug intervention strategies, and have been shown to lead to greater reductions in usage and related injuries in some cases (Dohnke et al 2012; Donovan et al., 2015). Some continue to build upon the brief intervention by offering a small number of follow-on free counselling sessions, motivational interviews or some form of prolonged mentoring (Newbury-Birch et al., 2016).

It is for these reasons, and others, that many brief interventions have been described merely as 'promising' or inconclusive rather than effective (Sherman et al, 1997; Newbury-Birch et al., 2016). That some initiatives can only encourage approximately half of the at-risk people identified to participate in a public health intervention at the outset does not seem

to bode well if substantial numbers of those who participate are prone to reporting bias and may not be contactable for subsequent evaluation. It means that the majority of identified at-risk people who could potentially be included in interventions may not actually participate in any meaningful way. In one A&E study of illicit drug interventions by Frausto and Bazargan-Hejazi (2009), 46% of respondents (of at least 18 years old) stated that they were 'not ready' to change their drug behaviour (while a further 21% were 'unsure').

Nevertheless, a language of positivity and of untold possibilities seems to surround teachable moment methodologies, with marginal successes or insignificant results being described as 'encouraging' or 'favourable', applicable to diverse geographical settings and patient populations (Bernstein et al., 2007; Gomez et al, 2012; Chariot et al, 2014; Neville et al 2014). Riding this wave of positivity, initiatives that have been piloted in hospital A&Es have been recommended for use in other locations, such as doctors' surgeries, oral and maxillofacial surgeries, and police custody suites. Alcohol and drug referrals, Liaison and Diversion Schemes, and the insertion of mental health nurses within custody suites have proliferated in recent years. Custodial and post-release settings in England and Wales and elsewhere are increasingly treated as legitimate sites for behavioural modification and the mitigation of risk factors for crime and violence (McGovern et al 2020). Since the age of criminal responsibility in England and Wales is ten, many of these developments concern children.

4.2.2 Police Custody

Teachable moments have been characterised as plausible in a range of criminal justice contexts. Every police-civilian contact, particularly the coercive kind, has been described as a teachable moment, in which police officers can potentially provide feedback and information about a person's relationship with the police, their status in society, legal processes, and the courteous, professional and fair aspects of policing (Tyler et al, 2014). In other words, every interaction is thought to produce learning and potentially enhance the legitimacy of the police. Alternatively, these powerful interactions can also be used to produce learning through coercion. Chicago's Violence Reduction Strategy, for example, involves invitations being sent to individuals known to be members or associates of street gangs to attend an hour-long 'call in' meeting in a public space with representatives from law enforcement, the community and social service providers whenever there are spikes in gang-related violence. At the meetings, police officers deliver a message that if the violence doesn't stop, there will be a swift 'crackdown' using the legal means at their disposal, for example by arresting suspects and revoking paroles. These types of initiatives, commonly known as focussed-deterrence strategies, are popular in the U.S and have been utilised in places such as Boston (Ceasefire), Stockton (Operation Peacekeeper), and Cincinnati (Initiative to Reduce Violence) (Papachristos and Kirk, 2015).

At the other end of the criminal justice spectrum, teachable moments might materialise within prisons, or upon release (often referred to as re-entry or resettlement), when offenders may be more open to mentoring, vocational development and addiction treatment. Gang members, for example, may feel alienated or aggrieved by the lack of support showed by other gang members during their trial and imprisonment and be more receptive to change (De Vito, 2020). Identifying the most appropriate agents to trigger the change process in various contexts remains contested, and there is a substantial body of

evidence which shows that the change process can occur somewhat organically as people 'age out' of crime and violence. In terms of population averages, studies show that age 13 is a peak age for violence (McAra and McVie, 2016). Alternatively, numerous initiatives eschew the coercive approach of some police and probation-led programmes by intervening in the lives of at-risk people in more individualised and voluntary ways. The Cure Violence model (formerly known as Chicago CeaseFire), for example, has been adopted in several U.S cities and uses shooting incidents and fatalities as an opportunity to change individual attitudes and group norms about gun violence through home visits by ex-gang members (known as 'violence interrupters') and community events, among other initiatives (Butts et al, 2015).

Ultimately, teachable moment methodologies appear to be applicable to a range of different people and contexts, from innocuous young learners in the classroom to people at significant risk of committing violent crimes. Hospital settings can be beneficial because they are likely to contain at least some victims of violence (and perpetrators) who could be at high risk of future harm. At-risk people who attend A&E with a medical emergency might not ordinarily visit healthcare professionals when their injuries, although frequent, are not so serious. Criminal justice settings, on the other hand, are more likely to contain violent offenders, suspects as well as their victims. Some of these people might live in unstable or chaotic environments and may not otherwise come to the attention of public or community agencies that are in a position to help, or have enough knowledge about their vulnerabilities to do so (these opportunities can also be called 'reachable moments' for this reason) (Newbury-Birch et al., 2016).

Temporary detention in a police custody suite, in particular, has been described as the 'ultimate teachable moment' (Skinns et al., 2017, p. 601). The ostensibly coercive physical conditions of this unique police setting generates a sense of disempowerment experienced as a result of being deprived of liberty and autonomy for an uncertain length of time, usually in lonely, uncomfortable and poorly lit cells (Skinns et al., 2017). These conditions are believed to be conducive to fostering a more reflective and receptive state of mind in the hours after arrest (Chariot et al, 2014; McGovern et al 2020). Various researchers have attempted to leverage this experience as a teachable moment; in other words to heighten detainees awareness of the connection between one or more underlying behaviours that contributed, at least in part, to their detention, and to go about modifying the relevant behaviours in order to prevent repeat offending. The focus, thus far, has centred predominantly on alcohol and drug addictions (Chariot et al, 2014; McGovern et al 2020).

There appears to be a number of factors to consider (and overcome) in any attempt to leverage teachable moments in police custody for the purposes of violence reduction. The most obvious is the physical environment that purportedly gives rise to a teachable moment; police custody is often perceived as a fraught, chaotic and highly coercive environment (Skinns, et al, 2017). A wealth of ethnographic research indicates that it is a distressing or, at the very least, dissatisfying experience for the majority of detainees. Locked doors, imposing booking-in desks, uncomfortable sleeping arrangements, and ubiquitous CCTV cameras, among other environmental features, allied to the unwelcome deprivation of liberty and autonomy, are associated with what are known as the 'pains of police detention' (Skinns et al, 2017). Interpersonal interactions and relationships with

custody staff can also add to these 'pains'. It is not unusual for detainees to exhibit frustration and anger about their detention, to question the decisions of arresting officers, and to challenge the legitimacy of custody staff (Chariot et al, 2014; Skinns et al., 2017). Very few young people who commit violent acts are detained by the police (or come to the attention of other agencies) so detainees may feel aggrieved about being singled out (McAra and McVie, 2016). Moreover, arresting officers are likely to have had only a partial understanding of the incident, so blame may not have been equally apportioned. Those arrested for carrying an offensive weapon or threatening violence, may simply claim that they were defending themselves, and question their arrest where no physical harm was caused.

The pains of detention are created, to a large extent, by the existence of a power imbalance between detainees, custody staff and other adults they encounter in custody. Not only are detainees subject to severe coercion but they are also expected to respond to inducements. Custody staff routinely use inducements to encourage more favourable reactions to questions, requests and orders (Skinns et al., 2017). Rewards such as additional hot drinks and snacks are often offered to detainees to help calm them down and to move them compliantly from place to place without incident. Short-term behavioural modifications serve clear and immediate purposes in custodial environments. It is precisely because children may be unduly influenced by short-term gains such as being released from custody, due in part to their young age and incomplete development, that they require various safeguards, such as Appropriate Adults. No matter the significant differences between the personalities, lived experiences or attitudes towards custody officers (whether cocky, abusive or care free) that children convey, they are considered, at least in law, to be innately vulnerable in police custody because of their inability to fully appreciate the significance of questions put to them, the implications of their replies and the consequences of their actions (even if they might reject a label of vulnerability) (Hodgson, 1994; Brown, 2015; Dehaghani, 2017).

Although a prolonged period of isolation from friends, family and associates on the outside world (and the context in which violence may have occurred), may, at first glance, appear to be a valuable ingredient for stimulating a reflective and receptive state of mind, detention can, in practice, lead to dangerous and insincere expressions of and behaviours conveying cooperation. Uncertainty around the length of time they will be detained, whether they will receive a penalty or sentence, and how it might impact them and their families are not conducive to long-term decision making. In more routine police settings, the obvious features of disempowerment and coercion have been shown to be negative predictors of cooperation (Jackson et al., 2015). This suggests that the pains of police detention may serve to distort the extent to which participants in any novel intervention are genuinely willing to adopt new goals and engage in activities and experiences with a view to long-term behaviour change. There is also a question of whether it is the child's first experience of police custody, to which they above may apply, or whether they have been through the custodial process several times previously, which can desensitise them to the experience. One of our respondents opined that: "*if it's the first time a person, a young person has been arrested, and they're in the cells and .. the whole world is facing them, yes, that is their teachable moment ….*" (Interviewee 3). However, for high risk children who have been in

and out of police custody for a long period of time, a teachable moment may not materialise (ibid).

Custody officers are not the only agents that young people interact with in custody either. Where appropriate, solicitors will expect disclosures to be made as part of a legal strategy, while an Appropriate Adult (who may be a parent or guardian, a social worker, a trained volunteer or another responsible adult aged 18 years or over who is not employed by the police) should provide advice and various forms of assistance (in private) to the young person. AAs, for example, should provide assistance whenever a child is informed of their rights, strip searched, cautioned, interviewed, asked to provide or sign a written statement, subject to an identification procedure or charged, among other processes (see the Police and Criminal Evidence Act 1984 Code of Practice C; Crime and Disorder Act 1998 s. 65(7)). This can involve discussing the child's concerns, comprehension of questions and processes, emotional and physical needs, and making representations concerning welfare and fairness to custody staff on their behalf (Medford et al, 2003).

The custody environment is essentially a relatively complex environment, somewhat crowded with adults who have the legal power or influence to shape a child's experience and immediate future. Children may even find that neither their solicitor, Appropriate Adult nor guardian are particularly helpful, with numerous research studies showing that AAs and parents can act unsupportively and unempathetically, provide poor or hurried advice, and fail to ensure their welfare (Medford et al, 2003; Dehaghani, 2017). Alternatively, a supportive adult may be relatively proactive but be unable to meet all of the child's welfare demands, relying almost entirely on the discretion of custody staff to do so.

Importantly, under the Crime and Disorder Act 1998 s. 37, there is already a duty on Appropriate Adults and all other agents and volunteers involved in the youth justice system to take steps to prevent reoffending. This can include asking young people what they think would help them to prevent future occurrences of offending behaviour, advising them about ways to prevent reoffending, passing them literature, securing local authority secure overnight accommodation or arranging transport home for them (Pierpoint, 2006). Different agencies frequently have alternative interpretations of what their volunteers should be doing to prevent reoffending under the Crime and Disorder Act (Pierpoint, 2006). Many of these actors may consider the child to be under their supervision or remit and will strive for behavioural change, at varying levels of intensity. Some arrestees may also be on probation and subject to programmes that revolve around the idea that close monitoring and increased levels of contact will inhibit offending (known as a surveillance approach) (Lipsey, 2009). Previous experiences of custody, and the work of adults they interact with, whether custody staff, solicitors, parole officers or other external visitors, may taint young people's attitudes towards all adults who operate in custodial environments.

If effective teachable moments require the participant to form a view of the present that extends to possible futures (Glasswell and Parr, 2009), then the uncertainties of the custodial environment might mean that teachable moments do not ordinarily materialise. If they do, the learning that takes place may not always be positive or desirable. In this context, it is unclear whether teachable moments are more likely to occur with one agent or adult, whether an Appropriate Adult, a healthcare professional or someone else. Since

timing is important in teachable moment methodologies, it is also largely unknown whether there are better or worse time during police custody to intervene, and whether staff or visitors can gain private access as required. There is a palpable lack of empirical examination of these issues. In its absence, some researchers have suggested that fraught and chaotic settings, such as hospital A&Es and policy custody, should more appropriately be seen as one in which patients are motivated to contemplate changing risk-related behaviours, but that this motivation should subsequently be capitalised upon at a later point, ideally after the immediate crisis has been resolved, when they may still be temporarily receptive to interventions (Donovan et al, 2015).

Respondents in this study felt that the period immediately after custody may continue to be chaotic to varying degrees, as children deal with numerous people and agencies, so it could even be beneficial to delay intervention for a matter of days. Various caseworker explained that:

> *'when a young person is arrested, or when there's a crisis point, everybody kind of jumps at that. So you've got all your professionals, you know, there could be a youth worker, a social worker, you know, a family worker, there's education, health care … it's just overwhelming … because statutory services have got no choice but to be there … what we've learned really is that sometimes, you know, just give them two or three days to actually let things calm down (Interviewee 3)*

> *"With this one young person, it was just too many professionals going to the house [post-release], so what I said is I'm going to start going to the school and seeing the young person on their lunch break for 15 minutes. Yeah, so we started doing that, you know, I mean, so that they can actually have a little bit of a breather" (Interviewee 9)*

4.3 Utilising Existing Staff (How important is the messenger?)

4.3.1 Hospital A&E

Time and place are central to teachable moment methodologies, since they happen when someone who needs to learn something is ready to learn it right then and there. They arise, in many contexts, for the purposes of solving an urgent problem. In the classroom, the teacher is central to the teachable moment, since they typically present the problem, and provide feedback so that the child can gradually move forward and produce learning. In hospital A&E settings, the doctor or physician can fulfil this role, by treating the injury and providing feedback about contributors and the risk of re-injury. However, often overburdened and facing a chaotic workload, physicians frequently prioritise the former.

Various research studies have conveyed a tendency of physicians to prioritise the standard treatment of patients' immediate injuries with the goal of discharging them home in the best possible physical health (Bernstein et al 2007; Gomez et al 2012). Things that are ancillary, even contributory, to the immediate trauma may not receive the same attention, especially when physicians frequently report struggling to find the time to provide standard

care for injured patients (Bernstein et al 2007; Cunningham et al 2009). The A&E nurse in this study reflected this reality by explaining that: '*We need organisations that meet the needs of the children, whether it is about communication or accessibility, how they present. I do not know because we do not do a lot of engagements on the wards'* (Stakeholder 1). It seemed as though more in-depth 'follow-up work' with young persons was considered to be outside the remit of the NHS staff, due largely to issues of time and competence. The nurse elaborated that:

> *I think that a lot of conversations that St Giles case workers have with young people are difficult conversations, and I think that they are probably conversations that medics and medical practitioners find challenging, … but they (St Giles) have knowledge, so they know who to engage, how to question, how to challenge, and I think, as I have said, that we in medicine we wouldn't be able to do that, we know how to deal with stab wounds, gunshot wound, and those conversations (that St Giles have) probably would be avoided or those questions would not be asked (Stakeholder 1)*

Even the idea of meeting with volunteers on a weekly basis to discuss cases was considered to be potentially unfeasible. The A&E nurse explained that *'Meetings every week would be useful to get through cases, to ensure that we are sharing information appropriately, but having capacity in my dairy would be challenging to do that every week"* (Stakeholder 1).

In addition, numerous studies of A&E-based public health interventions have reported that people who view the visit primarily as a medical issue can view a brief intervention to be an unrelated and unwelcome intrusion (Donovan et al 2015). For the above reasons, many of the purportedly promising or successful trials in healthcare settings revolve around specialist support staff or temporary research assistants. Dedicated support specialists are usually able to spend more time with a patient than physicians (research shows that longer conversations can overcome initial reticence), while they may also be in a position to forge longer-term relationships with individuals (and their families) through subsequent meetings and home visitation (Gomez et al, 2012; Chariot et al, 2014).

4.3.2 Police Custody

Studies focusing on whether and to what extent custody staff could or should add new public health approaches to their workload encounter many of the same challenges. Although custody staff are often interested in the wellbeing and life course of some of their detainees, studies indicate that there is a tendency to prioritise the control and care of individuals while they are in the custody suite over and above things that are ancillary to the containment function (McGovern et al 2020). Custody staff routinely ask arrestees about a range of health needs, including alcohol use and disabilities, when completing risk assessments during the booking-in process because these processes are considered to be directly relevant to the immediate safety of detainees, and a legal requirement. Completing baseline questionnaires, gathering consent and feedback and conducting brief interventions in addition to this, which may or may not bring about some behaviour change in the future, is often considered to be a less worthwhile and competing demand, as a 'nice to do' but not a necessity (McGovern et al 2020). Brief interventions frequently take longer than anticipated, and the advice that practitioners impart is considered by some to be overly

simplistic relative to the complex needs of the patient (McGovern et al 2020). Advising arrestees about issues such as alcohol misuse and other behaviours was also perceived to require a degree of skill and knowledge that custody staff didn't feel they possessed. Motivating young people to change, on the other hand, could possible be better realised through families, schools, social services and the courts system, rather than police detention.

Like the A&E patient who wants to see their injury treated and views a brief intervention as an unrelated and unwelcome intrusion, detainees may not want to be taught in the custody suite or in any other setting either. Previous brief interventions in custody suites have found large numbers of detainees to be resistant or hostile to attempts at behaviour change (Chariot et al, 2014; McGovern et al, 2020). In one study in a suburban area near Paris, Chariot et al (2014) found that fewer than half of the detainees in a population of c. 1000 detainees were willing to speak with physicians about addictive behaviours and fewer still (circa. 20 percent) expressed a willingness to change. An evaluation of a brief alcohol intervention carried out by McGovern et al (2020) in six custody suites across four police forces in England and Wales reported that staff interactions with arrestees was often difficult with high levels of hostility a common feature. Arrestee's, in their study, were often reluctant to listen to advice about health and wellbeing from custody staff, and conveyed a lack of motivation to change largely because they did not want treatment (ibid). In studies in English police stations, only approx. one-third of detainees agreed to participate (Brown et al, 2010). Interventions have been shown to be less effective on those who lack motivation or do not see a temporal relationship between their immediate circumstances, whether a hospital visit or an arrest, and more distant drivers such as alcohol or drug use (Donovan et al 2015). A scheme to deliver brief interventions (less than 30 minutes) in custody suites after an arrest, or an in noncustodial venues, was carried out across 12 police forces in the UK between 2007 and 2010, with no statistically significant differences found for reoffending rates (Newbury-Birch et al., 2016).

Detainees may also be concerned that their responses to questions about their experiences of violence may be used against them (or their family or friends) in a subsequent criminal cases, so remain cautious about any unnecessary disclosures (Skinns et al 2017). One respondent in this study observed that:

> *"… I think if the young person is in custody and they see someone come in … I don't know if the young person would automatically think this all going to get fed back to the police" (Interviewee 5)*

Ultimately, the power differential between detainees and custody staff (and other agents, such as probation officers and social workers) is thought likely to inhibit their ability to cultivate a non-threatening relationship for the purposes of a public health intervention (Snider et al, 2015; Weinrath et al, 2016). For custody staff, the possibility of creating unnecessary conflict (and risks to personal safety) by asking atypical questions of potentially agitated or aggressive arrestees and providing advice pursuant to an unproven intervention may not seem worth it. Rather than self-reporting perpetrated violence, various studies have shown that arrestees frequently report being the victims of violence (including by the police) (Chariot et al, 2014).

The relationship between custody staff and detainees is inherently complex, and antipathy is far from one-sided. Custody officers can also be averse to public health interventions for reasons other than time and workload. A body of evidence indicates that custody staff can form strong beliefs and perceptions about suspected offenders which can impact upon their therapeutic commitment (denoting their motivation to engage children in supportive and constructive processes rather than control and coercion, the degree of satisfaction and self-esteem they derive from the activity). This can include determinations of whether a child is actually vulnerable (which can depend on the type of offence alleged, whether they have a criminal record, and whether they are closer to 10 or 17 years of age) (Muncie, 2008; Dehaghani, 2017; McGovern et al 2020). Terms such as 'young people', 'young adults' or 'young men' are often used to label those children who police officers do not consider to be vulnerable, in order to reflect more adult qualities (ibid). Detainees frequently receive unequal treatment and attention as a result.

This would suggest that just because healthcare professionals and custody officers are capable, at least in theory, of adopting new approaches and modifying their own behaviours in order to help people become aware of and change their problematic behaviours, even if a case can be made that they have a moral obligation to do so, or a financial case can be made that the cheapest route is to incorporate new tasks into their workloads, it doesn't necessarily mean that they are the right agents to deliver interventions. Doing so, may adversely affect their more traditional primary functions (as viewed by themselves), or generate new conflicts where their therapeutic commitment is in question.

Instead, it is plausible that external visitors employed by third sector organisations, whether mental health specialists or alcohol referral workers, therapists or some other kind of specialist support staff, may be more suitable. Not only are external volunteers or youth workers likely to be in a position to spend more time with a patient or detainee, they may be seen as more legitimate delivery agents than custody officers due to their predominantly caring role (Chariot et al, 2014). Studies indicate that specialists tend to take more ownership of an intervention role and may actively distinguish themselves from custody staff for this purpose, engendering more engagement as a result (McGovern et al 2020). Many of the purportedly promising or successful trials in healthcare settings revolve around specialist support staff or temporary research assistants for this reason. Accessing the individual in custody also opens up the possibility for more extended or wraparound multicomponent interventions to which external specialists can be well suited. It is a common finding of evaluations of brief intervention that longer-term intensive treatment or 'case management' may be necessary to induce sustained behavioural change and reduce recidivism among high-risk offenders (Cunningham et al 2009; Bernstein et al, 2015; Newbury-Birch et al., 2016). Custody staff, in contrast, may simply be better suited to triggering or participating in the initial screening process which cues the intervention or referrals (carried out by someone else).

As Skinns et al (2017) argue, particularly custody staff should focus on using teachable moments, if they materialise, to treat at-risk people with dignity and show them that they are still valued members of society. Custody staff can attempt to do this simply by being deliberately polite to detainees, asking questions in a non-judgemental manner, listening to

them so that they are able to give their side of the story and feel they have a voice; speaking calmly and remaining neutral and unbiased, explaining their role and custodial processes, keeping detainees informed about what is happening in their case, and making them feel worthy of protection and deserving of help (Skinns et al 2017). Doing the opposite, in other words speaking to detainees abruptly, leaving them alone in the cell for longer or responding to challenging behaviours with force, could potentially have detrimental impacts on attitudes towards violence, crime and the police, particularly among children (Dehaghani, 2017).

4.4 Utilising Staff with Lived Experience (what impact do they have?)

Previous teachable moment initiatives in custody have focused predominantly on alcohol and drug-related interventions, mainly utilising custody staff, physicians and external healthcare specialists. External specialists are often considered, at least by the researchers themselves, as more legitimate interventionists. Staff with lived experience of recidivism have long been a feature of violence reduction and crime prevention strategies, particularly as mentors of at-risk children, for this reason (Sherman, 1997; Thornton et al., 2000). The ability to relate through 'lived experience' of similar childhoods, violence, offending, exclusion and detention (and the feelings associated with subsequent changes) is considered to be a key ingredient for the creation of a strong attachment with at-risk children. 'Attachment theory', more specifically, refers to the creation of a strong emotional base between a caregiver and a child (which at-risk children may not have), from which a child can heal, explore their environment, pursue positive lifestyle changes and return for comfort and support (Smith et al, 2015; De Vito, 2020). Children reportedly respond to the non-judgmental nature of people with lived experience, their tendency to accept them and support them without condition, and the creation of a safe emotional space where they can express their feelings and work out their anger and frustration (Smith et al, 2015).

This study indicates that perhaps the greatest tool available to a staff members with lived experience is that they have *'got something in common straightaway with the young person… [they're] someone that's actually been through those real things in life. And now they've changed and they're doing something different' (Interviewee 9)*. They know what it can feel like to be arrested for the first time, the stress of going to court, and the kinds of *'thoughts going through your head'* (Interviewee 6).

> *Like I got to prepare them … Your life's not over mate, understand that if you got two years on probation, a years probation … There's going to be a time where you don't have to disclose this … there's a lot of opportunities and second chances you can get." (Interviewee 6, St Giles Caseworker)*

They may also know what it feels like to be goaded or to feel compelled to retaliate:

> *they might get drawn out from social media posts. So it's getting them to understand like, Listen, people just posted on there what they want everybody to see. That's not reality. That's their 'best life'. That's what they can show you. It's not the real life, though (Interviewee 6)*

They can also have the cultural competence to converse with children 'on the same level' (Interviewee 8). One caseworker said it was like '*talking to his friends. Very casual, sat on a couch, making it clear though that he had been in trouble. Not overly structured or formulaic. What are your fears and aspirations etc?"* (Stakeholder 5). Another caseworker explained this as follows:

> '*they identify something relatable. It might be just my choice of clothing for that day, it can be my, my choice of phrases, you know, how I put sentences together. Now, some clients, I don't even talk formal with them, I just talk straight slang with them'. (Interviewee 6)*

A parent in the study observed that '"*He takes it better from them, doesn't sound or feel like nagging. He listens and understands them. … Not someone reading off a script - do this, do that - it'll be fine."* (Stakeholder 5). Another parent felt that the fact that the case worker was '*not seen as an authority figure like a teacher'* was a bonus (Stakeholder 4). A caseworker explained how children respond in particular to their passion and dedication: "*These kids, they can tell someone that's a fake. You know, they can tell a fraud. These kids are looking at you and saying 'oh he's just in it for the money' … they can tell someone that's passionate to help them*" (Interviewee 9). This can also be gauged by how contactable they are. One parent remarked that: "*I can contact him and he always gets back to me at the end of the day… he is always there to help, whereas some professionals aren't there … with some professionals I feel like they have to be there'* (Interviewee 1).

Staff members with lived experience of gang membership are particularly popular in gang-related mentoring programmes, whether in schools or in the community, because disengaging from gang membership can be extremely difficult due to features of victimisation and anti-social/ anti-authority beliefs that are designed, in part, to alienate young people from family and community support systems (Hritz and Gabow, 1997). Ex-gang members are considered to be well equipped to take on this task, partly because they can act as a surrogate gang or family for a child (Weinrath et al, 2016). If they can play a part in drawing a child away from gang life, then a host of problems around incidence of violence, knife carrying, school exclusion, and drug and alcohol use may improve. For a mentor who is an ex-gang member, not only may they enjoy the process of supporting vulnerable children but it may enhance their employability skills, prospects, self-efficacy and optimism about the future, among other benefits (Hodgson et al, 2019). It also represents an opportunity to use and value the lived experience of potentially marginalised individuals for the benefit of the wider community (a form of social justice) (Hodgson et al, 2019).

This study also identified how the reputation of caseworkers and the agency to which they are attached can play an important role. One police officer commented that: *they've got a name … they're trusted by the young people … So when you're having a chat a lot of the time they'll go 'oh yeah, my mate worked with them and they're alright'"* (Interviewee 7). The strength of their reputation can rest, in part, on their relationship with the police, as one caseworker observed: *"We always [get] asked at first 'are you the Feds?', meaning the Police. 'No, we're not the Feds*'. *Once they establish you're not linked to the Police or any statutory service in any way, that's when you get the engagement*" (Stakeholder 3). The police officer elaborated that:

St Giles have to be very careful because if they come to us with every piece of information about the young person their whole offer is going to be blown out of the water and very quickly no one will engage with them … If we demanded everything from St Giles, well, they wouldn't give it to use for one thing, rightly, but if they did they wouldn't after very long have a service because people just wouldn't engage" (Interviewee 7)

Mentoring initiatives have long been attractive, particularly to policy communities, because they are considered to be low cost mechanisms for change and flexible enough to serve youths from a wide array of backgrounds. The simple idea that a high-risk youth could benefit from a caring and supportive relationship with an unrelated adult role model, particularly when such an influence does not otherwise exist, is also considered to be somewhat intuitive (Grossman and Tierney, 1998; Thornton et al, 2000). Acting as a supportive adult, mentors are thought to be able to encourage emotional and social development, introduce them to new life experiences, help to structure their lives in beneficial ways, and redirect them from at-risk behaviours (De Anda, 2001). Smith et al (2015) observe that many policy-makers and supporters of mentoring programmes can likely bring to mind an older, more experienced individual who provided a measure of guidance in their life, serving as a kind of informal or natural mentor, even if their life was one of privilege. They suggest that this commonplace phenomenon of natural mentoring relationships is perhaps why mentoring seems so intuitive and attractive to large swathes of the public and policy communities.

Mentoring programmes do not typically fall within the category of brief interventions due to the more long-term nature of the concept. A mentor is routinely conceptualised as an older person who volunteers to assist in the personal development of a child or adolescent by having in-depth, meaningful conversations, providing sound advice on how to negotiate challenges in their family life and within their peer networks, challenging behavioural responses and values, and showing that they care about the young person's wellbeing. Ideally, they should be living the kind of lives that their mentee might want to emulate (Hritz and Gabow, 1997; Weinrath et al, 2016). Mentors can potentially teach social literacy and norms to a child by using informal influence rather than formal authority, reflecting desirable social skills and values simply by the way they behave. Using their own personal conduct to demonstrate that it is possible to be both law-abiding and respected within a criminogenic environment is often integral (Butts et al, 2015). The ability and desire to celebrate minor achievements, jointly attending referral meetings and engage in recreational activities together, such as playing football, working out at the gym or attending music events together, activities that reflect the things that a mentee is particularly interested in or has an aptitude for, is encouraged (Thornton et al, 2000; De Anda, 2001; Weinrath et al, 2016). Getting children involved in football leagues, boxing club, martial arts and youth clubs is a key way of facilitating new friendships and social groups based around positive behaviours. Recreational activities can also serve to 'burn off that adrenalin, and take their mind away from what's going on' (Interviewee 5). In some cases, charities will even pay for mentees to have a gym membership or to take their provisional driving licence exam. It is plausible that these kinds of recreational activities could

contribute to the kinds of reflective and thoughtful states that are reportedly conducive to teachable moments.

Mentors can also act as important service-brokers who can refer children to different services and introduce them to relevant professionals (Lipsey, 2009). By introducing children to statutory agencies and professionals, and helping officials to reengage with children, mentors have described their work as bridge-building. A caseworker elaborated upon how, once they built a relationship with a child, they could introduce other professionals, such as social workers, to them, someone who they might have been apprehensive to speak with (Interviewee 9). Encouraging children to consider attending school, liaising with teachers to discuss their issues and monitor work output (with the agreement of their mentee), and even taking them to college open days to pursue careers that they are interested in can fall within this role (Interviewee 3; Case Study KJ). One parent said that at the start of the school year, '*when his headspace wasn't good, and the process was all new, he was able to contact the St Giles youth worker, who could also work alongside schools to smooth things. They were there for him mentally and that helped a hell of a lot*' (Stakeholder 5). Helping a child return to education, transition to college and gain practical qualifications in popular areas of employment, such as construction, even if it involved arranging transport to and from the course, was a major facet of St Giles' work (Stakeholder 2, 3).

When youth-related crime is on the rise in a community or society, whether in the US in the 1990s or Scotland and England in the 2000s, volunteer mentoring programmes have been viewed as a way of turning young people away from community violence and involvement in gangs and towards healthier lifestyles (Hritz and Gabow, 1997; Grossman and Tierney, 1998; O'Connor and Waddell, 2015). Millions of pounds (and dollars) have been spent on mentoring programmes by agencies such as Home Office and the Youth Justice Board in the UK since the turn of the century (Medina et al, 2012; Hodgson et al, 2019). In 2008, for example, an estimated 3,500 mentoring schemes were running in the UK (Meier, 2008). Their popularity and growth appears to have continued unabated (Lakind et al, 2015; Smith et al, 2015).

4.5 Potential Mentoring Failures (Literature)

It is not unusual for mentoring programmes to fail. Mentors have reported role overload and feelings that they do not receive appropriate support from parents or other service providers (even where multi-agency case teams have been created) (Lakind et al, 2015). Perhaps most pertinently mentors have reported being wholly unable to reduce the powerful influence and prevalence of environmental risk factors in young people's lives (Brank et al., 2008; Lakind et al, 2015). The linking together of the concentric ecological circles conceptualised in Bronfenbrenner's typology cannot realistically be achieved by one person.

Sourcing activities to keep children occupied in the evening and at the weekends can be physically and emotionally challenging, especially in places where free, local services, recreational programmes and youth leagues do not exist (Medina et al, 2012). Instilling hope in the ability of community resources and assets to help with behaviour change where they are lacking raises issues of sincerity and integrity. One caseworker pointed out that

when he was a child there were '*youth clubs all over the place. You know, like, Boys Brigade, there was everything going on … there's a youth club there, a football tournament there, a rugby tournament there', but 'it's not like that'* now (Interviewee 9). Another caseworker argued that, *"to say to someone who is earning 1000 pounds a day … don't do that. You've got to have something else to be able to offer them and a legitimate career …. But that doesn't exist right now"* (Interviewee 3). The lack of job opportunities and routes into paid employment is often an issue. The same caseworker said that *"At one stage, we just said, let's get you, you know, some work in McDonald's, Co Op, whatever it is. … they don't know how good it feels when you've earned something in that way … we're struggling to kind of give them that as an opportunity"* (Interviewee 3).

Even within the family home, mentors rarely have qualifications, expertise or time to engage in informal family-based therapies (which may include activities that are designed to foster feelings of cooperation, communication skills, and the simple enjoyment of being together) (Brank et al., 2008). By simply forming a relatively secure emotional attachment, it does not mean the mentor can fix a broken family, their mentee's social network, or an area of concentrated deprivation. Mentoring can be challenging because the construction of youth and childhood is not homogenous, there is no such thing as one kind of childhood, and environmental risk factors can be extremely influential. For these reasons, some researchers argue that the role of mentor should simply be limited to that of a role model, one who forms a relatively small part of a much wider public health approach (De Vito, 2020).

Mentors can also bring undesirable elements to the process. Young people may exhibit behaviours and encounter daily stresses, such as violent neighbourhoods, that mentors are not adept at handling or they may seek to assert unwelcome influence (Lakind et al, 2015; Matheson et al, 2020). Mentors may hold unhelpful beliefs about resilience and a right way to deal with deprivation and distress (Matheson et al, 2020). Mentees may begin to feel that their mentor is operating from a place of judgement, becoming pushy or over-reaching, and subsequently become disinterested. Acting as a service-broker to introduce children to other professionals can become problematic since 'a lot of people push these kids' and 'talk at them' rather than giving them time and treating them as intelligent people (Interviewee 9). In one case, a caseworker attended a meeting at a school with a client and their mother where the school offered 'some good solutions', only to find out afterwards that the same issues and ideas had been discussed with the school on several previous occasions (Case Study KJ).

Boundaries can become blurred between fulfilling the role of a friend (who simply strives to share new experiences and create bonds of trust), a coach (may coax a child to acquire new skills), a teacher and a sponsor (Weinrath et al, 2016). Mentors may even become fearful of the mentee or their environment or become the subject of an accusation of improper conduct. For many of these reasons, it is not unusual for volunteer mentoring initiatives, including those which employ ex-offenders as mentors, to have a high turnover of staff and sites which are not fully staffed (Butts et al, 2015). Where a mentoring relationship is terminated by either mentor or mentee, often because of the gap between their expectations at the outset and their subsequent experiences, the whole process can result

in negative feelings self-worth of at-risk youths, leaving them worse off than when the mentorship started (O'Connor and Waddell, 2015).

To mitigate these hazards, various studies have recommended establishing clear expectations of mentors, an understandable theory of change for a mentor to follow, and training them in behavioural contingencies (Thornton et al., 2000; Medina et al, 2012). Training on topics such as empathy, privilege, self awareness, beliefs, relational skills, boundaries, and the precise nature and objective of the role, and how to deal with mentees' families is recommended (Howell and Hawkins, 1998; Thornton et al, 2000; Lakind et al, 2015; Hodgson et al, 2019; Matheson et al, 2020). So that the quality of implementation and fidelity to the project aims remain appropriate, supervision is also recommended. In his meta-analysis of youth interventions, Lipsey (2009, p. 127) found that quality of implementation was a major correlate of programme effectiveness, pointing out that 'a well-implemented intervention of an inherently less efficacious type can outperform a more efficacious one that is poorly implemented'. In the majority of studies he analysed, problems with the implementation of the programme (indicated by high drop out rates and limited training programmes etc.) could be found (Lispey, 2009). This means that the cost of training, supporting and supervising mentoring initiatives is not as cheap as it might first appear (Thornton et al, 2000; Medina et al, 2012; Hodgson et al, 2019). Mentoring interventions are likely to require a relatively large staff, if done well and at scale. Partly for these reasons, paid professional mentors, who already have a degree of expertise in cognitive behavioural techniques have been utilised instead of amateur volunteers in various interventions in the US and Canada (Medina et al, 2012; Weinrath et al, 2016).

4.6 Environmental/Contextual Challenges

In line with Bronfenbrenner's ecological model, environmental confounders also pose significant challenges to community-based mentors. A transient population (with low community participation), high rates of neighbourhood crime, limited economic opportunities, an absence of recreational activities, and low family economic status and cohesiveness can all contribute to criminogenic environments (Cunningham et al 2009; Dohnke et al 2012; Gomez et al, 2012). At-risk young people may live in households where parents misuse alcohol or function as hangout spots for drug abuse and alcoholism (De Vito, 2020). For those parents or guardians who would welcome change, they may be emotionally and economically distressed, and cut off from economic opportunities and financial, psychological and social support (Thornton et al. 2000). They may be heavily indebted, forced to move between poor quality temporary accommodation, be in and out of work, or have physical or learning disabilities. Children may be resigned to the idea that they must deal drugs or join a gang because it is a natural progression in life, based on the lives of their parents, siblings and friends, or feel compelled to earn money to provide basic goods (Hodgson et al, 2019; De Vito, 2020). A child may even have built up a drugs debt, or for other matters, and 'feel trapped' (Interviewee 7). School, in comparison, can appear to be a waste of time, with no prospect of reward (McAra and McVie, 2016). Violence itself represents a strategy to overcome experiences of vulnerability and gain a sense of power, status, self-worth and self-efficacy within homes and neighbourhoods (McAra and McVie, 2016). Knife carrying, street fighting and retaliation among young people can be commonplace in areas of deprivation (McAra and McVie, 2016; Hodgson et al, 2019). One of

the victims in the A&E intervention came in under police arrest with a stab wound following a fight with a gang member over money (Case Study LK). An interviewee reflected this anomie in the following way:

> *"what are we expecting these young people to do? They've got nothing, their families have got nothing. They're living in poverty, they need money. And they're actually using their head quite entrepreneurially, aren't they, by saying, 'I'm going to go and earn, this is what I'm going to do. This is how I'm going to do it'. And they probably are doing a really good job at earning that money… and they're probably getting themselves to the point they want to be" (Interviewee 5)*

Another caseworker explained that he preferred to learn about a client by watching them interact with others within the community:

> *"I like taking the young people out, you know, just to see how they interact with society and to know like, just to see how they talk to you know, like people in the shops … just walking along they want to screw everyone and intimidate people, but I let them crack on. I'll let them crack on with it, and then I'll challenge them on it afterwards… I'm not gonna challenge straight away cause then I won't see everything, they'll close in. So let them be themselves … and then we can start getting to work." (Interviewee 9)*

Due to the weaknesses inherent in many BIs, researchers frequently recommend longer interventions, ideally alongside a spate of 'wraparound' initiatives that target what Bronfenbrenner (1979) refers to as the microsystem, the mesosystem, the exosystem, and the macrosystem that shape children's attitudes and lives. His social ecological model exhibits violent behaviour within a series of widening contexts, depicting the multiple influences that may operate on an individual at once. These include the individual child (such as temperament, epigenetic inheritance, exposure to drugs and alcohol before birth, and damaging early experiences); the microsystem (family, peers, school, and satisfactory role models etc); the exosystem (neighbourhoods, social exclusion and low educational attainment); and the macrosystem (government social programmes and policies, socioeconomic factors, ideologies and attitudes of culture and institutional racism). Each system wraps around the other from the inside (the individual child) outwards to the macrosystem, indicating that rather than there being a single cause of violence, there is usually a complex confluence of factors that serve to generate violence both for individuals and groups. Integral to public health approach is the idea that 'great store is placed on avoiding the blaming of victims … The working assumption is always that the situation in which they find themselves makes healthy choices hard to make' (Donnelly and Ward, 2015). Donnelly and Ward (2015, p. 6) add that 'violence reduction … has yet to discover (and probably never will discover) a "magic" intervention such as the seat belt, the airbag, or the helmet'.

In other words, treating violence as a learned behaviour that is relatively easy to address through a standalone brief initiative has long been considered to be a myth (Thornton et al.,

2000; Cunningham et al 2009). Rather children's behaviours are shaped by a cascade of environmental factors and key institutional settings. Child maltreatment, for instance, can contribute to changes to brain architecture, altered biological factors, reduced cognitive ability and impaired psychosocial functioning, while parental behaviours can be caused or amplified by the stresses of poverty and economic marginalisation and overcrowding in poor quality housing among other factors (Merrick et al. 2015). In many cases the ecology can be traced back to adults at all levels, who generate the environmental features that shape violent events, and who children invariably depend upon (Cunningham et al, 2009). To realise sustained violence reduction, McAra and McVie (2016) argue for a new 'negotiated order' where schools, families, friends and police forces and other agencies seek to protect rather than victimise they at-risk young people they interact with, something they refer to elsewhere as a 'whole systems approach'.

Public health, more generally, recognises that many diseases and health-related conditions, including violence, cannot be fully understood without addressing the wider ecology contributing to violence generation (Farmer, 2004; Donnelly and Ward, 2015). The aim of the public health approach to violence reduction, at least in theory, is to identify and tackle a variety of risk factors of violence across a person's 'life course', both upstream (in the early lives of people – often referred to as primary interventions) and downstream (after they have started to show a pattern of violence – often referred to as secondary interventions) to prevent serious violence from occurring. Embedded in public health approaches is the 'life course approach' which examines opportunities to intervene at specific stages in peoples lives to improve health later in life (Marmot et al, 1991). The model breaks a life course down into stages from prenatal, pre-school, school, training and employment to retirement, where there are overlapping opportunities for family therapy, aggression management, education and skills development, among others. Family therapy and programmes of home visitations, for example, are considered to be one of the most effective initiatives to change the behaviours of and the relationships between parents/ guardians and the children in their care, leading to variable reductions in child neglect and abuse (Olds et al, 1998; Thornton et al. 2000). Other strategies can include facilitating some kind of direct reconciliation between offenders and victims to build empathy and attempt to repair the harm done (Lipsey, 2009). Taking a multi-faced approach to address these issues in unison, by coupling family therapies with initiatives like mentoring and skills development in schools, is now integral to public health approaches to (sustained) violence reduction (Howell and Hawkins, 1998; McVie and King, 2019). Mentoring often features as one component of broader public health approaches, partly because it can potentially span various stages of child development.

4.7 Individual Challenges

Mentoring on its own is not a panacea. As Smith et al (2015) point out, the kinds of natural mentoring relationships that many people form with a member of their extended family or with someone in their community is not automatically accomplished by simply pairing a mentor with a mentor, who are strangers to one another, within a formal mentoring programme. Each mentor-mentee pairing or dyad can be complex and nuanced at both the individual and environmental levels. Young people will be at different stages of development and behaviour change, ranging from unwillingness to contemplation to real

attempts to follow a change plan (Frausto and Bazargan-Hejazi, 2009). They may have a complex history of violence or no criminal history at all, and may have experienced an array of adverse childhood experiences such as a history of domestic violence, family substance abuse, the incarceration of a parent, the death of a parent, witnessing violent acts in the community or sexual abuse (Grossman and Tierney, 1998; Smith et al, 2015). Violent acts committed by the mentee may range from simple assaults to sexual violence, stabbings and shootings. Underage drinking also features heavily in patterns of violence in both the UK and the US (Brank et al. 2008; Bernstein et al, 2010; Neville et al 2014; McGovern et al 2020). Following a rapid systematic review of interventions from 2000 to 2014, Newbury-Birch et al., (2016, p. 57) found that 64 per cent of young people in the criminal justice system in the UK scored positive for an alcohol use disorder. Reducing alcohol consumption, limiting drug use, and dealing with chronic psychological disorders such as depression is rarely a quick or easy process, even if a child recognises the impact their behaviour is having on their health and the lives of the people they care about, and even where they are sufficiently motivated to change.

Separating children of all ages from delinquent friends and relationships may not be easy either. A coercive or exploitative relationship can make it difficult for mentors and other responsible adults to engage children. As one caseworker explained:

> *"We've had this where if you've got a young girl and she's with a man, that man won't leave her side. So to us then we know straightaway something's going on. It could be sex exploitation. It could be grooming. So these are the situations we have where we can't pull them apart … you can speak to the young girl but if she doesn't want to engage with you because she's being influenced, there's nothing we can do"* (Stakeholder 3).

In such situations the caseworker would attempt to discreetly give the young person something with St Giles' contact number on it, such as a pen or other object, to allow the young person to contact them later if they were in trouble (Stakeholder 3). More generally, the relationship between antisocial or delinquent peers and friends is considered to be one of the strongest correlates of violent behaviour, particularly in adolescence, because of the similar behaviours that can emerge between them(aggressive behaviours, cause trouble and witnesses violence, gang members etc.) (Brank et al. 2008).

A common thread throughout the interviews was that the idea of immediately changing behaviours, mindsets or social networks was not the focus, rather it was the creation of a healthy relationship with the client. Taking a less active approach to challenging problematic behaviour at the start meant that they were unlikely to face too much resistance from clients before the foundation of a stable relationship. As one youth worker explained: *'it's really about building that rapport with the person, relationship building, and doing all the groundwork before you can even get your foot in the door, before you can even begin the actual direct work that you want to do with them' (Interviewee 5). Another simply stated that the main objective was "getting them to speak what's on their mind, because a lot of the young people that I see, they don't want to speak", especially not the truth about their feelings and experiences (Interviewee 6).* Mentors efforts may simply be rebuffed at the outset by mentees due in part to a lack of trust, low self-esteem and social skills deficits

(Smith et al, 2015). Not all young people want, or will be ready for, a mentor (Herrera et al, 2013).

For many of these reasons, a common theme amongst the respondents was the importance of patience. One caseworker explained that one at-risk child was ' talking to me for 20 minutes on the phone. And he's telling me he don't want no help. So that's showing me he wants help. (Interviewee 6). Much like a teacher in the classroom, they saw teachable moments as opportunities that arose organically, often outside of periods of acute distress. During relatively innocuous conversations where children are talking about their experiences, feelings, perceptions and problems that they are struggling to address, whether within their family or social network, mentors can affect a change in cognition. One respondent stated that: '*for me, it's the teachable moment is where my caseworkers are actually engaging and saying, I've been where you are. Let's look at a different pathway … offer an alternative solution'.* (Interviewee 3). This can require a mentor being contactable within short notice, so that when a child is struggling to overcome a problem or in a risky situation, the mentor is 'ready to pick up the phone and guide them through it' (Interviewee 5). In other cases, the strong attraction of criminality can mean that teachable moments are rarer. One caseworker observed that some children don't see a problem with the lifestyle they are living, they don't think they need help because they are 'living their best life' (Interviewee 3).

> *"'… they're making money, they've got credibility, they're fearless … [we're] just waiting for, I guess, that crisis point to happen to change that view a little bit…, there'll be something that's going to happen to these young people, that's going to cause an anxiety or wobble, a change in that sense. And we're there and it's that reminder of, you know, these were the consequences and the risks that we were talking about." (Interviewee 3)*

It was not unusual for mentors to discuss their work as a process of planting seeds that are more likely to blossom at a later date. 'We plant the seeds', said one respondent, but they'll use it 'when they're ready, not when we want them to be ready' (Interviewee 5). One caseworker explained that:

> *' six months later, I'll get the call… I always say to the young that I can't get through to, "Look you've got my number … it sounds like you're having a great time at the minute. Yeah. Keep having a great time … when circumstances change, just remember I'm at the other end of that phone. … Something's gonna happen to you" … Then they come back… it's not overnight, but eventually they will." (Interviewee 9,)*

The same respondent added that children can *'get to the point where out of the blue they say, "I'm done with all of that. You remember you were saying about that course, can you get me doing that?"'* (Interviewee 9). A somewhat novel aspect of the St Giles model is that they stressed that the relationship between mentor and mentee (referred to as the caseworker and client) did not have any pre-specified duration. One caseworker simply questioned 'how can anyone put a time limit on a child' (Interviewee 9, St Giles Caseworker). Another explained the process as follows:

often we get asked 'how long do I have to work with you? How many sessions do I have to see you?' because they've learned that from other projects and other services, and when we say 'this is voluntary – you can, you can, you know, go now, you don't have to stay' … we work to their needs. So that ultimately means that, you know, sometimes they'll work intensively for a few weeks, then then they'll have a period of stability. And then, you know, it might be that something has happened within the community within their friendship groups, and they come back. So there's lots of variations of that engagement really, for us, which is … brilliant, because it means that they've got that trusting relationship." (Interviewee 3)

A similar ethos applied to the A&E initiative (run by the same organisation). The team manager explained that:

'"Even though we close cases, do they still have our numbers and they will give us a break if they get into major crisis again, because they know that they've worked with us, they know we're not linked to the police, So they trust us. And that is why we get so much engagement, I think." (Stakeholder 3)

4.8 Family-oriented Challenges

Whether and to what extent mentors should even engage in social bonding with family members in order to tackle some of these problems is heavily contested. Some researchers argue that being able to influence family members in positive ways can be integral to success (Dubois et al, 2002; Brank et al., 2008; Medina et al, 2012), whereas others warn that becoming a friend of the family can harm the primary bond between mentor-mentee and blur boundaries (Howell and Hawkins, 1998). This dichotomy is reflected in a study by Lakind et al (2015), in which one mentor stressed the importance of remaining uninvolved in family conflicts no matter how horrible, comparing it to watching National Geographic, whereas another mentor felt that it was their duty to step in and advise parents or guardians on what they should and should not be doing. It is not unusual for the latter approach, which can also feature in family therapies and parental training programmes, to be integral to mentoring programmes. For example, between 1997 and 2001, the South Oxnard Challenge Project (SOCP) in California, employed full-time members of staff, known as 'navigators', to mentor young people according to a customised challenge plan over a three year period. Each navigator had a caseload of approximately 15 young people, and was tasked to focus specifically on improving parent-child and peer relationships.

In the present study, mentors reported taking on numerous roles:

'I might have to do some sort of family work, you know, some sort of youth work, some sort of mentoring, some sort of counselling … you can be doing three roles at one given time. (Interviewee 6)

They too reported a tension between their relationship with the child and their relationship with the child's parent or guardian. Since mentee's often have strained relationships with their parents, some felt that their mentor was untrustworthy because they would disclose issues to their parents or vice versa. As one caseworker explained: "*we do work with families, but that actually can be a conflict - 'I'm not going to tell you because you're going to tell my mom' - or every time something happens, Mum rings, the caseworker*" (Interviewee 3). Another caseworker explained that '*the last thing they want to do is tell you something, parents hear it and their parents are using it as something to bash them with … they don't need that'* (Interviewee 6, St Giles Caseworker).

Mentors can also reportedly feel pressured to act as surrogate or quasi-parents or guardians in some cases, and become largely responsible for obtaining a range of different social services, applying for housing, social welfare payments, school enrolment, providing transportation to child care, schools and health clinics and mitigating gaps in care and service delivery. This reflects the fact that mentors typically have high levels of autonomy and discretion so that they can respond differently to their mentee's emotional and physical needs, and interests (Herrera et al, 2013; Smith et al, 2015; Lakind et al, 2015). The extent to which they should engage as a service-broker for mentees and their families, and where they should draw the line, is rarely crisply defined (Lipsey, 2009). How mentors understand their role and issues of vulnerability can vary greatly as a result (Lakind et al, 2015; Matheson et al, 2020). One respondent explained that:

> *"Once you start the engagement, things start to expand and grow in the sense of what is the issue. So then when you start working with the individual, then probably start with the whole family. And within that family, that could be six siblings, but they have issues so then expands" (Stakeholder 3)*

It is reportedly not unusual for referrals to come directly from families. This is considered to be attractive, particularly where another child may be at-risk of offending but has not yet done so, so the mentoring work can take place further up-stream (Interviewee 3). In one case, the parent of a client contacted a mentor after a younger sibling was arrested for robbery with a weapon, while in another case, a child was brought to the attention of a caseworker who was working with his cousin after his grandmother found drugs within the home setting and was concerned about gang activity (Case Study KJ). However, to overcome issues of role overload and the potential disillusionment of mentees, one caseworker recommended appointing a dedicated family caseworker who is not assigned to a specific child, but to the whole family, parents, siblings and grandparents where appropriate (Interviewee 3).

Alternatively, parents might not welcome the intrusion of a mentor. Like children who are often blamed for their violent behaviour as if it is an informed choice, parents may complain about the tendency of volunteers, schools and statutory agencies to criticise their parenting skills, while failing to understand the nature of the problems and challenges they face (Medina et al, 2012). They may even feel that the mentor is acting to damage their relationship with their child (Lakind et al, 2015).

4.9 Evaluating Mentoring Programmes

Like brief interventions, many longer-term initiatives such as mentoring programmes have reported a range of impacts. In Oakland, California, the mentor-led Caught in the Crossfire programme reported a 70% reduction in arrest rates six months after hospitalisation for a violent injury (Becker et al, 2004 p. 177). Reflecting a teachable moment methodology, mentors with lived experience (known as Crisis Intervention Specialists) commenced the mentoring process at the hospital beside or at the individual's home post-discharge (Becker et al, 2004). In Boston, a Re-entry Initiative which focused on resettlement after prison reported reductions in violent arrest rates of 30 percent after mentors worked with participants for up to 18 months post-release (Braga et al. 2009). However, much like brief interventions, systematic reviews of interventions across time and place depict a landscape potted with mixed results. In the 1990s, researchers such as Sherman et al (1997) and Grossman and Tierney, (1998) found no firm evidence that mentoring programmes led to significant and generalisable reduction in areas of violence reduction and crime prevention. More recently, researchers analysed 16 years of shooting and attempted shooting data through the popular Cure Violence initiative, and found that mentoring and associated interventions contributed to various kinds of violence reduction in five of seven sites (which included places such as Baltimore, Brooklyn and Pittsburgh) (Butts et al, 2015). However, in some cases the purported improvement was a reduction in shooting fatalities in a context of increased non-fatal shooting incidents (ibid).

Often without distilling between mentoring programmes involving 'lived experience' or school-based mentoring that might involve peer-led social-cognitive interventions that focus on teasing, gender norms or other initiatives, systematic reviews suggest that the positive effects of mentoring programmes on reoffending are usually small. For example, in Lipsey's (2009) meta-analysis of 548 study samples spanning 1958 to 2002 (mostly US-based), the mean recidivism reductions for mentoring, in particular, was circa 21% (Lipsey, 2009, p. 142). Lipsey (2009, p. 134) listed mentoring under a broader category of 'counselling' because it was concerned with the development of a personal relationship between an at-risk person and a responsible adult 'who attempts to exercise influence on the juvenile's feelings, cognitions, and behaviour'. Small, short-lived reductions in reoffending of 4-11% were reported in Joliffe and Farrington's (2007) rapid evidence assessment of the effects of mentoring for at-risk youths. However, this only applied to 7 of 18 studies; in the majority of initiatives they assessed no statistically significant reduction was reported. Similar results in this range were found by Tolan et al, (2005) in an analysis of 31 studies.

Much like brief interventions, the aforementioned researchers invariably raised concerns about the relatively low methodological quality and the methodological differences of the studies that informed their findings (Lipsey, 2009, O'Connor and Waddell, 2015). Variations in the services provided, programme implementation and evaluation formats hindered the making of comparisons between and rigorous analysis of many mentoring initiatives. One common criticism is that mentoring initiatives are rarely evaluated on their own, but alongside other initiatives, whereby the overall effects of a programme as a whole, encompassing a range of distinct intervention, are evaluated against general baseline and performance metrics such as a reduction in weapons carrying or reoffending or fatalities. As a result, it is often impossible to discern which individual intensive intervention led to which

exact effect and when (Becker et al. 2004; Bernstein et al. 2015). Glasgow's Community Initiative to Reduce Violence (CIRV), for example, reported a reduction in violent offending following three years (2008 to 2011) of various kinds and doses of family therapy, home visits, mentoring and focussed-deterrence police enforcement to tackle knife carrying by gang-related youths (Williams et al., 2014). The US-style focussed-deterrence element of the model reflects the fact that the model was based largely on the Cincinnati Initiative to Reduce Violence (CIRV) (Deuchar, 2013; Williams et al., 2014). On the other hand, Chicago's Cure Violence project, which sought to eschew the tactic of police coercion, could not reach firm conclusions about programme impact and neighbourhood-level change because the Chicago Police Department (CPD) pursued a Violence Reduction Strategy (VRS) which may have targeted some of the same individuals and groups (Papachristos and Kirk, 2015; Butts et al, 2015).

The evaluation of mentoring initiatives alongside other initiatives, which obfuscates their effect, is often undertaken because it is recognised that on its own any positive impacts on risk factors are likely to be negligible and temporary. Initiatives that are designed to isolate and evaluate the effect of mentoring initiatives on violence and crime, and attempt to reduce measurement and reporting bias, regularly report that mentoring initiatives on their own result in little to no statistically significant reduction in reoffending (O'Connor and Waddell, 2015). In some cases, programmes have not even set out to measure behavioural changes. A synthesis of a dozen programme evaluations of gang and youth violence projects in London found that most of the projects measured only the attitudes of children before and after the intervention, rather than any actual changes in behaviour (McMahon, 2013; O'Connor and Waddell, 2015).

Reports of positive effects concerning attitudinal change towards aggression, social relations, school performance and internalising problems, rather than offending rates, are commonplace (O'Connor and Waddell, 2015). DuBois et al., (2011), for instance, conducted a systematic review of randomised controlled trials and quasi-experimental designs concerning mentoring and found small positive effects primarily in areas of academic achievement, emotions and others. The famous US-based Big Brothers Big Sisters (BBBS) programme, in turn, has recorded reductions in instances of school truancy, alcohol misuse and hitting, in comparison to controls, but such findings often rely on internal evaluations and weak quasi-experimental designs (Grossman and Tierney, 1998; Thornton et al, 2000; Herrera et al, 2013). Another systematic review by Tolan et al (2008), reported a 40% reduction in aggression and more modest reductions in drug use and improvements in academic achievement. Herrera et al (2013) found in their study that the greatest reduction occurred in depressive symptoms, with no effect on problematic behaviours. Another peer-mentoring scheme within Scottish high school settings (known as Mentors in Violence Prevention) found that positive attitudinal and behavioural change was possible by using didactic teaching and role-playing to develop a group-based bystander approach to correct peer norm misperceptions around gender-based violence (Williams and Neville, 2017).

Due to the focus on self-reports of attitudinal change rather than more substantive metrics of re-offending and crime reduction, mentoring has been described as just a "drop in the bucket" for many at-risk children (Thornton et al., 2000, p. 165), while Medina et al (2012, p. 23) argue that it represents little more than 'tinkering around the edges' of more

entrenched socio-economic problems. Researchers, in many mentoring studies, tend to return to the decades-old recommendation that brief interventions supplemented by longer-term wraparound services are necessary to realise more sustained reductions in risk factors (Howell and Hawkins, 1998; Medina et al, 2012; Snider et al, 2015). Numerous commentators have speculated therefore that the rapid proliferation of mentoring programmes has been guided by enthusiasm rather than solid empirical evidence (Grossman and Tierney, 1998; Smith et al, 2015). Commentators occasionally question why 'the criteria identified in the literature as being important in achieving success' is often ignored (Medina et al., 2012, p. 15).

In this study, the participants elaborated on why it is so hard to measure blanket successes in mentoring programmes. One caseworker stated simply that "*I have seen changes in their, in their personalities, I've seen changes in their, in the way they speak. I've seen changes in the way they interact"* (Interviewee 9, St Giles Caseworker). Since each case is different, a success can be counted as getting a child back into school or into a new college, encouraging them to sit down and have a conversation with a social worker who they were previously unwilling to speak with, seeing them take their schoolwork more serious, hearing about a positive new group of friends, seeing them attending regular training sessions with a football club, or as simple as getting them to open up about their traumas and their feelings with the mentor or with a parent (Interviewees 3, 6 and 9). Someone who is constantly at house parties and away from home and returns, behaves positively in the home and seems happier in general is viewed as a success (Interviewee 3, 6), so too can helping a child '*with his night routine which in return has provided him with skills to get a good night's sleep'* (Case Study KJ).

This may help to explain why participants, parents, mentors, police officers and school officials frequently report high levels of satisfaction with mentoring programmes and describe them as important. The evidence would seem to suggest that even where mentors can form good relationships with mentees, which may not always work, positive effects are likely to be difficult to quantify and more likely to be visible in areas other than violence reduction. Caseworkers can 'see' improvements without necessarily being able to quantify them.

To a similar extent, both families who took part in the interviews were happy with the support provided by St Giles. However, one parent felt that her child would benefit from continued support to address issues around dealing with difficult situations and peer pressure, but the support ended - Cases could be closed following a risk assessment. The A&E nurse was also positive about the service and collaboration with St Giles, and how different this was from her usual way of working. The nurse was initially apprehensive thinking '*oh gosh they are 'not health', and I will share information with them?*' but was subsequently 'very proud' of the volunteers (St Giles) and how the 'unique and supportive' relationship formed (Stakeholder 1). The nurse said: '*I think we developed an excellent working relationship, and you know, I feel confident that they would support me as well if, you know I needed some support, I would always support them and they would support me I am sure!' (*Stakeholder 1).

5. Answering the research questions

5.1 How important is the messenger?

What impact does having someone with lived experience deliver the messages have on the overall outcomes (i.e. engagement, sustained involvement)?

Police custody staff (and A&E staff) are considered to be inappropriate 'messengers' for a number of reasons, centring mainly on issues of workload and function. Providing emergency primary care in the case of healthcare professionals, and carrying out statutory functions around care and control in the case of custodial staff, are invariably treated as primary functions. Undertaking brief public health interventions is widely perceived as a distraction, particularly because outcomes are vague and the effects of initiatives largely unproven for large populations.

These concerns do not seem to apply to volunteer or paid mentors or caseworkers who are conceivably able to spend significant quantities of time to realise some changes in people's moods, interests and interactions with others. Youth workers with lived experiences are widely perceived to be relatable, helping to develop relationships of mutual trust and respect, and engage children in a range of diversionary activities and discussions. It is clear that volunteers with lived experience can help at-risk children in a multitude of ways, be it providing an safe space for them to vent their frustrations or helping them join a football club so that they can release their energy in productive and pro-social ways, and make new friends along the way. The patient approach that they take in order to wait for teachable moments to materialise, perhaps weeks or months after their first interaction with a child, was considered by many to be integral. Professional healthcare and custodial staff, and other statutory agents, cannot conceivably realise the same level of engagement and sustained involvement, as presently constituted. **The lived experience of the mentors appeared to be a key lever facilitating delivery of the programme. The cooperation of custody officers and A&E nurses were also clearly key levers facilitating delivery**.

5.2 How important is the timing?

What proximity to the point of arrest does an initial intervention have to be in order to be effective (i.e. does it matter that the Peer Mentor cannot attend the custody suite, if he/she engages with the young person immediately after release?)

The custody (or hospital) based teachable moment seems to come into play as a catalyst to start otherwise hard-to-reach people on a journey of multi-pronged interventions designed to interrupt the causal processes that generate key risk factors. Mentoring itself appears to be conducive to a multitude of teachable moments that may plausibly occur unexpectedly, at any time, whenever a child encounters a problem or crisis and decides to discuss it during a pre-arranged interaction or decides to reach out for assistance by phone. This means that a legitimate messenger (one with lived experience) may be able to deliver the right kind of message at the right time, to teach something just when they are ready to learn it. It is conceivable that the opportunity could occur in a hospital A&E or outside a police custody suite. However, **it appears to be unlikely that an opportunity to modify violent behaviours**

or cognition through a right message - right messenger - right time approach can be capitalised upon at 'first contact' regardless of where that takes place, due largely to the absence of a pre-existing relationship and mutual trust.

Young people who have been through police custody several times previously are also thought unlikely to be in a significant state of reflection (which might apply more readily to first time offenders). Instead, the A&E and custody settings appear to be more suitable locations for children to be made aware of and extended an invitation to join a mentoring programme so that learning can be realised at some undetermined points in the future, if they choose to engage. In other words, children can possibly be taught about a mentoring programme and its potential benefits while awaiting police interview or medical treatment, but the teaching of health-promoting behaviours, and the subsequent learning and process of change and behavioural modification appears more likely to occur further into an intensive programme of interaction and monitoring, ideally alongside other interventions within a broader multicomponent programme.

We see no reason why awareness raising of an intervention, and an invitation to join one, should not take place within A&E. There is the potential to attract young people, and to enhance inter-agency collaboration between healthcare services and youth work in the community (the co-location of caseworkers and healthcare staff, and the information sharing between them – especially through the NHS computer system – was lauded).

The same benefits could theoretically be realised by co-locating case workers within police custody suites. One case worker indicated that a young person was even released early from custody in part because he had agreed to participate in a mentoring project (Case Study LK). This indicates that greater police awareness of and links to mentoring projects could lead to swifter releases from custody. **However, the narrative emanating from the academic literature is that negative connotations could be associated with external visitors, such as youth workers, who are seen to participate in or acquiesce to the 'pains of police detention'**. Important features of mutual trust and respect may be undermined by the potential powerlessness of volunteers who children interact within custody. Of course, co-locating volunteers within custody and hospital settings may not be what the volunteer signed up for, and may not be a not be the best use of the time relative to a community setting.

Ultimately, we cannot determine whether police custody or hospital A&E is more likely than any other point in time to be a teachable moment, or to lead to one, and under what particular circumstances. Nor can we tell how close in proximity first contact needs to be to the experience of police custody (or hospital A&E). To do this, consistent data would need to be collected that might allow both initiatives to be compared against other treatment and control groups. For example, one group could have had first contact in A&E, while another could have first contact two hours after A&E (once a patient returns home); another could have first contact two days after A&E; another could have first contact in police custody, and others at subsequent increments (in the community) etc (we note how St Giles already refers to proximity in terms of 'hot referrals' for those who were engaged directly in hospital and custodial settings, 'warm referrals' who are engaged shortly after release and 'cold referrals' who are identified only after release). In this example, various

kinds of 'first contact' could be compared in order to make some rough determination about which first contacts, and when, are potentially teachable moments, and which are potentially more influential. Even though first contacts were not made in police custody due to Covid, insights could still be drawn from the remaining control groups. In the absence of these, no determination (strong or weak) can realistically be made about the timing of teachable moment interventions.

Lastly, it is our understanding that an experiment was carried out which involved matching the Teachable Moment in Custody treatment group, who were allocated a caseworker/ mentor, with a control group by age, gender and ethnicity. We were not involved in the experiment and did not see the data or methodology underpinning the matching process. We were informed via email that 122 young persons were offered a caseworker and engaged following custody (of whom 15 reoffended during the project), 15 young persons who agreed but didn't subsequently engage (10 of whom reoffended), and 100 YP in the control group (33 of whom reoffended). On this basis, the odds of reoffending appear to be significantly ($p < 0.01$) lower for people who were offered St Giles (engaged or not) than those not offered it. However, we are unable to rely on these findings at present because we have not been able to review the methodology and the complete dataset. To be able to confidently state that the initiative contributed directly to a sustained reduction in violence, we would need to examine varying levels of engagement among the treatment group, how close to police custody 'first contact' took place within the treatment group, and the extent to which the young people in the treatment and control groups were isolated from other VRU interventions or mentoring initiatives among other variables. This experiment and the findings did not form part of our process evaluation.

5.5 Barriers to Cooperation

In terms of practical barriers**, the long vetting process for police custody, and the fact that caseworkers only worked on weekdays only were limitations**. The fact that the caseworkers were based in the hospital only on weekdays was considered to be a significant limitation, since injured children could be admitted overnight or over the weekend (Stakeholder 1). The A&E nurse observed that: if you are not here seven days a week … they will be gone so you missed the moment when they are there, when they are within ward being stitched up' (Stakeholder 1). The St Giles manager explained that: "initially when they started; the talk was that they would do sort of early shift, late shift and then weekends …which that never happened for one reason, or another …' (Stakeholder 1).

In respect to the police custody intervention, it is possible that it may become challenging in due course to recruit caseworkers who are willing to spend long hours in a police custody suite. The police custody initiative apparently needed to recruit a new caseworker to do this.

There was much more demand for allocation to the programs than availability (Interviewee 3).

5.6 Covid-19

The pandemic served to prevent the custody initiative from going ahead, although we are not clear on why caseworkers were permitted to work within hospital A&E but not police custody suites. More generally, there was reportedly an increase in issues relating to domestic violence and assaults between siblings and family members which were attributed to people being '*under the same roof locked in'* (Stakeholder 3). People were reportedly easily annoyed and frustrated at home, leading to confrontations with family members. In addition, the closure of schools and colleges meant that kids had more 'time off' which is often '*not the best situation for them*' (Stakeholder 4).

The pandemic affected caseworkers in a myriad of ways: they could no longer bring children to open days to get the 'buzz' of college life or the 'autonomy' that comes with going to college, and recreational activities that are routinely used for diversion (towards health-promoting activities and positive friendship groups) such as going to gyms, football clubs, rugby clubs, basketball, martial arts and boxing were no longer available (Interviewee 3).

To overcome some of these issues, caseworkers utilised video calls, text messages and met clients in some cases (Interviewee, 3, 6). To keep clients engaged in school work, St Giles supplied numerous laptops for children use (Case Study KJ). Regarding virtual engagement, one caseworker said that it '*worked brilliantly … we still had engagement*' (Interviewee 3). The laptops were even used to provide clients with fitness videos during lockdown (Case Study KJ).

Other caseworkers acknowledged the importance of regular face-to-face interaction: *'There's that type of person that when you go and visit them, they'll have a conversation with you. But they won't speak to you over the phone'* (Interviewee 6). In some cases, face-to-face meetings were arranged. One case manager explained that: '*The case worker would go find an appropriate area like a park or somewhere where they can go to sit with and have a coffee just to catch up with conversation*' (Stakeholder 3).

5.7 Funding Issues

With only a year's worth of funding, caseworkers, who have built relationships and knowledge about a range of criminogenic environments, have already started seeking out alternative employment. As their manager pointed out, '*they've got to think about their bills to pay … they might not have a job in six weeks. And that's tough as well'* (Interviewee 3). The manager added that they had 'nowhere at all to put 50/60 young people who are engaged, doing well making progress, seeing an alternative … And that is absolutely heart breaking' (Interviewee 3). Another caseworker argued that **the unstable funding situation served to fuel the view amongst service users that agencies and adults will eventually abandon them**:

> *"Services, come services, go. Funding's there, funding's not … people sort of say, yeah, yeah, I've heard this before. You've promised me this, You've promised me that and then let me down. And I think that is a problem because then we have to say and encourage them that that's not the case, we're here for you. We're going to support you. But then you've always got that issue, haven't you? … for them, it's being let*

down by services that come and go. And they need services. They need someone in their chaotic lives to say, OK, this is fine, there's an issue, but we can get through …." (Stakeholder 3)

Concerns about long-term funding were also shared by the A&E nurse, who said:

"it would be nice to know that this project will be here for longer, because it is hard to introduce something and everybody knows about it, and then when things like that get removed it leaves a void, it leaves a void in the organisation. You know, we have lots of great projects but by the time they are well established the funding runs out. Then you are left with a gaping hole really…." (Stakeholder 1).

6. Conclusion and Recommendations

Findings from detailed qualitative analysis identify the following as key to the Teachable Moments in A&E:

- Multi-agency collaboration and communication
- Building trust and confidence through the cultural competency and 'lived experience' of its staff team and a relational approach
- Taking a whole-family approach

The project has been challenged by low levels of sustained engagement, the availability of support for young people transitioning from child to adult services, and the overall profile of the project in terms of awareness within the hospitals.

Similarly, findings from detailed qualitative analysis identify the following as key to the Teachable Moments in Custody:

- Credibility of the staff team built on their lived experience and cultural competency and contextual awareness
- Offering longer term support, without a pre-determined duration and
- The passion and dedication of the staff team.

The project has faced challenges through the pandemic because of the lack of available 'alternative' opportunities for young people and the difficulties of maintaining a high level of communication with clients and their families.

Combining these findings and augmenting them with the narrative literature review, the key overall findings include:

- The 14 semi-structured interviews carried out with staff, stakeholders and parents involved in the two projects revealed numerous benefits, and some innovative approaches. The benefits mainly revolved around perceived behavioural changes in clients and new multi-agency working relationships. Caseworkers and parents reported seeing changes in the way young people speak and interact with their families and social networks; their willingness to speak about the traumas they have experienced; their desire to return home at night instead of attending house parties; the seriousness with which they attempt school work or consider enrolling at college; and even their attentiveness towards their sleep routine, among other benefits. These changes were usually attributed to the establishment of a relationship between young people and supportive and patient caseworkers/ peer mentors with lived experience.
- The more innovative procedural aspects of the initiatives included the establishment of new working relationships between St Giles caseworkers and NHS staff. This involved the use of NHS computer systems to upload information about interventions on a case-by-case basis, which could be used to link together other social services involved with an injured patient. Nurses, in particular, became more

comfortable sharing information with caseworkers as part of this initiative. NHS staff, more broadly, became more aware of the lived experience of young people and the terminology they used by attending joint training sessions with St Giles caseworkers. Separately, within police custody suites, custody officers routinely referred young arrestees to youth workers, and their enhanced awareness of the work of St Giles reportedly led to the swifter release of arrestees (who had agreed to participate in a mentoring programme) on at least one occasion.

- The interviews indicated that the projects ran efficiently and effectively during the pandemic, as judged by the participants, due in no small part to the enthusiasm and relatability of the St Giles caseworkers. There does not seem to be any real variation across stakeholder groups (in terms of perceptions).
- Stakeholders felt generally positive about the initiatives in general, the specific processes between staff and clients, and the processes used to link the relevant agencies in particular. The vetting required to co-locate a caseworker within police custody reportedly took a long period of time, but such experiences are not unusual when going through a vetting process.
- The pandemic affected the types of interactions and recreational activities that caseworkers would ordinarily engage in. Clients in lockdown were required to remain at home, which wasn't beneficial for their mental health or their motivation to engage in schoolwork or progress to college. However, St Giles reportedly kept processes alive by working with clients virtually and even provided some clients with laptops for use at home.
- Due to awaiting the Data Sharing Agreement (DSA: as noted elsewhere in this report), we were unable to request populated Monthly Performance Reporting (MPR) framework forms populated to carry out data review and analysis. However, following a review of the empty MPR templates, it would appear that to clearly identify teachable moments the forms require some amendments. At present, biographical data (age, gender, criminal history etc.) and intervention data (number of support sessions and types of assistance provided etc.) seem to be counted separately. The forms also seem to count only the number of instances without explaining how the completion or success was reached (and for whom) i.e. what is the threshold that must be passed before a box is ticked (or a zero turned into a one) etc. Tying intervention types to particular people, places and times, would enable examination of the causes and effects at an individual level (or identify potential teachable moments or their potency from case to case).
- The VRU Monitoring Template document connects some biographical data (such as age, gender, ethnicity and reason for referral) with free-text comments that can be made at 3, 6, 9 and 12 month follow-ups. It is not as detailed as the MPR form and we have not seen the types of comments routinely entered by caseworkers. However, if the data entered addresses all of the categories contained in the MPR form, and outlines additional information such as the point in time that particular

conversations or assistance took place (e.g conversations about drug use or knife carrying), whether and to what extent a client learned something from a caseworker following particular meetings, and outlined crime/hospital/ self-report data pertaining to violence at 3, 6, 9 and 12 month points, then it may be more conducive to identifying teachable moments (that could then be tested through experimentation). This is a point we wish to examine when the DSA is in place.

- We considered the 2019 Review carried out by JH Consulting. However, we did not find any substantive evidence to support the reachable/teachable moment claim made by JH. The consultants appeared to rely on figures showing a drop in participation from initial contact in hospital (highest point - 32 participants) to ongoing support after 6 weeks (lowest period of engagement - 10 participants) to deduce that initial contact in hospital was therefore a reachable/ teachable moment. It could be argued that this difference says little about teachable moments, and that the authors have possibly conflated the idea of a reachable moment (which is considered to be an opportunity to interact with someone who is otherwise hard to reach) with a teachable moment (which involves behavioural/ cognitive change). It is not clear that the outcomes following hospital contact were more potent than latter engagements. Comparisons could be made with control groups or other interventions that start, for instance, after hospital A&E. In addition, it is unclear how the JH Review measured some of the 'positive signs', like an improved ability to manage risk (29 participants). What specific thresholds were met, what did they entail, and who did they benefit most (characteristics, risk factors etc.)?
- At a population level, we remain unclear about whether and to what extent various kinds of interventions/ assistance interconnect and produce client outcomes, especially those outcomes related to violence. It is unclear, for example, how 'gang exit' and 'reduced risk of radicalisation' is attempted from a process perspective.
- The narrative emanating from the academic literature is that negative connotations could be associated with external visitors, such as youth workers, in custody settings if they are seen to participate in or acquiesce to the 'pains of police detention'. This may affect the willingness of young people to engage with caseworkers and undermine the reputation of external agencies. It may also become difficult to recruit volunteer caseworkers to operate in this environment.
- It appears unlikely that an opportunity to modify violent behaviours or cognition through a right message - right messenger - right time approach can be capitalised upon at 'first contact' regardless of where that takes place, due largely to the absence of a pre-existing relationship and mutual trust. Rather, teachable moments in A&E and police custody might be better suited to teaching young people about the availability and promise of mentoring initiatives etc. (with behavioural modification occurring later, during an intensive intervention).
- Awareness raising of an intervention, and an invitation to join one, could usefully continue to take place within A&E settings. There is the potential to attract young

people, and to enhance inter-agency collaboration between healthcare services and youth workers in the community (the co-location of caseworkers and healthcare staff, and the information sharing between them, was one of the more novel aspects of these initiatives). The same might not apply to the police custody suite due to the negative connotations often associated with adults who operate in that environment (as expressed in the academic literature).

- Cooperation between mentors, custody officers and A&E nurses were key levers facilitating delivery. The smoothness of inter-agency working, facilitated in part by how contactable St Giles reportedly were, indicates that the interventions were relatively effective at realising new forms of multi-agency cooperation.
- The lived experience of the mentors appeared to be a key lever facilitating delivery of the programmes but practical limitations included the long vetting process for police custody, and St Giles caseworkers only working on weekdays.
- The Covid pandemic affected caseworkers in a myriad of ways. For example, the recreational activities that are routinely used for diversion (towards health-promoting activities and positive friendship groups) such as football, rugby, basketball, martial arts and boxing were no longer available. To overcome some of these issues, caseworkers utilised video calls, text messages, and even provided some clients with laptops.
- Short-term VRU funding issues meant that some caseworkers had already sought out alternative employment. Unstable funding can fuel a view amongst clients that supportive adults will abandon them eventually.

<u>Recommendations</u>

1. To examine teachable moments fully would likely require additional categories of data to be collected, including the duration of meetings, activities undertaken and things addressed in each (using the list of activities) etc. to help identify methods, effects and teachable moments. For example, it would be helpful to know that drug use was discussed in a specific week and in a particular way, and knife carrying addressed at a different time and way etc (measured against longer term self-report and police/ hospital data etc.). Caseworkers could perhaps be asked to comment on whether they could identify teachable moments within each interaction and what they thought it looked like, and to ask clients (at some point) where they think learning took place and why
2. The monthly reporting templates could attempt to measure self-reports of violence in an effort to establish how frequently clients experience or commit violence acts (that don't come to the attention of healthcare or the police) on a daily, weekly or monthly basis, and whether this reduced during particular interventions/ forms of assistance. There is no mention either of knife carrying, and whether this is being addressed. Neither is there an attempt, at least within the monthly reporting form, to record awareness levels or performance of healthcare or police staff partners, and

how this affects outcomes. Data of this kind is arguably important in teachable moment methodologies.

3. In order to determine whether police custody or hospital A&E is more likely than any other setting or point in time to be a teachable moment, or to lead to one, and under what particular circumstances, a robust research method would need to draw comparisons. For example, a Randomised Controlled Trial – or method employing similar principles but with practical considerations balanced. As noted above, we reviewed an experiment that was carried out using the police custody participants, whereby offending rates were compared against a matched sample, indicating a reduction in violence among the treatment group. A more advanced design should take account og differing levels of engagement, the techniques used by mentors, external variables, or potential disproportionalities by race or ethnicity etc.
4. The decision-making processes of partner agencies could be clarified and reflected in the monthly reporting template and other documents/ case studies. It should be clear exactly how A&E staff and police custody officers screen people for referral: What thresholds do they use exactly? Who is excluded and why? Is decision-making potentially biased? These kinds of questions should be asked and answered as a matter of course.
5. A reasonable amount of time needed to complete vetting of St Giles caseworkers should be discussed with police partners and factored into the intervention. The intervention team should avoid reaching a point where it considers reconfiguring an intervention because of vetting issue.
6. In order to make 'first contact' with eligible young people in A&E and police custody settings, caseworkers should ideally be available on weekdays, weekends and weeknights as young people can enter these environments 24-hours a day.
7. Longer and more secure funding streams appear to be needed in order to avoid the possibility of leaving young participants feeling abandoned (by purportedly supportive adults) if funding is suddenly cut. The academic literature indicates that projects can end up doing more harm than good to a young person by enrolling them onto a programme that then fails them. Caseworkers and parents reportedly feared such an eventuality, which is not conducive to trust and confidence-building.
8. The St Giles ethos that caseworkers will never terminally close a case - and instead remain open to the possibility that a young person may reach out for support and present them with an organic teachable moment at some undetermined point in the future - appears to be one of the most novel aspects of these projects. With further evaluation and examination, it could potentially be promoted as best practice nationally and internationally.

Reference List

- Becker, M.G et al (2004) Caught in the Crossfire: The Effects of a Peer-based Intervention Program for Violently Injured Youth. Journal of Adolescent Health;34:177–183
- Bernstein E. et al (2007) The Impact of Screening, Brief Intervention, and Referral for Treatment on Emergency Department Patients' Alcohol Use. Ann Emerg Med 50(6), 699 – 710
- Bernstein, J et al. (2010) A Brief Motivational Interview in a Pediatric Emergency Department, Plus 10-day Telephone Follow-up, Increases Attempts to Quit Drinking Among Youth and Young Adults Who Screen Positive for Problematic Drinking. Acad Emerg Med, 17(8), 890 - 902
- Bernstein, S.L et al. (2015) Successful Tobacco Dependence Treatment in Low-Income Emergency Department Patients: A Randomized Trial. Annals of Emergency Medicine, 66(2), 140 – 147
- Bertram Gallant. T. (2017) Academic Integrity as a Teaching & Learning Issue: From Theory to Practice, Theory Into Practice, 56:2, 88-94
- Blow, F.C et al (2017) A randomized controlled trial of brief interventions to reduce drug use among adults in a low-income urban emergency department: the HealthiER You study. Addiction, 112, 1395 – 1405
- Braga, A. A., Piehl, A. M., & Hureau, D. (2009). Controlling violent offenders released to the community: An evaluation of the boston reentry initiative. Journal of Research in Crime and Delinquency, 46(4), 411-436.
- Brank, E., Lane, J., Turner, S., Fain, T., & Sehgal, A. (2008). An experimental juvenile probation program: Effects on parent and peer relationships. Crime and Delinquency, 54(2), 193-224.
- Brice, J.M and Boyle, A.A (2020) Are ED-based violence intervention programmes effective in reducing revictimisation and perpetration in victims of violence? A systematic review. Emerg Med J 2020;37:489–495
- Brown, K. (2015). *Vulnerability and young people: Care and social control in policy and practice*. Bristol: Policy Press
- Butts, J.A, Roman, C.G, Bostwick, L. and Porter, J.R (2015) Cure Violence: A Public Health Model to Reduce Gun Violence. Annual Review of Public Health, 36, 39–53
- Chariot, P. et al (2014) Alcohol and substance screening and brief intervention for detainees kept in police custody. A feasibility study. Drug and Alcohol Dependence 134, 235 – 241
- Cunningham, R. et al (2009) Before and After the Trauma Bay: The Prevention of Violent Injury Among Youth. Annals of Emergency Medicine, 53(4), 490 – 500
- De Anda, D. (2001) A Qualitative Evaluation of a Mentor Program for At-Risk Youth: The Participants' Perspective. Child and Adolescent Social Work Journal, 18(2), 97 – 117
- De Vito, K. (2020) Seeking a secure base: Gangs as attachment figures. Qualitative Social Work, 19(4), 754 – 769
- Dehaghani, R. (2017) 'Vulnerable by law (but not by nature)': examining perceptions of youth and childhood 'vulnerability' in the context of police custody. Journal of Social Welfare and Family Law, 39(4), 454-472

- Dohnke, B. et al. (2012) Do hospital treatments represent a 'teachable moment' for quitting smoking? A study from a stage-theoretical perspective. Psychology and Health, 27:11, 1291 to 1307
- Donovan, D. et al (2015) Lessons learned for follow-up booster counselling calls with substance abusing emergency department patients. Journal of Substance Abuse Treatment. 50, 67-75
- Farrington D.P. (1997) Early prediction of violent and non-violent youthful offending. Eur J Crim Policy Res, 5(2), 51–66
- Frausto, K and Bazargan-Hejazi, S. (2009) Who is Ready to Change Illicit Drug Use Behavior: An Emergency Department Study. Substance Abuse: Research and Treatment 2009:3 53–60
- Glasswell, K. and Parr, J.M (2009) Teachable Moments: Linking Assessment and Teaching in Talk around Writing. Language Arts, 86:5, 352 – 361
- Gomez, G. et al. (2012) Project Prescription for Hope (RxH): Trauma Surgeons and Community Aligned to Reduce Injury Recidivism Caused by Violence. American Surgeon, 78(9), 1000 - 1004
- Grossman, J.B and Tierney, J.P (1998) Does Mentoring Work? An Impact Study of the Big Brothers Big Sisters Program. Evaluation Review, p. 403 to 426
- Herrera, C., DuBois, D.L and Baldwin Grossman, J. (2013) *The Role of Risk: Mentoring Experiences and Outcomes for Youth with Varying Risk Profiles*. New York, NY: A Public/Private Ventures project distributed by MDRC.
- Hodgson, E., Stuart, J.R, Train, C., Foster, M. and Lloyd, L. (2019) A Qualitative Study of an Employment Scheme for Mentors with Lived Experience of Offending Within a Multi-Agency Mental Health Project for Excluded Young People. The Journal of Behavioral Health Services & Research, 46:1, 140 – 150
- Hodgson, J. (1997). Vulnerable suspects and the appropriate adult. *Criminal Law Review,* 785–795.
- Howell, J. C., & Hawkins, J. (1998) Prevention of Youth Violence. Crime and Justice: Review of Research, 24, 263-316.
- Hritz, S.A and Gabow, P.A (1997) A Peer Approach to High Risk Youth. Journal of Adolescent Health, 20, 259-260
- Lakind, D., Atkins, M. and Eddy, J.M (2015) Youth Mentoring Relationships in Context: Mentor Perceptions of Youth, Environment, and the Mentor Role. Child Youth Serv Rev. 2015 June 1; 53: 52–60.
- Lipsey, M.W (2009) The Primary Factors that Characterize Effective Interventions with Juvenile Offenders: A Meta-Analytic Overview. Victims and Offenders, 4, 124 – 147
- McAra, L. and McVie, S (2016) Understanding youth violence: The mediating effects of gender, poverty and vulnerability. Journal of Criminal Justice 45, 71–77
- McGovern, R. et al. (2020) Containment and care? A qualitative interview study exploring police custody staff views about delivering brief alcohol interventions to heavy drinking arrestees. Drugs: Education, Prevention and Policy, 27:6, 436-444
- McVie, S. and King, J. (2019) A public health approach to reducing violence: Can data linkage help to reduce demand on blue light services? International Journal of Population Data Science, 4:3:076
- Medford, S., Gudjonsson, G.H. and Pearse, J. (2003) The efficacy of the appropriate adult safeguard during police interviewing. Legal and Criminological Psychology, 8, 253 – 266

- Medina, J., Ralphs, R. and Aldridge, J. (2012) Mentoring Siblings of Gang Members: A Template for Reaching Families of Gang Members? Children and Society, 26, 14-24
- Muncie, J. (2008). The 'punitive turn' in juvenile justice: Cultures of control and rights compliance in Western Europe and the USA. Youth Justice, 8, 107–121.
- Neville, F.G et al (2014) Violence brief interventions: A rapid review, Aggression and Violent Behavior 19, 692–698
- Newbury-Birch, D., McGovern,R., Birch, J., O'Neill, G., Kaner, H., Sondhi, A., and Lynch, K. (2016) "A rapid systematic review of what we know about alcohol use disorders and brief interventions in the criminal justice system", International Journal of Prisoner Health, Vol. 12 Issue: 1, pp.57-70
- O'Connor, R.M and Waddell, S. (2015) What works to prevent gang involvement, youth violence and crime: A rapid review of interventions delivered in the UK and abroad. Home Office and Early Intervention Foundation.
- Olds, D., Henderson, C.R, Cole, R. et al (1998) Long-term effects of nurse home visitation on children's criminal and anti-social behaviour: 15-year follow-up of a randomized controlled trial. JAMA, 280(14), 1238 – 1244
- Papachristos, A.V and Kirk, D.S (2015) Changing the Street Dynamic: Evaluating Chicago's Group Violence Reduction Strategy. Criminology & Public Policy, 14 (3), 525 – 558
- Pierpoint, H. (2006) Reconstructing the role of the appropriate adult in England and Wales. Criminology and Criminal Justice, 6(2), 219 – 237
- Rhodes, J. (2002). Stand by me: The risks and rewards of mentoring today's youth. Cambridge, MA: Harvard University Press.
- Skinns, L. et al (2017) "Police legitimacy in context: an exploration of "soft" power in police custody in England", Policing: An International Journal, 40: 3, 601-613
- Smith, C.A, Newman-Thomas, C. and Stormont, M. (2015) Long-Term Mentors' Perceptions of Building Mentoring Relationships with At-Risk Youth, Mentoring & Tutoring: Partnership in Learning, 23:3, 248-267
- Snider C, Jiang D, Logsetty S, Strome, T. and Klassen, T. (2015). Wraparound care for youth injured by violence: study protocol for a pilot randomised control trial. BMJ Open. 1 - 6
- Svalin, K. et al (2018) Police employees' violence risk assessments: The predictive validity of the B-SAFER and the significance of protective actions. International Journal of Law and Psychiatry 56 (2018) 71–79
- Thornton, T.N., Craft, C.A., Dahlberg, L.L., Lynch, B.S., and Baer,K.,(2000) Best Practices of Youth Violence Prevention: A Sourcebook for Community Action. Centres for Disease Control and Prevention.
- Tyler, T.R, Fagan, J. and Geller, A. (2014) Street Stops and Police Legitimacy: Teachable Moments in Young Urban Men's Legal Socialization. Journal of Empirical Legal Studies, 11(4), 751–785
- Weinrath, M., Donatelli, G. and Murchison, M.J., (2016) Mentorship: A Missing Piece to Manage Juvenile Intensive Supervision Programs and Youth Gangs? Canadian Journal of Criminology and Criminal Justice. 58(3), pp 291 – 321
- Williams, D. J., & Neville, F. G. (2017). Qualitative evaluation of the mentors in violence prevention pilot in Scottish high schools. Psychology of Violence, 7(2), 213–223
- Williams, D.J et al (2014) Addressing gang-related violence in Glasgow: A preliminary pragmatic quasi-experimental evaluation of the Community Initiative to Reduce Violence (CIRV). Journal of Aggression and Violent Behavior 19, 686–691