EVALUATION REPORT

Re-Frame

Efficacy Trial Report

Professor Simon Coulton, Nadine Hendrie, Professor Theresa Gannon

April 2026

University of Kent

we are with you

YOUTH ENDOWMENT FUND

About the Youth Endowment Fund

The Youth Endowment Fund (YEF) is a charity with a mission that matters. We exist to prevent children and young people from becoming involved in violence. We do this by finding out what works and building a movement to put this knowledge into practice.

Children and young people at risk of becoming involved in violence deserve services that give them the best chance of a positive future. To make sure that happens, we'll fund promising projects and then use the very best evaluation to find out what works. Just as we benefit from robust trials in medicine, young people deserve support grounded in the evidence. We'll build that knowledge through our various grant rounds and funding activities.

And just as important, is understanding children and young people's lives. Through our Youth Advisory Board and national network of peer researchers, we'll ensure they influence our work and that we understand and are addressing their needs. But none of this will make a difference if all we do is produce reports that stay on a shelf.

Together, we need to look at the evidence and agree what works, then build a movement to make sure that young people get the very best support possible. Our strategy sets out how we'll do it. At its heart, it says that we will fund good work, find what works and work for change. You can read it here.

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The Centre for Health Services Studies is the largest research centre in Kent. It has over 70 staff members, all committed to delivering impactful applied health and social care research.

Prioritising a creative, inclusive research culture, we build the evidence base for policy and practice to prevent ill health, promote well-being and meet care needs, focusing on primary and community services, public health and social care and working with academic collaborators across the UK and the world.

As well as providing health and social policy insights for national decision-makers, we work with local government and health services across Kent, Surrey and Sussex to build research capacity and culture and address key health and social care research needs across our region.

The Centre of Research and Education in Forensic Psychology is a world leader in research and teaching on:

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Some of our current projects focus on specific forensic challenges:

- Arson and fire setting
- Cruelty towards non-human animals
- Harmful sexual behaviour in an online world
- Intergroup and interpersonal aggression and violence
- Prison gangs and street gangs
- Sexual abuse of children

Acknowledgements

Intervention Delivery team

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Participating staff in police forces in Kent, Cornwall, Sefton and Wigan.

Executive summary

The project

Re-Frame is a diversion programme for 10–17-year-olds in police custody who have been found in possession of class B or C controlled drugs. It aims to reduce substance use and offending by providing two one-to-one sessions, approximately 45-60 minutes each, with a qualified youth substance misuse worker. The programme was designed and delivered by WithYou, a drug, alcohol and mental health support charity. In session one, the 'Drug Triangle' is used, an exercise designed to build self-efficacy. Session two involves using the 'Drugs Grid', an exercise that teaches children and young people about different substances, aiming to dispel myths and provide information on the effects of different drugs. Children are also encouraged to reflect on how their actions have affected their lives, their family and the wider community.

The Youth Endowment Fund (YEF) funded a randomised controlled trial of Re-Frame, with participants randomised to either receive the Re-Frame programme or business as usual. Business as usual consisted of a single, routine conversation offering advice, information and signposting, including details of local WithYou drug and alcohol services. The evaluation aimed to establish whether Re-Frame reduced the number of offences committed by young people six months after the trial. It also measured the impact on the frequency of substance use and self-reported offences and the effect on emotional regulation, prosocial behaviour, peer problems, hyperactivity and conduct problems, well-being, quality of life, self-efficacy, motivation to change and beliefs about the benefits of drug use. A total of 364 children in Kent, Cornwall, Sefton and Wigan police force areas who had been arrested and were considered suitable for diversion took part in the trial. 184 young people received Re-Frame, and 180 joined the control group. The trial included an implementation and process evaluation, which involved 15 interviews with young people, 14 interviews with the staff who delivered the intervention and police officers and three focus groups with family support workers, substance use practitioners, local authority commissioners, criminal justice staff, safeguarding leads and young people recovery workers. The study took place between February 2022 and February 2025. 89% of children in the trial were White; 6% were from mixed or multiple ethnic groups; 2% were Asian or Asian British; 2% were Black, Black British, Caribbean or African; and 4% identified as coming from another ethnic group.

Key conclusions
Re-Frame demonstrated **a moderate negative impact** on children's offending. Children who received Re-Frame were more likely to offend than children who did not receive Re-Frame. There is uncertainty surrounding the estimate. This result has **a moderate security rating**.
Re-Frame showed mixed results on secondary outcomes: a small positive impact on emotional regulation, beliefs about the risks of substance use and beliefs about benefits from drug use; and a moderate positive impact on frequency of substance use, peer problems and self-efficacy. Re-Frame showed a small negative impact on hyperactivity/inattention behaviours, well-being and quality of life and a moderate negative impact on self-reported offences, prosocial and conduct behaviour, and motivation to change. These are secondary outcomes and should be treated with caution.
Re-Frame was well received by the participants and staff involved, and compliance was very high. The young people found the content informative and reported that the substance misuse workers were friendly and really listened to them in a non-judgemental way. Police officers and senior management perceived Re-Frame to be valuable, especially for first-time and low-level offenders.
The participants were relatively infrequent substance users of class B or C controlled drugs who did not perceive their use of the drugs as a problem. In qualitative interviews, many of the young people described cannabis as harmless or a substance they used to self-medicate the experience of neurodivergence.
Some staff thought that, while the programme could slot in quite easily to current services without major structural change, two sessions might not be enough time to change substance use and offending behaviours.

YEF security rating

These findings have a **moderate** security rating. The trial was a well-designed two-armed randomised controlled trial that was randomised at the individual level. Attrition and risk of bias were very low; very few children (1.1%) who started the trial were not included in the final analysis. No significant threats to internal validity were identified. However, trials that aim to measure the impact on offending often require very large sample sizes to detect meaningful impacts, and in this trial, the sample size was smaller than ideal.

Interpretation

Re-Frame demonstrated **a moderate negative impact** on children's offending behaviour. Children who were diverted due to being in possession of class B and C controlled drugs and who received Re-Frame were, six months after entering the trial, slightly more likely to offend than children who were diverted but did not receive the programme. This result has a **moderate security rating**. Re-Frame showed mixed results on secondary outcomes: a small positive impact on emotional regulation, beliefs about the risks of substance use and beliefs about benefits of drug use and a moderate positive impact on the frequency of substance use, peer problems and self-efficacy. Re-Frame showed a small negative impact on hyperactivity/inattention behaviours, well-being and quality of life and a moderate negative impact on self-reported offences, prosocial and conduct behaviour, and motivation to change. These are secondary outcomes and should be treated with caution. There is statistical uncertainty regarding all outcomes, and the findings are also consistent with there being no impact.

The theory of change for Re-Frame, which hypothesised that a brief drug education would reduce substance use and, in turn, reduce offending, is not supported by the findings of this evaluation. Qualitative findings suggest many young people did not perceive their substance use as problematic, with cannabis often described as harmless or used to manage neurodiversity, and this might have reduced the young people's motivation to change their behaviours. The study participants were relatively infrequent substance users, and around three-quarters did not offend in the six months before or after the trial, partially limiting the scope for detectable impact. Some staff also questioned whether two sessions were sufficient to influence substance use or offending, given the time required to build rapport and trust. For this study, the young people who had been found with class A substances were excluded at the request of the police; more research is needed to assess whether substance use interventions may be better targeted at young people who screen positive for a substance use disorder.

Minority ethnic children were under-represented in referrals and trial participation, and the study was unable to explore equity in diversion decision-making because of data issues. Further research is needed to understand how diversion operates across different ethnic groups.

The trial was designed to test the impact of Re-Frame as an intervention used in a diversion context, not as a diversion overall. While Re-Frame did not show a positive impact on offending, the wider evidence base suggests that diversion, on average, reduces reoffending and violence. Diversion schemes that include the provision of support for drug and alcohol use, family relationships, school engagement and self-esteem show stronger reductions in violence and crime. This report, and the primary and secondary outcome findings, only presents the findings of one study. When making decisions about diversion and associated support, practitioners and commissioners should consider this study alongside the broader evidence and use their professional judgement.

Summary of impact

Outcome	Effect size (95% confidence interval)	Impact	Evidence security	No. of children	P-value
Number of offences in the six months post-randomisation	0.18 (−0.01 to 0.36)	Moderate negative		360	0.097

Introduction

Background

Adolescence is a critical developmental stage where young people make behavioural and lifestyle choices that have the potential to impact their health and well-being into adulthood. While risk-taking is important for healthy psychological development, for many, inappropriate risk-taking is significantly associated with health and social harm during adolescence, and these harms persist well into adulthood (Odgers et al., 2008). Young people are much more vulnerable than adults to the adverse effects of substance use because of a range of physical and psychological factors that often interact and the differential impact of substances on the developing brain (Battistella et al., 2014; Copeland et al., 2013; Parlar et al., 2021). Substance use is defined as the use of alcohol, controlled drugs or novel psychoactive substances or the inappropriate use of prescribed medication. In addition to an increased risk of accidents and injury (National Health Service [NHS], 2018), substance use in adolescence is also associated with poor educational performance and exclusion from education. Over the academic years 2023–2025, almost 6% of permanent school exclusions in state secondary schools were due to alcohol and substance use (Department for Education [DfE], 2025). In the longer term, substance use is also associated with the increased prevalence of non-communicable diseases such as cancer, cardiovascular disease and gastrointestinal disorders (Aldington et al., 2008; World Health Organization [WHO], 2014). 13% of those aged 14 years and 23% of those aged 15 years reported having used drugs in the last year, and 2% of 14-year-olds and 4% of 15-year-olds reported using class A substances at least once (NHS, 2023).

While the relationship between criminal activity and substance use is complex, there is clear evidence that the prevalence of substance use is far higher in the youth offending population than in the general youth population. Approximately 25% of young people engaged in structured alcohol and substance use treatment are referred from criminal justice (Office for Health Improvement and Disparities [OHID], 2022), and data derived from the youth offending team AssetPlus system indicates that most young people in the criminal justice system (CJS) use substances (76%) and 72% have a mental health need (Youth Justice Board, 2020). The Juvenile Cohort Study indicates that 32% of young offenders score 2 or more on the ASSET tool for substance use, indicating that substance use is at least in part a reason for them engaging in criminal activity, and 12% score 3+ (Wilson, 2013,Youth Justice Board., 2006). While the relationship between substance use and criminal activity is complex, it is clearly a major issue in the youth offending population.

In the CJS, substance use and offending are related in the context of other forms of disinhibitory behaviour, such as aggression and risk-taking. Young people who offend experience a range of complex multiple risks and vulnerabilities, including neglect and abuse (Moustafa et al., 2018; Social Exclusion Unit, 2002), substance use and related problems (Coffey et al., 2003), and exclusion from school (Galahad Substance Misuse Solutions, 2004; Arnez and Condry, 2021). Research has shown that young people who offend are more likely to experience a range of inequalities in later life, for example, worse physical health (Coffey et al., 2003), early pregnancy (Ritakallio et al., 2005), higher rates of tobacco use and drug and alcohol dependence (Bardone et al., 1998; Galahad Substance Misuse Solutions, 2004, 2009; Lennox, 2014), reduced employment opportunities, and increased economic hardship (Willmott and van Olphen, 2005). Indeed, there is widespread agreement that young people who offend are at increased risk of health and social problems, making them one of the most vulnerable populations in the UK (British Medical Association [BMA], 2014). Furthermore, the UK has one of the highest youth custody populations in Western Europe

(Khan, 2010). Epidemiological studies highlight the fact that, in common with other vulnerable groups of young people, such as the homeless and those in care, young offenders are a hard-to-reach group from a health needs perspective, only accessing physical and mental health services in times of crisis, with such access often being associated with involvement with other agencies (Anderson et al., 2004; Bardone et al., 1998; Stallard et al., 2003). The experiences associated with criminality, police involvement, legal issues and potential detention are traumatic and stressful and associated with higher levels of mental illness in this population (Lennox, 2014).

Evidence from the Youth Endowment Fund's (YEF's) *Children, violence and vulnerability* report (YEF, 2024) highlights the link between substance use and offending, with rates of substance use significantly higher among the victims and perpetrators of violent offences: 19% of victims and 22% of perpetrators of violent crimes reported cannabis use in the past 12 months, compared to 6% who had not experienced violence. Substance use overlaps with poor mental health, disengagement in education, gang membership and involvement in crime. Young people view substance use as a major factor associated with youth violence in their area, with 66% seeing substance use, 65% addiction and 64% drug supply as major drivers in the committing of violent offences. Since 2009, there has been a reduction in the number of young people accessing substance use services: 16,212 in 2024–25 versus 24,494 in 2008–09. This is in part associated with reduced funding for services. It is critical that substance use services provide appropriate support for young people who use drugs and often have complex and multiple vulnerabilities.

Ethnic minorities, particularly Black boys, are disproportionately represented in the offending statistics, both as victims and perpetrators of crime. Data from the Youth Justice Board in 2024 highlights that while 6% of young people in the UK aged 10–17 years are of Black heritage, they represent 20% of those stopped and searched, 12% of those arrested, 11% of those cautioned and 26% of those in custody. The reasons for this disproportionality are complex, but many ethnic minority groups are more likely to experience discrimination, poverty, neighbourhood deprivation or exclusion from school; have emotional and mental health needs; use drugs; or be less likely to have access to early intervention. All of these are key risk factors for offending.

While the prevalence of substance use in the past year for those aged 11–15 years is similar across ethnicities – except for Asian populations, who have a lower prevalence (odds ratio [OR] = 0.39; 95% confidence interval [CI] = 0.19 to 0.81) – the proportion of those receiving treatment is far lower: 5% of ethnic minorities versus 89% White British. The reasons for this disparity include a lack of awareness of available services, a lack of culturally sensitive services and a lack of trust, which stems from previous negative experiences with services. Furthermore, the complexities of the intersectionality of marginalised communities also play a role in an individual's openness to engage with and their experience of a range of support and statutory services, from healthcare to the justice system.

The Youth Justice System in England and Wales works to prevent offending and reoffending by those under the age of 18 years. The latest available data indicates that there were 19,000 arrests of young people in 2019, which is an 82% drop from 2009 (Youth Justice Board, 2020). Of these, boys made up 83%, and the average age was 15.3 years. Over the same period, there were 11,000 first-time entrants to or first reprimands or warnings of community conviction given by the Youth Justice System, which is a reduction of 84% since 2009 (Youth Justice Board, 2020). It is estimated that 38.5% of new offenders go on to reoffend after serving their initial sentence (Youth Justice Board, 2020). The Crime and Disorder Act 1998 is clear that the principle of youth justice is prevention; diverting young people away from youth justice is a critical part

of achieving this goal. A number of pathways exist for young people found in possession of illicit substances; these include out-of-court disposals, where young people are not formally charged but instead dealt with by the police. This approach might also include referrals to specialist services for intervention, community resolutions, formal cautions and conditional cautions. An international systematic review and meta-analysis (Petrosino et al., 2010) that included 22 studies and surveyed 7,300 young people found that formal processing within youth justice services appears to increase rather than reduce offending. In the UK, similar effects have been observed; the *Edinburgh study in youth transitions and crime* (McAra and McVie, 2007) found that young people brought to court were twice as likely to commit another offence within 12 months than a matched sample who had not been brought to court, and a study in Northamptonshire (Kemp et al., 2002) found that prosecution increased the likelihood of reoffending compared to that of a similar matched sample. Being arrested constitutes an opportunistic 'teachable moment' that can act to maximise the effect of a behaviour change intervention (Lawson and Flocke, 2009).

The number of young people arrested rose sharply between 2002 and 2006 and then dropped sharply between 2006 and 2014, in part due to a concerted policy effort to divert young people away from the CJS. Recent research by the Nuffield Foundation (Brodie et al., 2025) highlights that the diversion from CJS has not been applied to all young people in the same way; while first-time entrants to the CJS fell on average by 78%, this fall is far greater for young people with a White background than for those with a minoritised background. In 2022, 73% of young White people were given a community resolution as an alternative to court, with the equivalent figure for young Black people being 66%.

Systematic reviews of interventions for substance-using offenders to date have not identified a clear, evidence-based intervention strategy (D'Amico et al., 2013; Henderson et al., 2016; Perry et al., 2006, Perry et al., 2019a; Perry et al., 2019b), but they have highlighted the paucity of good-quality research in the area and the lack of UK-based and scientifically rigorous studies focusing on young offenders. A recent meta-analysis of 22 studies (Steele et al., 2020) synthesised the evidence regarding the use of motivational interventions for adolescents (age 12–20) who use substances. Results showed that, compared to treatment as usual, the use of motivational interventions reduces heavy alcohol use days by 0.7 days per month (95% CI = –1.6 to –0.02), substance use days by 1.1 days per month (95% CI = −2.2 to –0.3) and overall substance-related problems by a standardized net mean difference of 0.5 (95% CI = –1.0 to 0.0). Further, a meta-analysis addressing brief interventions for co-occurring alcohol and illicit substance use among adolescents found a significant benefit for both alcohol and substances if the specific illicit substance use was addressed at the same time (Tanner-Smith et al., 2015). Brief psychosocial interventions delivered using a motivational interviewing approach within a FRAMES paradigm have shown evidence of potential effect among adolescents (Steele et al., 2020, Winters and Leitten, 2007); they offer an opportunity to allow structured reflection on substance use and identify strategies to enhance self-efficacy, manage expectancies and motivation to change. The FRAMES approach (Miller, 1994) highlights six key aspects of behavioural change interventions: providing feedback on the relationship between substance use and behaviour; identifying the individual as being responsible for change; offering advice and managing ambivalence; providing a menu of options for change; being supportive and empathetic; and enhancing the individual's self-efficacy.

Drug education and skill development are widely used in drug prevention, health promotion and treatment plans. In a literature review of best practice, Darcy (2021) identified key elements of an effective drug education. These include multi-component programmes that incorporate an understanding of drugs and drug-related harm, as well as multiple structured skill development sessions in how to manage risk, age and

developmental appropriateness, understanding and communicating risk, and dispelling misconceptions. The Re-Frame intervention builds on both the FRAMES approach to behaviour change and best practice in drug education and skill development.

A pilot evaluation of the Re-Frame intervention was conducted and 76 participants were recruited, 38 in each of the intervention and control groups. In the pilot evaluation, we set several a priori parameters that would indicate whether an efficacy study was feasible. All these criteria were met: 93% of those referred were eligible and of these, 80% consented, 92% adhered to all the interventions and 88% were followed up at six months. The primary outcome was available for 100% of participants (Coulton et al., 2023).

The qualitative analysis found the intervention was considered acceptable to all stakeholders: the young people, the interventionists and the police. The qualitative analysis found no substantial hindrances to the implementation of the Re-Frame intervention, but it did highlight some areas where improvements to the referral processes could be made. These included raising awareness within the police and streamlining referral pathways.

This trial was a mixed methods prospective — an individually randomised efficacy trial with equal probability of being allocated to one of two arms: the Re-Frame intervention or control. The trial included an implementation and process evaluation[1].

Intervention

After a young person received either the intervention or control, they were referred back to the police, who entered no further action (NFA), and the young person received no formal police charge. If a young person did not attend the intervention or control, they were referred back to the police as non-compliant, and the police took whatever action they would take in the absence of a diversion scheme. Intervention and control were delivered by staff employed by WithYou, a non-statutory young people's substance misuse service in the participating areas.

Re-Frame intervention group

Two sessions of brief intervention were delivered, each lasting 45–60 minutes, one week apart and delivered by skilled young people's drug and alcohol workers with a minimum level of qualifications (such as a NVQ level 3 in tackling substance misuse) and experience of working with vulnerable young people (including those who used drugs or alcohol). Staff training was conducted by a senior young people's substance misuse worker and was overseen by the service manager. The training was delivered online over a working week; an assessment of competence and ongoing supervision were provided monthly. The intervention was delivered either in person or online, according to the young person's preference, and the young person was allowed flexibility in how both parts of the intervention were delivered. In the pilot study, for example, some decided to 'walk and talk'; the content of the intervention remained the same irrespective of the mode of delivery. In the session, the young people used a Drugs Grid based on work by Zinberg (1984) to reflect on how their actions had affected their lives, their family and the wider

[1] A full protocol for the efficacy study and the statistical analysis plan are available at the following locations: https://youthendowmentfund.org.uk/wp-content/uploads/2023/07/Re-Frame-Evaluation-protocol.pdf; https://youthendowmentfund.org.uk/wp-content/uploads/2024/03/Re-Frame-SAP-Mar-24.pdf.

community. The young person had the opportunity to recall their arrest experience and explain how this had impacted them. The practitioner helped the young person to critically reflect on this event and offered support in relation to the trauma or consequences the young person felt.

The first brief intervention session used the Drug Triangle, based on an in-house psycho-education tool, delivered one week after session one. Using the Drug Triangle, the young person focused on the fixed nature of the substance use mindset (Dweck et al., 1995). Young people see their beliefs and behaviour as static, where they lack agency to change. The exercise aims to provide skill development in situational confidence and self-efficacy; enhance motivation to change; and develop a growth mindset, whereby the young person can embrace challenges, develop new strategies and learn from prior mistakes. The exercise also explored what led the young person to the session, including the relevant legislation and how that legislation had been applied in their situation. The young person spent time reflecting on how their arrest has affected them, their family, their school (if applicable) and their community. At the end of the session, the participant was advised about their rights in relation to stop-and-search procedures, should they require it in the future, as well as about assertion techniques and other advice relating to the procedure itself.

The second brief intervention session, the Drugs Grid, was a drug education exercise that enabled the young person to demonstrate their current understanding of substances (including medication, novel psychoactive substances and image- and performance-enhancing drugs). As they went through the exercise, the young person learned about these substances (e.g. depressants and psychedelics), being led by their own experience and building on their knowledge base. The worker could dispel myths and provide information on the effects of each substance, including the risks of polydrug use and overdose (Zinberg, 1984). The exercise addresses the young person's ambivalence regarding the negative and positive expectancies associated with substance use.

In the pilot study, the Drugs Grid was delivered as session 1, and the Drug Triangle was delivered as session 2. After feedback from participants, it was decided to reverse the order of session delivery for the efficacy trial. To address any potential impact the order of delivery had on the study outcomes, 'pilot versus efficacy' was included as a fixed effect in the analysis.

At the end of the two sessions, the aim was that the young person would have greater clarity about the risks they had taken; the links between substance use, risk-taking behaviour and offending; and the potential for criminal prosecution. The short-term aims are that the young person will have a greater understanding of their personal needs, increased confidence to reduce substance use and a positive shift from precontemplation to action and maintenance in the cycle of change. The logic model for the intervention is presented in figure 1.

Figure 1: Logic model of the Re-Frame intervention

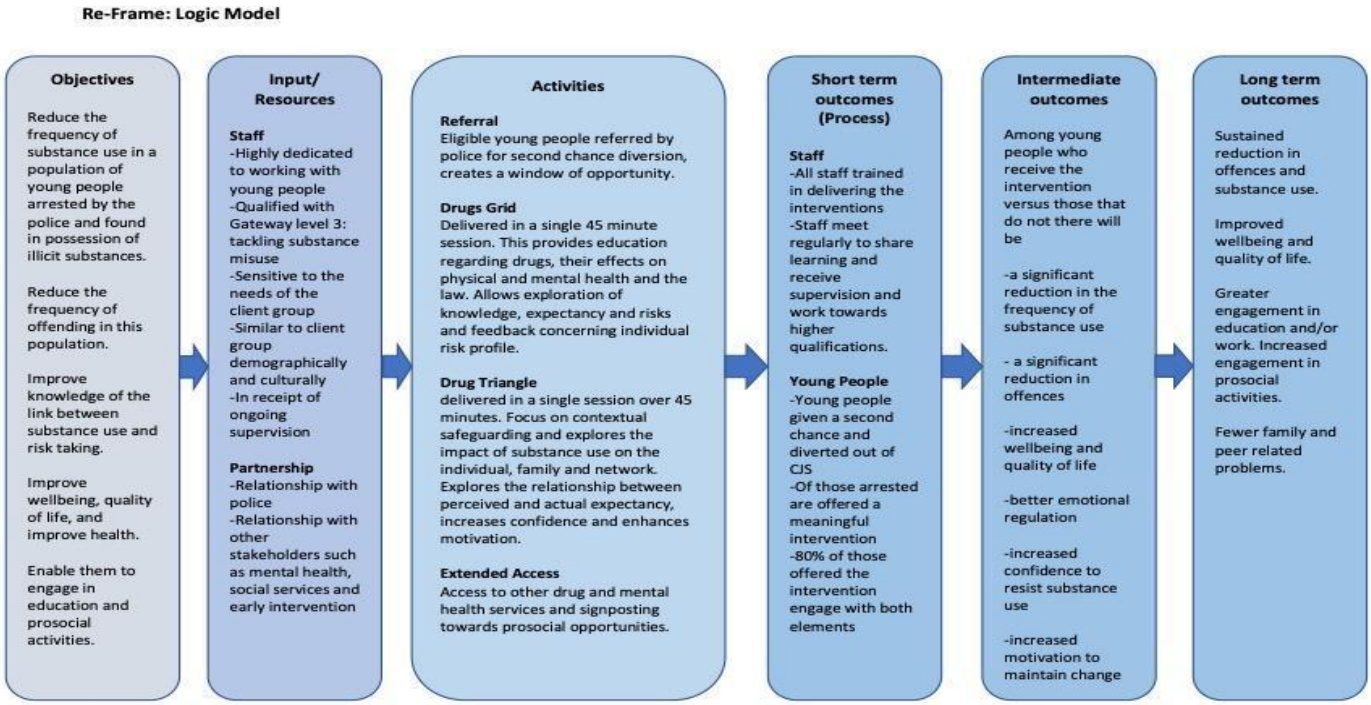
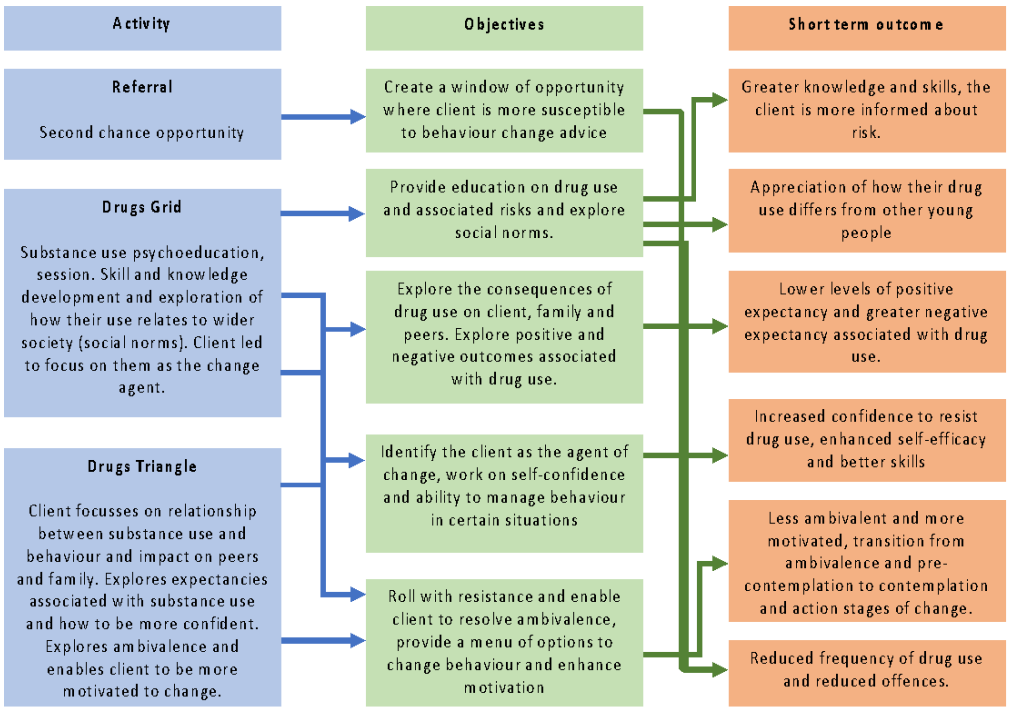


Figure 2 highlights how the overarching theory of change links intervention activities with objectives and outcomes.

Figure 2: Re-Frame intervention: theory of change blueprint



Control group

The young person received one advice, information and signposting session; was offered information about the WithYou drug and alcohol service in their local area; and was encouraged to access the service for support if required. Advice, information and signposting is a tier 1 universal level of support. It is unstructured, is based on a conversation only and is business as usual for initial referrals to the service.

Staff delivering the intervention and control were trained in delivering interventions in a way that takes account of the cultural sensitivities of young people; steps were taken to make an ethnically diverse staff population available and to provide translators, if required. The young person chose where and how the intervention and control were delivered (online or in person by the drug and alcohol service, in a community setting or at school). The intervention and control and all materials were reviewed by a young people's advisory group that consisted of a range of ethnicities, neurodiversities and backgrounds.

Evaluation objectives

Primary research question

RQ1 What is the difference in the number of offences committed (derived from the local police database) in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

Secondary research question

RQ2 What is the difference in the frequency of alcohol and substance use, in terms of per cent days abstinent, in the 28 days prior to the six-month post-randomisation follow-up for those receiving the Re-Frame intervention versus those receiving the control?

RQ3 What is the difference in self-reported delinquency, derived from the volume score of the Self-Report Delinquency Scale (SRDS), in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

RQ4 What is the difference in emotional regulation, prosocial behaviour, peer problems, hyperactivity and conduct problems, derived from the Strengths and Difficulties Questionnaire (SDQ), in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

RQ5 What is the difference in well-being, derived from the Short Warwick–Edinburgh Well-Being scale (SWEMWBS), in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

RQ6 What is the difference in quality of life, derived from the Child Health Utility Scale (CHU-9D), in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

RQ7 What is the difference in substance use self-efficacy, derived from the Situational Confidence Questionnaire (SCQ8), in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

RQ8 What is the difference in motivation to change, derived from the Readiness Ruler (RR), in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

RQ9 What is the difference in positive and negative expectancies, derived from the Substance Use Expectancies Scale (SUES), in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

RQ10 What factors – age, sex, ethnicity, material deprivation (index of multiple deprivation [IMD]), family environment (BFES), adverse childhood experiences (ACEQ), adherence, depression (PHQ9), anxiety (general anxiety disorder [GAD]) – impact the primary outcome observed for both groups?

RQ11 What factors – age, sex, ethnicity, material deprivation (IMD), family environment (BFES), adverse childhood experiences (ACEQ), adherence, depression (PHQ9), anxiety (GAD) and therapeutic alliance – impact the primary outcome observed for the intervention group?

RQ12 Are there potential interactions between demographic factors and the outcome observed for the primary outcome six months after randomisation?

RQ13 Are there differences in the number of offences at six months for the participating sample versus a cohort of young people found in possession of class B or C substances who were not referred to the study?

RQ14 What is the cost per participant of delivering the Re-Frame intervention?

Ethics and trial registration

Ethical guidance was sought prior to embarking on participant recruitment and was provided by an independent ethics committee: University of Kent Social Science Research Ethics Committee, Ref. SRC0498.

The trial was registered (ref: ISRCTN 28516899) and is available at https://www.isrctn.com/ISRCTN28516899.

Data protection

All systems and personnel were approved for the management of clinical and sensitive data and are certified as meeting ISO 27001 requirements. This includes all physical systems, systems to detect intrusion, encryption of data from the point of collection to storage, quality assurance and any audit trails associated with the data collected. All identifiable data collection was performed with explicit consent and limited to data that would allow participants to be contacted for follow-up. Data linkage involves employing a unique identifier, where the link to identifiable information is stored on an encrypted secure database. Researchers were trained to good clinical practice (GCP) standard and complied with all relevant data protection legislation. Once the final follow-up had been completed, personally identifiable information was deleted from the data set held by the university, and where consent had been granted, encrypted data was transferred to the YEF data archive. Data collection and management were governed by a trial-specific standard operating procedure agreed and approved by the ethics committee.

The public task basis was used as the basis for processing personal data. We only used special category information (such as information about health, religion, race or ethnic origin or any criminal offence information) if it were necessary for research or statistical purposes that are in the public interest. Potential participants and their carers, if applicable, were provided with a trial-specific privacy notice (Appendix C) prior to providing consent. This privacy notice outlined what data was being collected, for what purposes and for how long. In addition to the trial-specific privacy notice, the evaluation team at the University of Kent, the intervention delivery team at WithYou and each participating police force signed an information-sharing agreement highlighting what information would be shared, the reasons for sharing information and the means of sharing information.

Project team / stakeholders

Evaluation team

Professor Simon Coulton: Principal Investigator and Quantitative Methodologist, University of Kent.
Nadine Hendrie: Trial Manager, University of Kent.
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Intervention Delivery team
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The Intervention Delivery team played a role codesigning and conducting the research study by delivering the allocated intervention; they played no role in the analysis of the study. The study was funded by a grant from the YEF.

The Evaluation team has no conflicts of interest to declare.

Methods

Trial design

Table 3: Trial design

Trial design, including the number of arms		Two-arm individually randomised efficacy trial with embedded internal pilot
Unit of randomisation		Participant
Stratification variables (if applicable)		Site (Kent, Cornwall, Sefton, Wigan); age group (10–14, 15–17 years)
Primary outcome	Variable	Count of all offences six months post-randomisation
	Measure (instrument, scale, source)	Local police databases
Secondary outcome(s)	Variable(s)	Self-reported offences, emotional regulation, substance use frequency, psychological health and well-being, situational confidence, readiness to change, expectancies
	Measure(s) (instruments, scales, sources)	Self-Report Delinquency Scale (SRDS), Strengths and Difficulties Questionnaire (SDQ), Timeline Follow-Back (TLFB28), Short Warwick-Edinburgh Mental Well-being Scale (SWEMWBS), Child Health Utility (CHU-9D), Short Situational Confidence Questionnaire (SCQ-8), Readiness to Change Ruler (RR) and Substance Use Expectancy Scale (SUES) at six months post-randomisation
Baseline for primary outcome	Variable	Number of offences in six months pre-randomisation
	Measure (instrument, scale, source)	Local police database
Baseline for secondary outcome	Variable	Self-reported offences, emotional regulation, substance use frequency, psychological health and well-being, situational confidence, readiness to change, expectancies
	Measure (instrument, scale, source)	SRDS, SDQ, TLFB28, SWEMWBS, CHU-9D, SCQ-8, RR and SUES at baseline

The trial was a mixed-methods, prospective, individually randomised efficacy trial with an embedded internal pilot. Participants had equal probability of being allocated to one of two arms: the Re-Frame intervention or the control.

Participants allocated to the control group received one session of advice, information and signposting. The young people were offered information about the WithYou drug and alcohol service in their local area and encouraged to access the service for support if required. Advice, information and signposting is a tier 1 universal level of support. It is unstructured and based on conversation only.

Our primary outcome was a count of offences six months post-randomisation, obtained directly from the local police database.

Frequency of alcohol and substance use was assessed at six months using the Timeline Follow Back (TLFB) method (Levy et al., 2004; Sobell and Sobell, 1995). To minimise the burden on the young people, we used the 28-day version. This tool allowed us to derive the per cent days abstinent (PDA) from alcohol and substance use and allowed the derivation of several other outcomes over the period (e.g. quantity and type of substances consumed). As there is evidence of assessment reactivity being associated with TLFB in brief intervention studies (Clifford and Maisto, 2000), we only measured TLFB at six months and employed a single 'frequency of substance use' question at baseline for inclusion in the analytical model as a covariate.

Mental health and well-being was assessed using the Short Warwick–Edinburgh Mental Well-Being Scale (SWEMWBS; Clarke et al., 2011). Emotional regulation and behaviour were assessed using the self-completed Strengths and Difficulties Questionnaire (SDQ; Goodman, 1997). Self-reported offending was assessed using the Self-Report Delinquency Scale (SRDS; Smith and McVie, 2003) over the previous six months. All these instruments were assessed at baseline and at six months. Health-related quality of life was derived from a short five-level, five-domain instrument used extensively in this population (Child Health Utility [CHU-9D]; Furber and Segal, 2015).

To explore the process of change within the logic model, we assessed three domains that are key targets of brief interventions. Motivation to change was assessed using the Readiness to Change Ruler (RR; Maisto et al., 2011). Self-efficacy was assessed using the short Situational Confidence Questionnaire (SCQ-8; Breslin et al., 1998). Positive and negative expectancy were assessed using a four-item expectancy measure that assesses drug-effect expectancy (Substance Use Expectancy Scale [SUES]; Montes et al., 2019). These instruments were assessed at baseline and at the six-month follow-up point.

In addition to the key demographics and the age, gender, ethnicity and age of first substance use that we assessed at baseline, we used several short validated instruments to assess potential predictors of change and identify potential subgroups within the study. These included a short assessment of the family environment to assess relationships, conflict and cohesion using the Brief Family Relationship Scale (BFRS; Fok et al., 2014), anxiety using the General Anxiety Disorder (GAD-7) questionnaire (Mossman et al., 2017), depression using the Personal Health Questionnaire for Adolescents (PHQ-A; Mansour et al., 2020) and adverse childhood experiences using the Adverse Childhood Experience Questionnaire (ACEQ; Dong et al., 2004).

The internal pilot evaluation of the Re-Frame intervention (Coulton et al., 2023) was conducted and recruited 76 participants, 38 in each of the intervention and control groups. In the pilot, we set several a priori parameters that would indicate whether an efficacy study were feasible. All these criteria were met: 93% of those referred were eligible and of these, 80% consented, 92% adhered to all the intervention and 88% were followed up at six months. The primary outcome was available for 100% of participants.

The qualitative analysis found the intervention was considered acceptable to all stakeholders: the young people, the interventionists and the police. The qualitative analysis found no substantial hindrances to the implementation of the Re-Frame intervention, but it did highlight some areas where improvements to the referral processes could be made. These included raising awareness within the police and streamlining referral pathways.

Throughout the design and conduct of the study, we aimed to be inclusive. The trial design and materials were reviewed by a young person advisory group that included a variety of ethnicities, research and intervention materials were available in a variety of languages and translators were made available if necessary. We recognise there was little ethnic diversity in the research team – all of the research team members were White – but there was diversity in the intervention delivery team, including staff who were Black and Asian. A limiting factor in recruiting participants from a range of ethnicities was the fact that we could only recruit from the pool of participants who had been referred by the police for diversion; some ethnicities, particularly young Black people, were significantly under-represented in this pool of potential participants.

Participant selection

Participants were assessed for initial eligibility by police custody staff in the participating areas: Kent, Sefton, Cornwall and Wigan. Inclusion criteria included being aged 10–17 years inclusive and being found in possession of class B or C controlled substances; those in possession of class A substances were excluded at the request of the participating police forces. Young people were excluded if they had been arrested for a sexual or serious violent offence, had a history of four or more previous offences or had a substance misuse severity that required specialist clinical intervention (such as detoxification or medically assisted maintenance). Assessment of need for specialist intervention was made in police custody, initially by custody staff and confirmed by police custody medical staff. All eligible participants were referred to WithYou using a secure criminal justice email system.

Staff at WithYou established whether potential participants were interested in participating in the trial, and if they were, the staff provided a paper or email copy of the information sheet and passed their contact details to the trial research staff. If the young person was not interested in participating, they were processed as usual by the police. For those willing to participate, trial research staff contacted the young person, checked they understood the information sheet and answered any queries. If the young person was considered Gillick-competent, full signed consent was taken. Gillick competence is particularly relevant to children under 16, who are considered to have the capacity to consent if they have sufficient understanding and intelligence to fully understand what is involved in a research study, including its purpose, nature, likely effects and risks, and chances of success and the availability of other options. Gillick competence was assessed by specifically trained staff. If a young person was not considered Gillick-competent, signed assent was taken from the young person and formal consent from a primary carer.

Immediately after consent, the young person completed the baseline outcome measures and was immediately randomised using a remote, independent secure randomisation service, Sealed Envelope, to the Re-Frame intervention or the control. WithYou was informed of the allocation and delivered the allocated intervention.

Participants could decide how they preferred the intervention to be delivered. This could be in person at WithYou offices, at school or at a youth centre or delivered remotely using video technology. Six months after randomisation, the researcher contacted the young person by telephone or email and conducted the six-month outcome assessment.

Outcome measures

Primary outcome

Our primary outcome was the count of offences six months post-randomisation, which was obtained directly from the local police database. Police data officers at each site were sent the unique identifier, name, date of birth and date of randomisation of each of the young people participating in the study by secure email. They returned data on offences for the six months prior to randomisation and six months post-randomisation using secure email with the participant's name, date of birth and date of randomisation removed. The data was then matched with other outcome data using the unique identifier.

Secondary outcomes

Frequency of substance use was assessed at six months using TLFB-28 (Levy et al., 2004, Sobell and Sobell, 1995), which is a valid and reliable tool for assessing the frequency and quantity of multiple substances (Martin-Willett et al., 2020) over time periods ranging from 1 to 365 days. TLFB-28 is validated specifically for adolescents (Levy et al., 2004) and is used in studies of adolescents in criminal justice settings (Coulton et al., 2023; Dakof et al., 2015). To minimise burden, we used the 28-day version, which takes about 10 minutes to complete and demonstrates an excellent level of agreement with longer versions (Robinson et al., 2014). This tool allowed us to derive the PDA from substance use and the derivation of several other outcomes over the period (e.g. the quantity and type of substances consumed). As there is evidence of assessment reactivity being associated with TLFB in brief intervention studies, we only measured TLFB at six months and employed a single 'frequency of substance use' question at baseline for inclusion in the analytical model as a covariate. The single frequency question asked on how many days in the past 28 days the young person had used alcohol and/or substances.

Mental health and well-being was assessed using SWEMWBS (Clarke et al., 2011), which is a seven-item self-completed scale addressing different aspects of eudemonic and hedonic mental well-being.

Health-related quality of life was derived from a short five-level, five-domain instrument used extensively in this population (CHU-9D; Furber and Segal, 2015).

Emotional regulation and behaviour were assessed using the self-completed SDQ (Goodman, 1997), which assesses behaviour across several domains: conduct, hyperactivity, emotional regulation, peer relationships and prosocial behaviour. Self-reported offending was assessed using the SRDS (Smith and McVie, 2003) over the previous six months. All these instruments were assessed at baseline and at six months.

To explore the process of change within the logic model, we assessed three domains that are key targets of brief interventions. Motivation to change was assessed using the RR, a single question that assesses motivational stage in adolescents (Maisto et al., 2011). Self-efficacy was assessed using the short SCQ-8 (Breslin et al., 1998). Positive and negative expectancy were assessed using a four-item expectancy measure that assesses substance use expectancy (SUES; Montes et al., 2019). These instruments were assessed at baseline and at the six-month follow-up point and have established psychometric properties in the adolescent population.

In addition to assessing key demographics such as age, gender, ethnicity and age of first substance use, at baseline, we used several short validated instruments to assess potential predictors of change and identify potential subgroups within the study. These included a short assessment of the family environment,

assessing relationships, conflict and cohesion using the BFRS (Fok et al., 2014); anxiety using GAD-7 (Mossman et al., 2017); depression using PHQ-A (Mansour et al., 2020); and adverse childhood experiences using ACEQ (Dong et al., 2004). All these instruments are validated for use in an adolescent population.

Compliance

We assessed compliance by recording attendance at each element of the intervention and the control. For those in the intervention group, we assessed fidelity by randomly recording 20% of the brief intervention sessions, stratified by age group, interventionist and site, and independently scoring them using the Behavioural Change Counselling Index (BECCI; Lane, 2002). We asked participants in the intervention arm to complete the Short Revised Therapeutic Alliance Scale for Children (TASC-r) after the second intervention session (Shirk and Saiz, 1992). There is emerging evidence that the perceptions of interventionists play a key role in the quality of intervention delivered, particularly in terms of the perceived legitimacy of their role and their self-efficacy, both of which are targets of training and ongoing supervision. To assess these perceptions, we asked interventionists to complete the Drug and Drug-Using Populations Perceptions Questionnaire (DDPPQ; Connors et al., 2019) just prior to training and six months after being trained.

Sample size

Sample-size calculations were derived using Stata 16 SE. In calculating the sample size, we used an effect size difference of 0.3 (Tait and Hulse, 2003), like other studies that address alcohol and/or substance use in adolescents. This equated to a number needed to treat (NNT) of 8, where delivering the intervention to eight young people would result in an important reduction in offences in at least one individual, equating to a 13% difference between the groups in the number of offences in the six months post-randomisation. This equates to a small-to-medium effect size; any smaller is unlikely to have a meaningful effect on the primary outcome. To detect this effect size, or greater, with 80% power, an alpha of 0.05 and a two-sided test requires 350 participants, 175 in each group, followed up at six months. As the primary outcome is sourced independent of the participant, we expected the follow-up rate to be close to 100%, but we erred on the side of caution and allowed a 20% loss to follow-up. This inflated the required sample to 438, 219 in each group. In our pilot study, the consent rate was quite high, about 80%, and the eligibility rate was 88%. In our pilot study, we successfully recruited 76 young people, leaving 362 to recruit in the efficacy study. As our actual follow-up rate for the primary outcome was 99.2%, the recruitment of 364 young people across both the pilot and efficacy studies was sufficient to provide an adequate sample. We included 360 young people in the intention-to-treat analysis, slightly more than the estimated 350 required (for three participants, police data was not available, and one participant was deceased). Using the same parameters as the original sample size calculation, 80% power, an alpha of 0.05 and a two-sided test meant the detectable effect size reduced from 0.3000 to 0.2961.

Randomisation

Individual participants were randomised according to a schedule provided by Sealed Envelope, an independent secure health research provider. Allocation strings were developed, encrypted and embedded within a third-party allocation programme. Random permuted blocks of varied length were used (4, 6 and 8), stratified by site (Kent, Cornwall, Sefton and Wigan) and age group (10–14 and 15–17 years). Baseline measures were collected prior to randomisation, and researchers were not blind to individual randomisation assignment at the six-month follow-up assessment.

Statistical analysis

The analysis plan was developed a priori before randomisation commenced, and all analyses were conducted using Stata 16 SE. In the overall analysis, data from the internal pilot and efficacy study were combined and analysed blind to group allocation. The overall efficacy analysis was conducted and presented in accordance with CONSORT guidelines. The validity of randomisation was explored by presenting measures of central tendency and estimates of precision for continuous variables and proportions for categorical variables, broken down by allocation arm and stratification factors.

Primary analysis

The primary outcome was the number of offences recorded by the police in the six months after randomisation. The primary analysis was based on the intention-to-treat data set. This contained all available data for participants, who were randomised regardless of whether they had complied with their allocation. This data set included participants who were/had withdrawn from the trial post-randomisation, unless withdrawn participants specifically requested that their data not be included in the analysis. These analyses are a lower bound estimate of treatment effects, as they represent the effect of offering an intervention, rather than the effect of receiving an intervention.

An examination of the distribution of the primary outcome indicated over-dispersion with zero inflation, where the conditional variance was far greater than the conditional mean. To address this in the analysis, we employed a negative binomial regression model adjusted for the baseline value of the primary outcome (volume score in the six months prior to randomisation), the stratification variables (age group and site) and whether the participant was part of the internal pilot or efficacy trial population (as a fixed effect) and their allocated group. Marginal mean differences between the groups and associated 95% CIs were derived:

$$log\ log\ (m6offence)\ = \alpha + \beta(m0offenc) + \beta(site) + \beta(agegrp) + \beta(study).$$

Secondary analysis

Secondary outcomes were analysed using an appropriate regression approach that accounted for both the distribution and the numeric form of the outcome. Each regression was adjusted for the baseline values of the outcome and the stratification variables (age group and site), with whether the participant was part of the internal pilot or efficacy trial population included as a fixed effect. Results are presented as marginal means, mean differences and the associated 95% CI.

The PDA in the past 28 days at the six-month end point was analysed using a fractional regression approach, because PDA is a proportion constrained by 0 and 1. Mental health and well-being, assessed using SWEMWBS at month 6, and emotional regulation and behaviour were analysed using an ordinary least squares (OLS) linear regression as the distribution tended to normality. The volume score of the SRDS at month 6 exhibited a similar distribution to the offence data, showing over-dispersion and zero inflation. This was analysed using a negative binomial regression.

No interim analysis was undertaken.

Analysis in the presence of non-compliance

We planned to assess treatment effects in the presence of non-compliance for the primary outcome, with compliance measured at the individual level, and to include all those allocated as part of the trial in an instrumental variable framework (Complier Average Causal Effect [CACE]).

Compliance was defined as attending the two sessions of the Re-Frame intervention. Compliance was high (89%) in the intervention group. CACE employs a two-stage least squares approach. The crucial first stage involves the generation of a prognostic model of compliance and the use of that model to identify those in the control group who would not have complied if they had been offered the intervention. It was not possible to fit a model at this first stage, probably because of an information deficit due to a high compliance rate.

To explore the potential impact of compliance with the intervention, we used a per-protocol (PP) data set. This contained all the data of participants who completed the trial as planned – in treatment and control groups – and without any major protocol violations or exclusions. PP analysis essentially drops those individuals who have not strictly complied with their allocated treatment. This means that PP represents a likely best case scenario for treatment effect estimation. The primary outcome was analysed with the PP dataset, using the methods employed for the primary analysis, a negative binomial regression model adjusted for the baseline values of the primary outcome, stratification factors and an indicator of study as a fixed effect.

Missing data analysis

In our statistical analysis plan, we stated that we would explore the pattern of missing data and data imputation if the quantity of missing data on the primary outcome exceeded 5% at the six-month endpoint. As the quantity of missing data was 0.8%, we did not impute missing data for the primary analysis.

Subgroup analyses

Three exploratory analyses were undertaken.

The mechanism of change was explored using a mediation model approach and incorporating motivation (RR), self-efficacy (SCQ-8) and expectancy (SUES) at six months, adjusted for baseline covariates. The allocated group was included as an interaction term.

Linear regression analysis was performed to model the relationship between pre-randomisation factors: age, gender, ethnicity, IMD, BFRS, ACEQ, GAD-7 and PHQ-9 and observed outcomes at six months. The analysis was performed separately for the primary outcome and PDA substance use. Interaction terms within the allocation arm were included in the analysis, and a significance level of 0.1 was used to determine which factors were to be included in the regression model.

Pre-randomisation factors included gender, age, ethnicity, IMD decile, adverse childhood experiences, anxiety and depression, and family cohesion. This analysis was augmented by an additional analysis that included participants in the intervention arm and used the same pre-randomisation factors but also included process measures of adherence, intervention fidelity, therapeutic alliance and interventionist identity and perceptions.

Additional analyses and robustness checks

No additional analyses were conducted.

Estimation of effect sizes

Unless otherwise specified, estimates are presented with 95% CIs. Significance tests are two-tailed, and a significance level of <0.05 is considered statistically significant. For analyses involving negative binomial regression, offences and the volume score of the SRDS, standardised mean rates are provided with 95% CIs and effect sizes derived. For continuous normally distributed variables, a mean difference and associated 95% CIs are derived: for proportional outcomes, the mean difference was derived using a marginal effects approach, and for dichotomous outcomes, Cramer's V and the associated 95% CI are presented. This study has a predefined primary outcome measure at a specific time point and involves a single comparison between two treatment arms; therefore, no adjustment for multiplicity was required. As participant randomisation was conducted within the site, no adjustment for site cluster effects over and above the inclusion of the site as a fixed effect in the models was required.

As the primary outcome and the volume score of the SRDS had a distribution with both zero inflation and over-dispersion, the magnitude of effects was calculated using the standardised mean difference in rates between the intervention and control groups, in a similar manner to that used for continuous outcomes. As the sample is large, effect size differences were calculated using Cohen's d, as specified in the following equation:

$$\delta = (Y_i - Y_c)/S,$$

where Y_i and Y_c are the regression-adjusted means for the intervention and control groups, respectively, and S is the pooled standard deviation.

For categorical variables, the effect size was calculated using Cramer's V:

$$V = \sqrt{\frac{x^2}{n}}/min\,(k-1, r-1),$$

where X is the chi-square statistic, n is the sample size, k is the number of columns and r is the number of rows.This provides an effect size between 0 and 1. A Cramer's V of <0.2 indicates a weak effect, >0.2 and < 0.4 a moderate effect and >0.4 a strong effect.

Effect sizes will be reported with 95% CIs and p-values to reflect statistical uncertainty.

Implementation and process evaluation[2]

Research questions

Exploring quality

A stated objective of our efficacy study was 'To assess the fidelity of intervention delivery and explore the role that fidelity, therapeutic alliance and baseline demographic and psychological factors play in the

[2] See the Education Endowment Foundation's IPE guidance for further details.

outcomes observed'. To achieve this, we recorded a random sample of interventions, stratified by the four interventionists, and had these independently scored using an established tool for assessing fidelity in behavioural change interventions: BECCI (Lane, 2002). This instrument provides an overall score ranging from 0 to 4, where 0 indicates low fidelity and 4 indicates high fidelity. We proposed conducting an analysis to explore the roles that fidelity, adolescents' perception of therapeutic alliance and interventionist legitimacy play in the outcomes observed. Completion of the TASC-r by interventionists at the end of the second session was poor, with less than half completing the questionnaire. We used a regression model with the primary outcome as the dependent variable, adjusting for key covariates that were identified using a variable reduction approach. The result of this analysis allowed a quantification of what fidelity dimensions were most associated with changes in outcomes. This enabled an exploration of whether certain domains are more important than others and should be emphasised in the intervention delivery and, by extension, the training.

Exploring dosage

We explored dosage using a PP approach, as compliance was high in both groups and the control included attendance at a session. This analysis used the same methods as the primary analysis but included only those who had complied with their allocated intervention or control.

In addition to this, we wanted to explore whether certain factors were associated with non-compliance to identify potential clusters of participants who did not comply. We conducted a latent class analysis (LCA) to identify potential clusters associated with non-compliance; this allowed an exploration of whether there were subgroups of participants who were less likely to comply than others and, by augmenting this quantitative approach with targeted qualitative interviews with the young people and interventionists, enabled the wider research group to explore what adaptations might be necessary to increase accessibility and compliance.

Exploring reach

We reported the study using CONSORT guidelines. This enabled us to explore the relationship between those who were potentially eligible, those who consented and those who engaged, using the key demographic indicators age, gender and ethnicity. Significant differences in these key demographic indicators at each point informed our qualitative research; we purposively sampled those who did not consent and those who withdrew to explore the reasons why they did so and understand the perceived acceptability of the intervention or control for these participants.

A key area to explore in terms of reach is whether all potential participants were being identified and referred to the study. In previous studies of diversionary schemes for substance use offences, some critics have highlighted the disproportionate inclusion of White, middle-class males, who are not necessarily representative of the target demographic. To explore this, we planned on working with public health colleagues with access to Police National Computer data, using a comprehensive cohort approach to understand outcomes for those who are referred or not referred to the scheme. This approach would allow an anonymised aggregate analysis of differences between the referred or not referred cohorts and the anonymised aggregate analysis of outcomes for those not referred. This information would allow us to quantify any inherent biases associated with referral in terms of key demographics and to further explore these with our stakeholder interviews. This approach would enable us to understand how generalisable the

study results are and whether changes need to be made to referral pathways or intervention delivery to make the population more inclusive.

Exploring responsiveness

An aspect of our qualitative work with key stakeholders involves examining stakeholders' positive and negative experiences of the referral process and intervention, exploring how these perspectives concur with those who deliver the intervention and investigating at what points negative and positive experiences are at their greatest and what steps could be taken to ameliorate these experiences to improve the delivery and acceptability of the intervention.

Exploring adaptation

The mechanism of change was explored using a mediation model approach and incorporating motivation, self-efficacy and expectancy at month 6, adjusted for baseline covariates. The allocated group was included as an interaction term. The factors that impact the mechanism of change were assessed using regression analysis to model the relationship between pre-randomisation factors and observed outcomes at six months; the analysis for the primary outcome and for PDA from substance use were conducted separately. Interaction terms within the allocation arm were included in the analysis, and a significance level of 0.1 was used to determine which factors were included in the regression model. Pre-randomisation factors included gender, age, ethnicity, IMD decile, adverse childhood experiences, anxiety and depression and family cohesion.

In addition to quantitatively understanding the mechanism of action, the qualitative analysis provided an opportunity to explore the perceptions of the intervention from the point of view of a variety of stakeholders. The analysis allowed us to explore which elements of the interventions were useful and which were unnecessary, issues around how the interventions were planned and implemented, and the perceived barriers to or facilitators of implementation in usual practice.

Through a detailed exploration of the key dimensions, we planned on stating our logic model at the start of the project and revising it during the pilot phase and again at the end of the efficacy stage. The logic model would incorporate the qualitative research exploring stakeholder perceptions of acceptability and usefulness and the hindrances and facilitators associated with the process and intervention. It would also include quantitative analysis exploring adherence, dosage, fidelity and the mediators associated with behaviour change. This mixed methods synthesis would enable us to understand what works, how it works, when it works and for whom it works and would provide a detailed elaboration of the mechanisms and processes through which it works.

Exploring factors affecting implementation

Within the CJS, there is no central recording mechanism for recording informal out-of-court disposals and diversions. It is estimated that 40% of first-time youth entrants to CJS receive an informal diversion (Brodie et al., 2025). As part of the efficacy trial, we planned a survey of police forces in England to explore the nature and extent of diversion for first-time substance use offences among young people, working in collaboration with colleagues with the police and senior staff involved in criminal justice at the OHID. This survey aimed to address the varieties of diversionary schemes employed, eligibility, referral mechanisms, numbers referred annually and source of funding. It would provide an overview of the current state of play,

where interventions take place, the process of implementation, and the associated costs and sources of funding.

Key questions addressed by the qualitative component will be informed by and inform elements of the quantitative analysis. They include:

- Do participants, providers and police perceive any external or logistical issues as impacting referral, intervention delivery, attrition or study assessments?
- What are participants' positive and negative intervention experiences, and how do these fit with providers' perceptions? At what points in the intervention are these most likely?
- What reasons do participants offer for their substance use and their intervention responses?
- Can practices associated with the intervention be amended to increase its acceptability and perceived impact?
- Do police perceive the intervention as impacting participants' offending?

To address these research questions in depth, the qualitative aspect of the work involved the collection of narrative accounts from a range of individuals using semi-structured interviews. These were collected from the young people participating and the staff involved in the programme delivery and professionally associated with the young people. Professionals were sampled purposively from the different staff groups, and the young people were also purposively sampled.

To explore beyond the realms of the research project itself, we also conducted several qualitative focus groups with key stakeholders not involved in the study itself. These groups were comprised of six to eight individuals and were repeated until data saturation was reached. This purposive sample was guided by the findings of the survey of practice across the country and included areas of low/high activity, capacity and deprivation. These focus groups explored views on organisational capacity, intervention delivery, eligibility, referral mechanisms, the optimal number of standardised measures required to monitor intervention delivery, minimum standards of experience for interventionists, delivery of training and ongoing supervision. A synthesis of these data sources would allow a detailed overview of the implementation and processes associated with the successful delivery of the intervention.

Quantitative data was collected using participant questionnaires (n = 360) and qualitative data collected using a combination of semi-structured interviews and focus groups, the 15 young people who participated in the study, the five staff who delivered the intervention and the 15 police officers in the areas where the study took place. Seven focus groups in areas where the intervention was not available were conducted; these consisted of family support workers, substance use practitioners, local authority commissioners, criminal justice staff, safeguarding leads and young people recovery workers.

The young people were interviewed within six weeks of completing the intervention; they received a £20 Amazon gift code as an incentive and a thank you for their time. After informed consent had been gained, interviews were conducted over the phone by experienced researchers and recorded with an encrypted Dictaphone. Data was stored securely and analysed using NVivo Lumivero software.

Analysis

The data was analysed using a provisional list of orienting codes based on the theoretical framework of how the programme was developed. During the process of coding, new grounded codes were added to the provisional codes based on relevant items found in the data (Strauss and Corbin, 1998). An iterative approach was used between the data and the codes; thematic categories were developed and organised. These themes are the basis of the qualitative findings. This approach has allowed a detailed description of key themes and an analysis of the extent to which emergent themes are linked to quantitative outcomes such as changes in self-efficacy, peer relationships, prosocial behaviours, expectancy and motivation to change behaviour.

Table 4. Implementation and process evaluation (IPE) methods overview

IPE question	Data collection methods	Participants / data sources (type, number)	Data analysis methods	Research questions addressed	Implementation / logic model relevance
Fidelity / adherence / differentiation / quality	Participant survey Therapeutic alliance BECCI checklist Session data	360 participant surveys and TASC-r BECCI fidelity assessment	Regression analysis	Quantification of the role fidelity and quality plays in the outcomes observed	Better-quality interventions that involve better alliance and communication between young people and practitioners are associated with better outcomes
Dosage	Session planned and attended Outcome data	360 participant surveys Process database	CACE analysis	Estimation of the role dosage plays on observed outcomes at variable thresholds	Greater frequency of intervention is associated with better outcomes
	Factors associated with non-compliance	360 participant surveys Process database	LCA	Exploration of factors associated with non-compliance	Create targeted opportunities to reduce non-compliance and maximise acceptability.
Reach	Comprehensive cohort approach	Data on all young people referred to the service compared with data on those who consented	Logistic regression model with consent as the dependent outcome	Exploration of whether the intervention was accessible to all those referred to the services	Identify any potential issues with accessibility
	Qualitative interviews with service leads and key stakeholders	14 semi-structured interviews	Transcribing and inductive analysis to allow themes to emerge naturally	Identification of any populations that experienced limited accessibility and the potential reasons for this.	Identify issues with accessibility and how these may be addressed
Responsiveness	Qualitative interviews with participants	15 semi-structured interviews with participants 14 semi-structured interviews with key stakeholders	Inductive analysis	Exploration of the acceptability of the referral and intervention process Exploration of positive and negative	Understand how the referral and delivery processes can be maximised.

		Purposive sampling to get variety by site, age and ethnicity		experiences and when these occur	
Adaption	Quantitative analysis	360 participant surveys	Mediation analysis including allocated arm as an interaction term	Exploration of the factors at baseline that mediate the outcomes observed	Understand the mechanisms of change and provide information for refinement of the theory of change model
	Qualitative analysis	15 semi-structured interviews with participants 14 semi-structured interviews with key stakeholders Purposive sampling to get variety by site, age and ethnicity	Inductive analysis	Exploration of participant and practitioner perspectives on how the intervention works and perceived barriers or facilitators to the intervention	Understand how the intervention works and who it works for to refine the theory of change
Implementation	Qualitative analysis	15 semi-structured interviews with participants 14 semi-structured interviews with key stakeholders Purposive sampling to get variety by site, age and ethnicity	Inductive synthesis	Synthesis of qualitative findings to explore positive and negative experiences and how changes can be made to maximise the impact of the intervention	Identify potential modifications that can be made to maximise the impact of the intervention

Timeline

Table 5: Timeline

Dates	Activity	Staff responsible / leading
28/02/23	The Youth Endowment Fund (YEF) receives and approves amended information sheets, privacy notices and ethical approvals	Kent (NH)[3]
01/03/23 to 28/02/24	Recruitment and baseline assessments	Kent (SC)
31/03/23	Provide the YEF with statistical analysis plan for peer review	Kent (SC / TG / NH)
31/08/23	Submit final statistical analysis plan with peer review responses	Kent (SC)
01/09/23 to 31/08/24	Schedule and conduct participant qualitative interviews and focus groups	Kent (TG / NH)
01/09/23 to 31/08/24	Conduct month 6 assessments	Kent (NH)
01/03/23 to 28/02/24	Schedule and conduct stakeholder qualitative interviews and focus groups	Kent (TG / NH)
01/03/23 to 28/02/24	Assess and calculate cost data	Kent (SC)
01/11/23 to 30/09/24	Extract Local Police Database data	Kent (NH)
01/09/24 to 30/10/24	Produce statistical and qualitative analysis	Kent (SC / TG / NH)
01/09/24 to 30/10/24	Produce synthesis of findings	Kent (SC / TG / NH)
30/10/24	Submit draft of final report	Kent (SC / TG / NH)
31/02/25	Respond to peer review and submit final report	Kent (SC / TG / NH)

[3] Nadine Hendrie (NH), Simon Coulton (SC), Theresa Gannon (TG)

Participant flow, including losses and exclusions

Figure 3. CONSORT diagram of progress through the trial

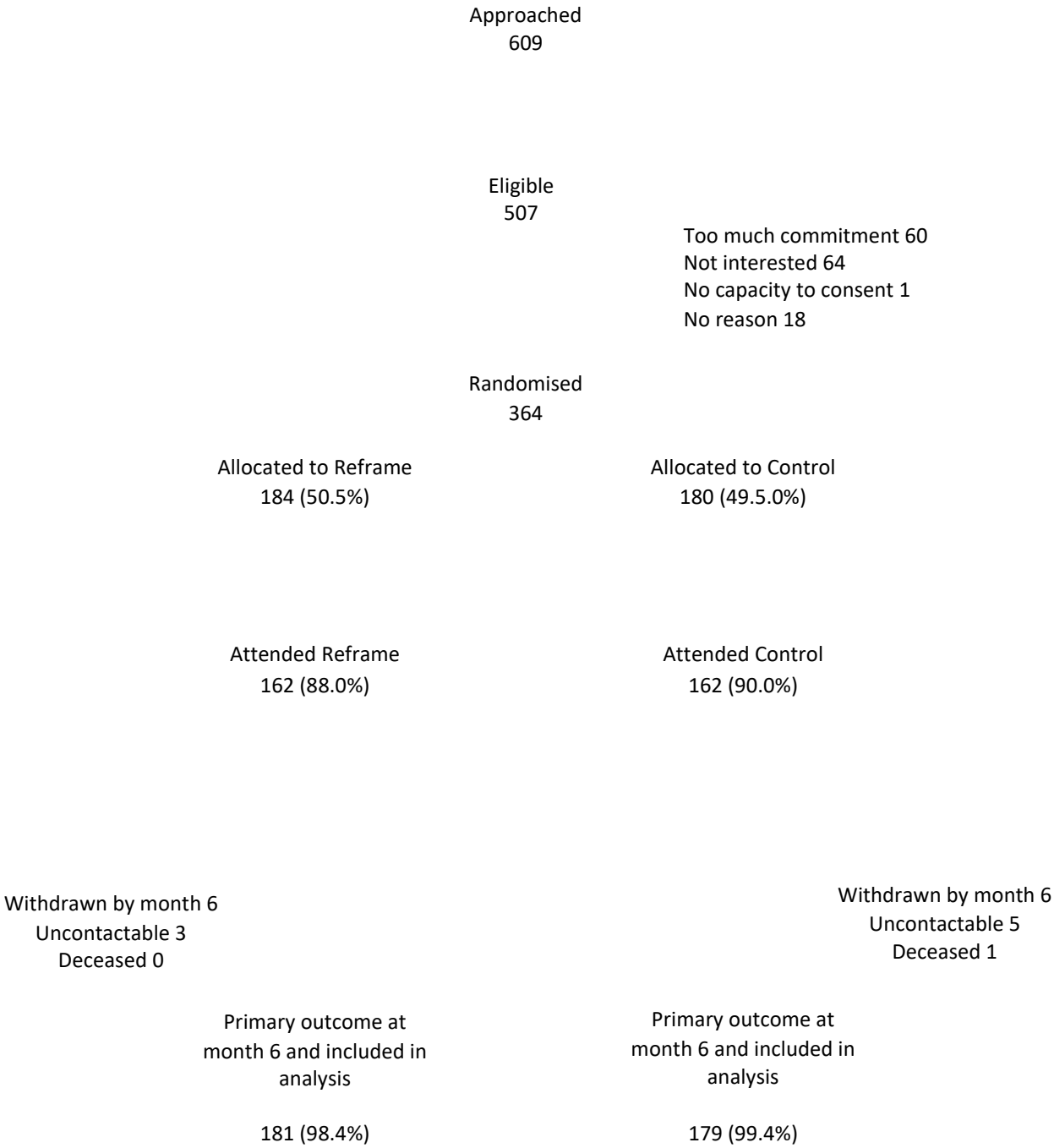


Table 6. Demographic characteristics

	Referred	Recruited	Randomised	T0 data	T1 data	Final sample
Ethnicity						
Asian or Asian British	9	3	3	3	3	3
Treatment	–	–	1	1	1	1
Control	–	–	2	2	2	2
Black, Black British, Caribbean or African	16	8	8	8	8	8
Treatment	–	–	2	2	2	2
Control	–	–	6	6	6	6
Mixed or multiple ethnic groups	27	23	23	23	22	22
Treatment	–	–	15	15	15	15
Control	–	–	8	8	7	7
White	446	323	323	323	320	320
Treatment	–	–	162	162	160	160
Control	–	–	161	161	160	160
Other ethnic group	9	7	7	7	7	7
Treatment	–	–	4	4	4	4
Control	–	–	3	3	3	3
Sex						
Male	437	309	309	309	305	305
Treatment	–	–	152	152	149	149
Control	–	–	157	157	156	156
Female	66	51	51	51	51	51
Treatment	–	–	31	31	31	31
Control	–	–	20	20	20	20
Prefer not to say	4	4	4	4	4	4
Treatment	–	–	1	1	1	1
Control	–	–	3	3	3	3

Attrition

The overall rate of attrition between randomisation and analysis was 1.10%: 1.63% in the intervention group and 0.56% in the control group. No differences in attrition rate were observed by ethnicity or sex.

Table 7: Participant-level attrition from the trial (primary outcome)

		Intervention	Control	Total
Number of participants	Randomised	184	180	364
	Analysed	181	179	360
Participant attrition (from randomisation to analysis)	Number	3	1	4
	Percentage	1.63	0.56	1.10

Participant characteristics

Baseline variables for participants by allocated group are provided in table 8. The distribution of each variable was examined, and all continuous variables met the assumption of normality with the exception of the offence data and the SRDS volume score; estimation of p-values for these variables were derived using non-parametric methods. As these variables also demonstrated zero inflation and over-dispersion, the effect size is presented as the incident rate ratio (IRR); effect sizes for all other continuous variables use Cohen's d.

Participants were referred by the police from four localities: Cornwall, Kent, Wigan and Sefton. Police forces have different criteria for diversion, with Cornwall, Sefton and Wigan considering diversion as part of a review at a youth panel, and Kent allowing individual officers to decide about whether to divert a child.

No differences were observed between the allocated groups on any of the baseline values, and we can be confident the randomisation process worked as intended and the groups were equally balanced at baseline. As only four out of the 364 participants had no primary outcome at month 6, we can also be confident that the analysed groups were balanced with respect to baseline covariates.

Table 8: Baseline characteristics of groups as randomised

	Re-Frame intervention (n = 184)	Control (n = 180)	P-value	Effect size (95% CI)
Centre n (%)				
Cornwall	32 (17.39)	31 (17.22)		
Kent	75 (40.76)	74 (41.11)		
Wigan	24 (13.04)	24 (33.33)		
Sefton	53 (28.80)	51 (28.33)	0.99	0.07[a]
Age group n (%)				
10–14 years	26 (14.13)	25 (13.89)		
15–17 years	158 (85.87)	155 (86.11)	0.95	0.01 (–0.32; 0.34)[b]
	67.25 (35.45)	69.04 (35.13)	0.63	0.05 (–0.16; 0.26)[c]

	Re-Frame intervention (n = 184)	Control (n = 180)	P-value	Effect size (95% CI)
Mean per cent days abstinent from	16.06 (1.26)	15.76 (1.28)	0.56	0.21 (–0.24; 0.66)[c]
substances n (%)	157 (87.22)	152 (82.61)	0.29	0.20 (–0.12; 0.52)[b]
Mean age in years (SD)				
Male n (%)	162 (88.04)	161 (89.44)		
Ethnicity n (%)	15 (8.15)	8 (4.44)		
White	1 (0.54)	2 (1.11)		
Mixed	2 (1.09)	6 (3.33)		
Asian	4 (2.17)	4 (2.17)	0.33	0.11[a]
Black	13.53 (1.72)	13.74 (1.54)	0.23	0.13 (–0.32; 0.58)[c]
Other	12.92 (2.30)	12.74 (2.83)	0.11	–0.07 (–0.53; 0.39)[c]
Mean age of first substance use				
Mean age of alcohol use	0.37 (0.75)	0.37 (0.71)	0.58	0 (–0.21; 0.20)[c]
Mean police-reported offending (SD)	0.02 (0.15)	0.03 (0.20)	0.82	0.03 (–0.17; 0.24)[c]
Offences	0.03 (0.22)	0.04 (0.22)	0.47	0.05 (–0.15; 0.26)[c]
Charges	0.32 (0.70)	0.30 (0.56)	0.07	–0.03 (–0.24; 0.18)[c]
Cautions				
Warnings	10.06 (12.76)	9.00 (13.64)	0.92	–0.08 (–0.28; 0.12)[c]
Mean self-report delinquency: SRDS	2.50 (2.37)	2.20 (2.35)	0.58	–0.13 (–0.34; 0.08)[c]
(SD)				
Volume score	15.16 (6.27)	14.75 (6.39)	0.54	–0.06 (–0.27; 0.14)[c]
Quantity	3.00 (2.34)	3.07 (2.38)	0.77	0.03 (–0.17; 0.24)[c]
Mean strengths and difficulties: SDQ	3.26 (2.08)	3.02 (2.15)	0.27	–0.11 (–0.32; 0.09)[c]
(SD)	6.22 (2.52)	6.00 (2.41)	0.40	–0.09 (–0.29; 0.12)[c]
Total score	2.67 (1.68)	2.66 (1.89)	0.92	–0.01 (–0.22; 0.20)[c]
Emotional problems	6.93 (1.97)	6.88 (1.88)	0.82	–0.02 (–0.23; 0.18)[c]
Conduct problems	20.58 (3.88)	20.71 (4.36)	0.77	0.03 (–0.17; 0.24)[c]
Hyperactivity	0.85 (0.11)	0.86 (0.13)	0.55	0.06 (–0.15; 0.28)[c]
Peer Problems	5.99 (5.26)	5.61 (5.36)	0.50	–0.07 (–0.28; 0.23)[c]
Prosocial Behaviour	8.56 (6.30)	8.11 (6.42)	0.50	–0.07 (–0.27; 0.13)[c]
Mean well-being: SWEMWBS (SD)				
Mean quality of life: CHU-9D (SD)	1.62 (1.99)	1.46 (1.98)	0.44	–0.08 (–0.29; 0.13)[c]

	Re-Frame intervention (n = 184)	Control (n = 180)	P-value	Effect size (95% CI)
Mean anxiety: GAD-7 (SD)	0.74 (1.030	0.67 (1.00)	0.51	–0.07 (–0.28; 0.13)[c]
Mean depression: PHQ9 (SD)	2.10 (1.88)	1.93 (1.86)	0.38	–0.09 (–0.30; 0.12)[c]
Family environment: BFRS (SD)				
Cohesion	46.95 (27.64)	42.88 (29.29)	0.18	–0.13 (–0.35; 0.07)[c]
Expression	62.83 (28.86)	65.20 (29.67)	0.43	–0.08 (–0.12; 0.29)[c]
Conflict	3.13 (1.57)	3.46 (1.56)	0.05	0.21 (0; 0.42)[c]
Mean expectancy (SD)	71.51 (25.30)	69.72 (27.00)	0.54	–0.07 (–0.28; 0.15)[c]
Positive				
Negative				
Mean readiness to change: RR (SD)				
Mean self-efficacy: SCQ (SD)				

[a] Effect size presented as Cramer's V, where <0.1 (negligible), 0.1–0.3 (small), 0.3–0.5 (moderate) and >0.5 (large).

[b] Effect size converted to Cohen's d from odds ratio using the formula $\ln(OR) = d\pi/\sqrt{3}$.

[c] Effect size represented as Cohen's d.

Note: SD = standard deviation

Table 9: Month 6 outcomes for those completing follow-up, by allocated group

	Re-Frame intervention (n = 148)	Control (n = 142)	P-value	Effect size Cohen's d (95% CI)
Mean police-reported offences (SD)[a]	0.54 (0.12)	0.31 (0.05)	0.07	–0.19 (–0.40; 0.02)
Mean self-Report delinquency: SRDS (SD)				
Volume score	5.21 (0.61)	4.32 (0.50)	0.27	–0.13 (–0.36; 0.10)
Quantity	23.29 (0.81)	23.24 (0.86)	0.96	–0.01 (–0.24; 0.23)
Mean per cent days abstinent (SD)				
Alcohol and substances	70.01 (2.79)	71.63 (2.76)	0.68	0.05 (–0.18; 0.28)
Substances only	76.70 (2.68)	79.86 (2.55)	0.39	0.10 (–0.13; 0.33)
Alcohol only	93.46 (0.91)	91.79 (1.18)	0.26	–0.13 (–0.36; 0.10)
Mean strengths and difficulties: SDQ (SD)				
Total score	14.50 (0.56)	14.46 (0.52)	0.95	–0.01 (–0.24; 0.22)
Emotional problems	3.12 (0.21)	3.23 (0.21)	0.69	0.05 (–0.18; 0.28)
Conduct problems	2.80 (0.17)	2.53 (0.15)	0.25	–0.14 (–0.37; 0.10)
Hyperactivity	5.88 (0.22)	5.79 (0.21)	0.77	–0.03 (–0.26; 0.20)
Peer problems	2.71 (0.14)	2.90 (0.15)	0.37	0.11 (–0.12; 0.34)
Prosocial behaviour	7.07 (0.16)	7.26 (0.16)	0.39	0.10 (–0.13; 0.33)
Mean well-being: SWEMWBS (SD)	21.43 (0.35)	21.28 (0.34)	0.76	–0.04 (–0.27; 0.20)
Mean quality of life: CHU-9D (SD)	0.85 (0.01)	0.85 (0.01)	0.98	0 (0.24; 0.23)
Mean expectancy (SD)				
Positive	41.51 (2.65)	40.54 (2.33)	0.78	–0.03 (–0.27; 0.20)
Negative	69.88 (2.27)	69.84 (2.09)	0.99	–0.01 (–0.24; 0.23)
Mean readiness to change: RR (SD)	3.05 (0.14)	3.26 (0.14)	0.27	0.13 (–0.10; 0.36)
Mean self-efficacy: SCQ (SD)	74.61 (2.14)	70.13 (2.40)	0.16	–0.17 (–0.40; 0.07)

[a] The sample was larger for the month 6 offences outcome: 179 in the control group and 181 in the intervention group.

Outcomes and analysis

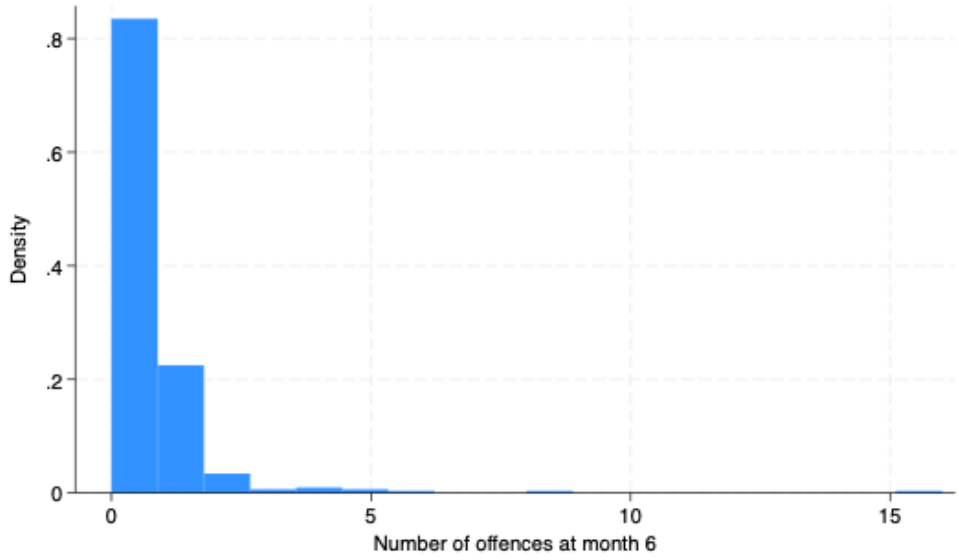
Primary analysis

The primary outcome was the number of offences recorded by the police in the six months after randomisation. The primary analysis was based on the intention-to-treat dataset. This contains all available data for participants who were randomised, regardless of whether or not they complied with their

allocation. This dataset includes participants who were/had withdrawn from the trial post-randomisation. These analyses are a lower-bound estimate of treatment effects, as they represent the effect of offering an intervention rather than the effect of receiving the intervention.

Of the 360 participants followed-up at month 6, only 93 (25.8%) – 50 (27.6%) in the intervention group and 43 (24.0%) in the control group – committed an offence in the six months after randomisation. This is an indication of zero inflation, where the majority of the sample committed zero offences. An examination of the relationship between the conditional mean and conditional variance for each group indicated an element of over-dispersion, where the conditional variance is larger than the conditional mean, and this was confirmed by examining the distribution (figure 4).

Figure 4: Histogram of the density of offences at month 6



To address this in the analysis, we employed a negative binomial regression model adjusted for the baseline value of the primary outcome (volume score in the six months prior to randomisation), the stratification variables (age group and site) and whether the participant was part of the internal pilot or efficacy trial population (as a fixed effect) and their allocated group.

Table 10 provides the results of the analysis. Baseline offences, being referred from Kent, are significantly associated with more offences at six months. Being in the older age group is significantly associated with fewer offences at six months.

Table 10: Negative binomial model with offences at month 6 as the dependent variable, controlling for baseline offences, age group, centre, study and intervention

	Incident rate ratio (95% CI)	P-value	Cohen's d (95% CI)
Baseline offences	1.59 (1.22; 2.10)	0.001	–
Age group[a]			
15–17	0.63 (0.38; 1.05)	0.077	–
Centre[b]			
Kent	2.31 (1.21; 4.39)	0.010	–
Wigan	0.96 (0.36; 2.53)	0.929	–
Sefton	0.53 (0.22; 1.29)	0.161	–
Study[c]			
Efficacy	1.19 (0.64; 2.20)	0.585	–
Allocation[d]			
Intervention	1.41 (0.94; 2.12)	0.097	0.18 (–0.01 to 0.36)

[a] Contrast with 10–14 age group.

[b] Contrast with Cornwall.

[c] Contrast with pilot study participants.

[d] Contrast with control group.

Primary outcome analysis in the presence of non-compliance

Rates of compliance with the intervention and control conditions were high: 162 (88.0%) in the intervention group and 162 (90.0%) in the control group.

To explore the potential impact of compliance with the intervention, we used a PP data set. This contained all the data for the participants who completed the trial as planned – in the treatment and control groups – and without any major protocol violations or exclusions. PP analysis essentially drops those individuals who have not complied with their allocated treatment. This means that PP represents a likely 'best case scenario' for treatment effect estimation. As the control group were expected to attend a single session, it is reasonable to assume that those who complied would be likely to attend the two intervention sessions if allocated to the intervention; as such, the PP analysis is a reasonable estimate of effects, taking into account non-compliance.

The primary outcome was analysed with the PP dataset, using the methods employed for the primary analysis, a negative binomial regression model adjusted for the baseline values of the primary outcome, stratification factors and an indicator of study as a fixed effect.

Table 11: Negative binomial model with offences at month 6 as the dependent variable, controlling for baseline offences, age group, centre, study and intervention, including only those who complied with the allocated intervention

	Incident rate ratio (95% CI)	P-value
Baseline offences	1.62 (1.17; 2.25)	0.004
Age group[a]		
15–17	0.51 (0.27; 0.96)	0.036
Centre[b]		
Kent	3.06 (1.64; 5.73)	<0.001
Wigan	1.03 (0.34; 3.14)	0.958
Sefton	0.62 (0.24; 1.59)	0.317
Study[c]		
Efficacy	1.18 (0.59; 2.10)	0.731
Allocation[d]		
Intervention	1.50 (0.96; 2.34)	0.075

[a] Contrast with the 10–14 age group.

[b] Contrast with Cornwall.

[c] Contrast with pilot study participants.

[d] Contrast with control group.

The results of the PP analysis were similar to the intention-to-treat analysis.

Missing data analysis for the primary outcome

In our statistical analysis plan, we stated that we would explore the pattern of missing data and data imputation if the quantity of missing data on the primary outcome exceeded 5% at the primary six-month endpoint. As the quantity of missing data was 0.8%, we did not impute missing data for the primary analysis.

Those allocated to the Re-Frame intervention had a higher rate of offences in the six months after randomisation than those allocated to the control (IRR = 1.41; 95% CI = 0.94 to 2.12), giving a Cohen's d effect size of 0.18 (–0.01 to 0.36) when comparing the intervention group to the control. Noting that the majority of the sample in both groups did not offend in the six months post-randomisation, this can be interpreted as saying that each offence in the control group was associated with 1.41 offences in the intervention group, but this difference was not significant. When compliance was accounted for, those who complied had a similar IRR (= 1.50; 95% CI = 0.96 to 2.34), but again, this was not significant.

Secondary analysis

Per cent days abstinent at month 6

We recorded PDA from alcohol and/or substances in the 28 days prior to the six-month follow-up point. PDA is a proportion that can be transformed to a number between 0 and 1. To analyse this, controlling for baseline values for PDA from substances and the stratification variables used in the randomisation, age group, centre and study, we employed a fractional regression.

The PDA increased in both groups between baseline and month 6 – 68.0% to 79.9% in the control group, and 67.2% to 76.7% in the intervention group – indicating a significant reduction in the frequency of substance use in both groups, an effect size of 0.30 (95% CI = 0.14 to 0.45).

Table 12: Fractional regression model with per cent days abstinent at month 6 as the dependent variable, controlling for baseline per cent days abstinent, age group, centre, study and intervention.

	Marginal mean (95% CI)	P-value	Cohen's d (95% CI)
Age Group			
15–17	–0.03 (–0.14; 0.08)	0.61	–
Centre			
Kent	–0.07 (–0.15; 0)	0.06	–
Wigan	–0.07 (–0.19; 0.53)	0.27	–
Sefton	0 (–0.08; 0.09)	0.90	–
Study			
Efficacy	0.02 (–0.05; 0.09)	0.56	–
Allocation			
Intervention	–0.02 (–0.08; 0.04)	0.48	0.10 (–0.08 to 0.14)

There were no significant differences observed for the PDA at month 6. The mean difference, intervention versus control, was –0.02 (95% CI = –0.08 to 0.04), which equates to a non-significant effect size derived using Cohen's d of 0.10 (–0.08 to 0.14).

Self-reported delinquency at month 6

Self-reported delinquency at month 6 was measured using the volume score of SRDS. The volume score is calculated as the number of times a young person has committed an offence for the 19 items of the SRDS. Overall, 64.5% reported engaging in delinquency, and this differed by allocation: 61.3% in the control group and 67.6% in the intervention group. The distribution of the volume score demonstrated zero inflation and over-dispersion.

To address this in the analysis, we employed a negative binomial regression model adjusted for the baseline value of the primary outcome (volume score in the six months prior to randomisation), the stratification

variables (age group and site) and whether the participant was part of the internal pilot or efficacy trial population (as a fixed effect) and their allocated group.

Table 13 provides the results of the analysis. Baseline delinquency was significantly associated with greater delinquency at six months. There were no significant differences in the IRR by allocated group (= 1.11; 95% CI = 0.82 to 1.50) when comparing the intervention group rate with the control group rate; the Cohen's d effect size comparing the intervention group to the control group was 0.13 (95% CI = –0.10 to 0.36).

Table 13: Negative binomial model with the volume of self-reported delinquency at month 6 as the dependent variable, controlling for the baseline volume of self-reported delinquency, age group, centre, study and intervention

	Incident rate ratio (95% CI)	P-value	Cohen's d (95% CI)
Baseline delinquency	1.05 (1.04; 1.07)	<0.001	–
Age group[a]			
15–17	0.81 (0.48; 1.38)	0.442	–
Centre[b]			
Kent	0.75 (0.48; 1.16)	0.199	–
Wigan	0.42 (0.23; 0.78)	0.006	–
Sefton	0.84 (0.54; 1.31)	0.440	–
Study[c]			
Efficacy	0.73 (0.52; 1.05)	0.088	–
Allocation[d]			
Intervention	1.11 (0.82; 1.50)	0.491	0.13 (–0.10; 0.36)

[a] Contrast with the 10–14 age group

[b] Contrast with Cornwall

[c] Contrast with pilot study participants

[d] Contrast with control group

Strengths and difficulties

Emotional regulation, prosocial behaviour, peer problems, hyperactivity and conduct problems were derived from the SDQ in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control intervention. As the domains were all normally distributed, an OLS linear regression was conducted. The means, standard deviations, mean differences and effect sizes are presented in table 14.

Table 14: Strengths and Difficulties Questionnaire (SDQ) domains at month 6, mean difference derived from ordinary least squares linear regression, mean difference, effect size and associated 95% confidence intervals.

	Month 6 Intervention (n=147) Mean (SE)	Month 6 Control (n=142) Mean (SE)	Mean difference (95% CI)	Cohen's d (95% CI)	p-value
SDQ total	14.47 (0.39)	14.49 (0.35)	−0.02 (−1.05; 1.01)	−0.007 (−0.237; 0.224)	0.969
Regulation	3.17 (0.15)	3.17 (0.14)	−0.01 (−0.42; 0.40)	−0.047 (−0.184; 0.277)	0.962
Prosocial	7.09 (0.15)	7.24 (0.13)	−0.14 (−0.54; 0.25)	−0.102 (−0.129; 0.333)	0.478
Peer problems	2.74 (0.12)	2.87 (0.12)	−0.13 (−0.47; 0.21)	−0.106 (−0.124; 0.337)	0.446
Hyperactivity	5.86 (0.15)	5.80 (0.17)	0.06 (−0.39; 0.50)	0.034 (−0.265; 0.196)	0.798
Conduct	2.72 (0.13)	2.62 (0.11)	0.10 (-0.24; 0.44)	0.136 (−0.367; 0.095)	0.554

Note: CI = confidence interval; SE = Standard Error

No differences were observed by allocated group for any of the SDQ domains.

Well-being and quality of life

Well-being was derived from SWEMWBS and quality of life from CHU-9D in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control.

As both outcomes were normally distributed, an OLS linear regression was conducted. The means, standard deviations, mean differences and effect sizes are presented in table 15.

Table 15: Well-being and quality of life at month 6 (mean difference derived from ordinary least squares linear regression, mean difference and effect size, and associated 95% CIs)

	Month 6 intervention mean (SE) (n = 147)	Month 6 control mean (SE) (n = 142)	Mean difference (95% CI)	Cohen's d (95% CI)	P-value
SWEMWBS	21.36 (0.31)	21.35 (0.30)	0.01 (–0.84;0.85)	–0.03 (–0.27; 0.19)	0.988
CHU9D	0.85 (0.01)	0.85 (0.01)	0 (–0.03; 0.02)	–0.002 (–0.23; 0.23)	0.803

Note: SE = Standard Error

No differences were observed by allocated group for any of the well-being or quality-of-life measures.

Substance use attitudes

Substance use attitudes included motivation to change (derived from the RR), self-efficacy (derived from SCQ8) and positive and negative expectancy (derived from SUES) in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control.

As these outcomes were normally distributed, an OLS linear regression was conducted. The means, standard deviations, mean differences and effect sizes are presented in table 16.

Table 16: Motivation, self-efficacy and expectancy at month 6 (mean difference derived from ordinary least squares linear regression, mean difference, effect size and associated 95% confidence intervals (CIs)

	Month 6 intervention mean (SE) (n = 141)	Month 6 control mean (SE) (n = 134)	Mean difference (95% CI)	Cohen's d (95% CI)	P-value
Motivation – Readiness Ruler	3.10 (0.13)	3.23 (0.14)	–0.13 (–0.51; 0.25)	–0.128 (–0.340; 0.102)	0.514
Self-Efficacy – Situational Confidence	73.39 (2.19)	71.79 (2.19)	1.57 (–4.48; 7.68)	0.169 (–0.405; 0.068)	0.606
Expectancy	41.53 (2.31)	42.48 (2.19)	–0.94 (–7.24; 5.35)	–0.033 (–0.270; 0.203)	0.768
Positive	71.05 (2.16)	69.52 (1.88)	1.53 (–4.14; 7.19)	0.002 (–0.234; 0.231)	0.596
Negative					

Note: SE = Standard Error

No differences were observed by allocated group for motivation, self-efficacy or positive and negative expectancy.

Subgroup analyses

Additional analyses and robustness checks

Estimating the mediating effects of situational confidence, motivation to change and expectancies.

The mechanism of change was explored using a mediation model approach and incorporating motivation, self-efficacy and expectancy at month 6, adjusted for baseline covariates. Allocated group was included as an interaction term. This analysis was conducted on the primary outcome, number of offences in the six months post-randomisation and frequency of substance use in the 28-days prior to the six-month follow-up.

Table 17: The proportion of each effect mediated by for the number of offences and frequency of substance use at month 6

	Proportion mediated (95% CI)	
	Number of offences at month 6 (n = 275) %	**Frequency of substance use (n = 275) %**
Motivation – Readiness Ruler	3.4 (11.3; 18.2)	4.1 (-21.3; 13.2)
Self-efficacy –situational confidence	0.2 (–14.9; 15.2)	0.2 (-29.3; 28.9)
Expectancy		
Positive	0.9 (–10.1; 11.9)	4.9 (-27.2; 17.2)
Negative	1.5 (–18.2; 15.3)	1.3 (–11.1; 13.7)

Note CI = confidence interval

Changes in the number of offences and frequency of substance was not mediated by any of the hypothesised variables.

Relationship between pre-randomisation factors, offences and frequency of substance use at six months

An item-reduction exercise was undertaken to explore the association between pre-randomisation factors: age, gender, ethnicity, IMD, BFRS, ACEQ, GAD-7, PHQ-9 and observed outcomes at six months. This was conducted separately for the primary outcome and PDA substance use, with a significance level of 0.1 in the association between the predictor and the dependent variable used to determine which factors were to be included in the regression model.

The model for offences at six months included age group, family conflict and number of adverse experiences.

Table 18: Negative binomial regression model with number of offences at month 6 as the dependent variable, controlling for baseline age group, family conflict and adverse childhood experiences

	Incident rate ratio (95% CI)	**P-value**
15–17 years[a]	0.318 (0.150; 0.672)	0.003
Baseline family conflict	1.064 (0.944; 1.200)	0.307
Adverse experiences	1.145 (0.986; 1.331)	0.077

[a] Contrast with the 10–14 age group

Note: CI = confidence interval

Only being in the older age group at baseline significantly predicted fewer offences at month 6. No interactions were observed between the variables in the model and the allocated group.

The model for the frequency of substance use at month 6 consisted of age group, sex, family cohesion, family expression, family conflict, adverse childhood experiences and depression.

Table 19: Fractional regression model with frequency of substance use at month 6 as the dependent variable, controlling for baseline age group; sex; family conflict, expression and cohesion; adverse childhood experiences (ACE); and depression

	ß (95% CI)	P-value
15–17	–0.12 (–1.01; 0.76)	0.788
ACE	–0.07 (–0.25; 0.11)	0.461
Sex	–0.59 (–1.36; 0.18)	0.133
Family cohesion	–0.04 (–0.22; 0.14)	0.639
Family express	–0.04 (–0.36; 0.28)	0.798
Family conflict	–0.17 (–0.06; –0.01)	0.037
Depression	–0.01 (–0.06; 0.03)	0.567

Note: CI = confidence interval

Family conflict showed a small but significant predictive value, with lower levels of family conflict predicting a higher frequency of substance use at six months. No interactions were observed between the identified variables and allocation.

Overall, the results do not tend to support the original logic model. The study participants were not frequent offenders, and the vast majority did not reoffend in the six months post-randomisation: 25.8% in the study versus a national rate of 32.5% in 2024 (Youth Justice Board, 2025). The frequency of substance use decreased in both groups in the six months post-randomisation, but the change in frequency was not predicted by those outcomes hypothesised to change.

Summary of research questions

Primary research question

RQ1 **What is the difference in the number of offences committed (derived from the local police database) in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?**

There was a moderate increase in the rate of offending among those allocated to the intervention group compared to those allocated to the control group (IRR = 1.41; 95% CI = 0.94 to 2.12) and a Cohen's d effect size of 0.18 (95% CI = –0.01 to 0.36). However, the difference was not statistically significant at the 5% level (p = 0.097). This outcome was similar when compliance with the allocated group was accounted for.

Secondary research question

RQ2 What is the difference in the frequency of alcohol and substance use, in terms of PDA, in the 28 days prior to the six-month post-randomisation follow-up for those receiving the Re-Frame intervention versus those receiving the control?

The PDA from substance use increased in both groups between baseline and month 6 – 68.0% to 79.9% in the control group and 67.2% to 76.7% in the intervention group – indicating a large reduction in the frequency of substance use in both groups. The PDA at six months was slightly higher in the control group; there was a mean difference when comparing the intervention group to the control group of –0.02 (95% CI = –0.08 to 0.04) and a Cohen's d effect size of 0.10 (95% CI = –0.13 to 0.45); this difference was not statistically significant at the 5% level (p = 0.48).

RQ3 What is the difference in self-reported delinquency, derived from volume score of the SRDS, in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

Greater delinquency at baseline was significantly associated with greater delinquency at six months in both groups. The IRR at month 6 was higher in the intervention group than in the control group (IRR = 1.11; 95% CI = 0.82 to 1.50), with a Cohen's d effect size of 0.13 (95% CI = –0.10 to 0.36). This difference was not statistically significant at the 5% level (p = 0.49).

RQ4 What is the difference in emotional regulation, prosocial behaviour, peer problems, hyperactivity and conduct problems, derived from the SDQ, in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

The SDQ total score was slightly higher in the control group than in the intervention group, indicating higher overall behavioural problems in the control group; there was a mean difference of –0.02 (95% CI = –1.05 to 1.01) and a Cohen's d of –0.007 (95% CI = –0.24 to 0.22). This was not statistically significant at the 5% level (p = 0.97).

Emotional regulation was similar in both groups at month 6, indicating similar problems with emotional regulation; Cohen's d was –0.05 (95% CI = –0.18 to 0.28), but this was not statistically significant at the 5% level (p = 0.96).

Prosocial behaviours were higher in the control group, indicating that there was more prosocial behaviour in the control group; there was a mean difference of –0.14 (95% CI = –0.54 to 0.25), a Cohen's d of –0.10 (95% CI = –0.13 to 0.33) when comparing the intervention group to the control group, but this was not statistically significant at the 5% level (p = 0.48).

The peer problems score was higher in the control group than in the intervention group, indicating that the control group exhibited more problems with their peers; there was a

mean difference of –0.13 (95% CI = –0.47 to 0.21) and a Cohen's d of –0.11 (95% CI = –0.12 to 0.24), but this was not statistically significant at the 5% level (p = 0.45).

Hyperactivity was higher in the intervention group than the control group, indicating that there were greater problems associated with hyperactivity in the intervention group; there was a mean difference of 0.06 (95% CI = –0.39 to 0.50) and a Cohen's d of 0.03 (95% CI = –0.26 to 0.19), but this was not statistically significant at the 5% level (p = 0.80).

Conduct problems were higher in the intervention group than the control group; there was a mean difference of 0.10 (95% CI = –0.24 to 0.44) and a Cohen's d of 0.14 (95% CI = –0.37 to 0.10), but this was not statistically significant at the 5% level (p = 0.55).

RQ5 What is the difference in well-being, derived from the SWEMWBS, in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

Well-being was slightly greater in the intervention group at six months, with a mean difference of 0.01 (95% CI = –0.84 to 0.85) when comparing the intervention group to the control group and a Cohen's d effect size of 0.03 (95% CI = –0.27 to 0.19), but this was not statistically significant at the 5% level (p = 0.99).

RQ6 What is the difference in quality of life, derived from the CHU-9D, in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

Quality of life was similar for both groups at six months, with a mean difference of 0 (95% CI = –0.03 to 0.02) when comparing the intervention group to the control group and a Cohen's d effect size of 0 (95% CI = –0.23 to 0.23), but this was not statistically significant at the 5% level (p = 0.80).

RQ7 What is the difference in substance use self-efficacy, derived from the SCQ8, in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

Situational confidence (the confidence that a young person could resist using substances) was higher in the intervention group, indicating greater confidence; at month 6, there was a mean difference of 1.57 (95% CI = –4.48 to 7.68) when comparing the intervention group to the control group and a Cohen's d effect size of 0.17 (95% CI = –0.40 to 0.07), but this was not statistically significant at the 5% level (p = 0.61).

RQ8 What is the difference in motivation to change, derived from the Readiness Ruler (RR), in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

The intervention group had lower motivation to change substance-using behaviour; at month 6, there was a mean difference of –0.13 (95% CI = –0.51 to 0.25) when comparing the

intervention group to the control group and a Cohen's d effect size of –0.13 (95% CI = –0.34 to 0.10), but this was not statistically significant at the 5% level (p = 0.51).

RQ9 What is the difference in positive and negative expectancies, derived from the SUES, in the six months after randomisation for those receiving the Re-Frame intervention versus those receiving the control?

The intervention group had lower positive expectancies and positive views about substance use; at month 6, there was a mean difference of –0.94 (95% CI = –7.24 to 5.35) when comparing the intervention group to the control group and a Cohen's d effect size of –0.03 (95% CI = –0.27 to 0.20), but this was not statistically significant at the 5% level (p = 0.77).

The intervention group had higher negative expectancies and negative views about substance use; at month 6, there was a mean difference of 1.53 (95% CI = –4.14 to 7.19) when comparing the intervention group to the control group and a Cohen's d effect size of –0.002 (95% CI; –0.23 to 0.23), but this was not statistically significant at the 5% level (p = 0.59).

RQ10 What factors – age, sex, ethnicity, material deprivation (IMD), family environment (BFES), adverse child experiences (ACEQ), adherence, depression (PHQ9), anxiety (GAD) – impact the primary outcome observed for both groups?

After variable reduction, age group, baseline family conflict and adverse childhood experiences were included in a prognostic model. At baseline, only age group was found to predict the number of offences at month 6. The IRR comparing those older (age 15–17 years) versus younger (10 to 14 years) was 0.32 (95% CI = 0.15 to 0.67), indicating that those in the older age group at baseline had committed fewer offences by month 6, a large effect size difference. Cohen's d was –0.45 (95% CI = –0.74 to –0.15); this effect was statistically significant at the 5% level (p = 0.003). There were no interactions between age group at baseline and the allocated group.

RQ11 What factors – age, sex, ethnicity, material deprivation (IMD), family environment (BFES), adverse childhood experiences (ACEQ), adherence, depression (PHQ9), anxiety (GAD) and therapeutic alliance – impact on the primary outcome observed for the intervention group?

No factors impacted on the number of offences in the six months after randomisation in the intervention group alone.

RQ12 Are there potential interactions between demographic factors and the outcome observed for the primary outcome six months after randomisation?

LCA yielded no significant subgroups of baseline demographic variables that predicted offences in the six months after baseline.

RQ13 **Are there differences in the number of offences at six months for the participating sample versus a cohort of young people found in possession of class B or C substances who were not referred to the study?**

This question could not be addressed due to data limitations. When young people had not been referred to the study, they were often classed as NFA, and local police databases did not contain information on this population.

RQ14 **What is the cost per participant of delivering the Re-Frame intervention?**

Total upfront costs were estimated as £554.40 (£3.01 per participant) and recurring costs as £13,890.84 (£75.49 per participant). Total costs were estimated as £14,445.24 (£78.50 per participant).

Implementation and process evaluation results

Introduction

The aim of the qualitative analysis was to link samples by grouping, comparing responses from all data sources to address the research questions. This allowed for a concentrated and meaningful analysis of the impact of the Re-Frame intervention through its contexts and mechanisms and perceived impact by the thematic blending of the data collected.

The qualitative analysis explored the perceptions of the Re-Frame intervention from the experiences of various stakeholders; these included the young people who received the intervention, the practitioners who delivered the intervention, police officers in both frontline and management roles and focus group participants. The analysis explored which elements of the Re-Frame intervention were useful and which were unnecessary, as well as identifying perceived facilitators and barriers for implementation.

Research questions addressed by this analysis:

- Do participants, providers and police perceive any external or logistical issues as impacting referral, intervention delivery, attrition, or study assessments?
- What are participants' positive and negative intervention experiences, and how do these fit with providers' perceptions? At what points in the intervention are these experiences most likely?
- What reasons do participants offer for their substance misuse and for their intervention responses?
- Can practices associated with the intervention be amended to increase its acceptability and impact?
- Do police perceive the intervention as impacting participants' offending?

Methods

Data collection

29 interviews and three focus groups were conducted, and narrative accounts were collected from a range of stakeholders using a semi-structured interview approach (table 20). Qualitative data was collected using semi-structured interviews with young people, intervention staff and police officers from the four participating sites. Online focus groups were also held to include wider stakeholders from across seven non-Re-Frame areas (table 24). All participants were sampled purposively by site; young people were additionally sampled by age and gender. Focus groups were conducted across six regions in the UK. We had originally intended to approach young people who had dropped out to take part in the interviews; however, due to a high adherence rate, this was not necessary.

In addition to the focus groups, we had planned to interview young people from across the country who met the same criteria as Re-Frame participants but had received a criminal justice outcome. However, we were unable to access these young people despite approaching several local authorities and drug treatment services.

Table 20. Interview participants

Re-Frame interviews	n
Young people	15
Delivery staff / interventionists	5
Police officers	9

Table 21. Young people's (YPs') demographic characteristics

ID	Age	Gender	Ethnicity	Site
YP 1	17	Male	White British	Kent
YP 2	17	Female	White British	Sefton
YP 3	16	Male	White British	Sefton
YP 4	16	Female	White British	Wigan
YP 5	16	Male	Asian British	Wigan
YP 6	16	Male	Black British	Wigan
YP 7	14	Male	White British	Wigan
YP 8	17	Male	White British	Wigan
YP 9	15	Male	White British	Kent
YP 10	17	Male	White British	Sefton
YP 11	17	Male	White British	Sefton
YP 12	17	Male	White British	Kent
YP 13	15	Female	White British	Cornwall
YP14	16	Male	White British	Cornwall
YP 15	15	Male	White British	Kent

Table 22. Re-Frame delivery interventionist (INT) and role

Delivery ID	Role
INT 1	Program delivery
INT 2	Program delivery
INT 3	Program delivery
INT 4	Program delivery
INT 5	Program management

Table 23. Police staff and site

Police (PO)	Site
PO 1	Kent
PO 2	Cornwall
PO 3	Sefton
PO 4	Kent
PO 5	Kent
PO 6	Sefton
PO 7	Cornwall
PO 8	Wigan
PO 9	Cornwall

The police and focus group participants' professional areas of specialism have not been identified by site and area to ensure the confidentiality of participants and maintain ethical research standards. The officers interviewed had experience in frontline policing (including in response teams), youth justice, safeguarding teams and senior management. The focus group participants' professional roles are summarised in table 25.

Table 24. Focus groups areas

Region	Area
North East	Redcar
South West	Bournemouth, Christchurch & Poole
North East	Darlington
North Yorkshire & County Durham	Cleveland
North East Lincolnshire	Grimsby
West Midlands	Shropshire
North West	Wigan

Table 25. Focus group participants

Focus group – stakeholder roles
Family support workers
Substance use practitioners
Local authority commissioners
Team leads
Criminal justice leads
Safeguarding leads
Young people's recovery workers

Exploring the quality of the intervention delivered

A stated objective of our efficacy study was 'To assess the fidelity of intervention delivery and explore the role that fidelity, therapeutic alliance and baseline demographic and psychological factors play in the outcomes observed'. To achieve this, we recorded a random sample of interventions, stratified by the four interventionists, and had these independently scored using an established tool for assessing fidelity in behavioural change interventions: BECCI (Lane, 2002). This instrument provides an overall score ranging from 0 to 4, where 0 indicates low fidelity and 4 indicates high fidelity. 32 audio recordings were assessed, and the overall mean BECCI score for the intervention was 3.00 (95% CI = 2.93 to 3.08), indicating a high level of fidelity in the delivery of the intervention.

We conducted an analysis to explore the role that fidelity, adolescents' perception of therapeutic alliance and interventionist legitimacy play in the outcomes observed. Completion of the TASC-r by interventionists at the end of the second session was poor, with less than half completing the questionnaire. We used a negative binomial regression model with the primary outcome as the dependent variable, adjusting for key covariates that were identified using a variable reduction approach. The result of this analysis allowed a quantification of what fidelity dimensions were most associated with changes in outcomes. This enabled an exploration of whether certain domains are more important than others and should be emphasised in the intervention delivery and, by extension, the training.

The analysis found only offences committed in the six months prior to baseline impacted on the number of offences in the six months after baseline; therapeutic alliance and interventionist legitimacy had no impact on the number of offences in the six months post-randomisation.

Exploring the relationship between dosage and outcome

The result of the analysis is similar to the primary outcome analysis, except that the difference between the intervention and control groups in the IRR for offences in the six months after randomisation was 1.50 (95% CI = 0.96 to 2.34). This is as would be expected for a study with high levels of compliance. To test whether compliance was associated with fewer offences, we conducted a negative binomial model that included only those in the intervention group and used age group and number of offences in the six months prior to

baseline as covariates; this indicated a lower IRR for those who complied (IRR = 0.57; 95% CI = 0.30 to 1.08), but this was not significant (p = 0.084).

In addition to this, we wanted to explore whether certain factors are associated with non-compliance to identify potential clusters of participants who did not comply. We conducted an LCA to identify potential clusters associated with non-compliance; this allowed an exploration of whether there were subgroups of participants who were less likely to comply than others and, by augmenting this quantitative approach with targeted qualitative interviews with the young people and interventionists, enabled the wider research group to explore what adaptations might be necessary to increase accessibility and compliance.

The qualitative interviews highlighted some potential issues associated with compliance. They highlighted delays from the initial police incident to starting the first intervention session. The delays were more common towards the end of the study and appeared to be at intervention sites where full-time workers had moved on from the project and sessional staff had taken over in addition to their usual caseload. This was mainly noted in Wigan, where delays had sometimes been a few weeks or, on occasion, months, as noted by YP 6. The delay from referral to intervention contact did cause some a gap in communication. According to one young person, 'it took about two months before anyone messaged my mum or anything' (YP 6). Another had waited for a few weeks in between sessions 1 and 2 and found that very frustrating (YP 8).

Delivery workers also found this a challenge later in the project. They also shared the frustrations of the young people but understood that, because of the delivery restructure, sessional staff often had busy caseloads outside of Re-Frame, which meant that the programme was not their primary focus. They viewed this as an operational staffing issue linked to them as providers, not as a weakness in the programme model (INT 4 and 5).

Exploring reach

We reported the study using CONSORT guidelines. This will enable us to explore the relationship between those who are potentially eligible, those who consent and those who engage, using the key demographic indicators age, gender and ethnicity. Significant differences in these key demographic indicators at each point will inform our qualitative research; we will purposively sample those who do not consent and those who withdraw to explore the reasons why and to understand the perceived acceptability of the intervention or control for these participants.

A key area to explore in terms of reach is whether all potential participants were being identified and referred to the study. In previous studies of diversionary schemes for substance misuse offences, some critics have highlighted the disproportionate inclusion of White middle-class males, who are not necessarily representative of the target demographic. The population referred for diversion was not ethnically diverse; previous research suggests that while young Black people are overrepresented in both stop and search and their involvement with criminal justice, they constitute only 3% of those referred for diversion (Brodie, 2025). Of those young Black people referred, only 50% agreed to participate in the study, compared with 72% of White young people. One factor that hampered any detailed analysis of who was potentially eligible for diversion versus who was referred for diversion was the lack of recording of ethnicity in local police databases.

As those classed as NFA or given a warning are not entered on the Police National Computer, we were not able to conduct an anonymised aggregate analysis of differences between the cohorts referred or not referred or an anonymised aggregate analysis of outcomes for those not referred.

In the qualitative interviews, the issue of police discretion was raised by intervention staff, who felt the issue of discretion might lead to some young people being overlooked for diversion:

> *I feel really passionate that there shouldn't be police discretion about whether someone's referred to Re--. I think every young person caught in possession, whether it's a crumb in their grinder or 2 grams – if they're charged with possession, they need to come to Re-Frame.* (INT, 1)

Some police officers discussed whether police-led drug diversion should become a formal policy and identified possible benefits and challenges. Officers fed back that a policy framework could help ensure greater consistency and equity in decision-making so that all young people are treated fairly regardless of circumstance. They felt it would streamline processes for frontline officers by providing a clear referral route, reducing workload and improving efficiency, something noted in the Re-Frame sites. However, limiting officer discretion was discussed as a possible issue:

> *Potentially limiting officer discretion would be negative for young people, as some officers may have valuable insights into individual cases or wider circumstances that could inform decision making*. (PO 9)

PO 9 felt that officers have valuable insights into individual cases and that too rigid a policy might overlook important contextual factors.

Despite the complexities, there was a strong sense from nearly all the police interviews that every child who comes into contact with the police should have access to intervention and support. Some officers expressed that some police have a negative view of diversion, as they may view it as 'enabling drug use' or being 'too lenient' (PO 2 and 4).

Exploring responsiveness

In order to explore whether there are specific clusters of young people who reoffend, we conducted an LCA after item reduction. The model contained offending at month 6 (yes/no), age group (10–14 / 15–17) and centre (Cornwall/Wigan/Kent/Sefton). The LCA identified no specific clusters of characteristics associated with reoffending. This was probably attributable to a low offending rate and model entropy due to a lack of sample variability.

An aspect of our qualitative work with key stakeholders involves examining stakeholders' positive and negative experiences of the referral process and intervention, exploring how these perspectives concur with those who deliver the intervention and investigating at what points negative and positive experiences are at their greatest and what steps could be taken to ameliorate these experiences to improve the delivery and acceptability of the intervention.

The positive intervention experiences that young people told us about fit well with providers' perceptions; the key areas were the avoidance of a negative criminal justice outcome and the understanding that this was a 'second chance', the flexibility of delivery, the intervention content and the communication style of the delivery workers.

Second chance

Nearly all the young people acknowledged that being diverted was a positive experience and had been a 'no-brainer' (YP 9), with many stating that it had offered them a second chance. All the young people clearly understood that having been found in possession of an illegal substance by the police could have resulted in a criminal justice outcome and a criminal record, which they understood could negatively impact their future:

> *I think it was sort of a no-brainer, really. I don't know why I wouldn't have done it – it sort of just makes sense to do it.* (YP 9)

> *I think it's, erm, obviously good, 'cause as you're growing up, people tend to make mistakes and experience things … I feel like every teenager goes through something like this, and instead of being punished for it, they should be taught to do it safely, and that's what it is, and I think that's good. Better than, erm, a punishment, really.* (YP 3)

> *I had the choice of either get a kind of criminal record or maybe not get a criminal record, but it'll go down the route with the police. Or I can have it, erm, where I interact with Re-Frame and then I won't have any more interaction with the police, and obviously I chose to do it … 'cause I wouldn't want to, erm, have a record or anything.* (YP 14)

Intervention staff also reported that having a second chance was a motivation for some of the young people to engage with the intervention, but often only if they had plans for the future. Further education and travel were noted as reasons for understanding the impact a criminal justice outcome might have had. Part of the intervention content in session 1 provided time to discuss why the young person had been referred into Re-Frame and to discuss the contact with the police. The young people were encouraged to consider the alternative options and consequences. One worker felt that this process was useful, as it redirected the young people to consider the impact a criminal record might have on their future:

> *I think, for a lot of them, it is just letting them process what's kind of happened and how that, how that can impact the future … unless they want to go to sixth form or university, some are not really bothered about the future impact bit.* (INT 2)

Flexibility of delivery

The option for virtual or face-to-face delivery accommodated the young people's preferences and needs.

Virtual sessions

The young people liked having the choice of how to engage with the delivery worker in a way that suited them. One young person reflected that they enjoyed the virtual session and told us, 'I didn't expect it to be as nice' (YP 11). Another said they found meeting strangers difficult but that the virtual sessions alleviated the worry of meeting a new person:

> *I can't physically go and meet a stranger and then have a full-on conversation with them. Well, I can, but I would struggle with it. I was worried … But yeah, with this, I've been in the comfort of my own home. I am able to just sit indoors and have a conversation without being uncomfortable. (YP 12)*

I think, sometimes, that [virtual] can be better than in person for some people. 'Cause I know people, yeah, like, get anxiety or nervousness about it. So, I think having the option to be virtual is, is nice as well. (YP 2)

Another found that the virtual sessions were easy, as they were used to engaging with people on their phone:

'Cause kids are addicted to their phones [laughs] – *it's easy and saves them some time, doesn't it?'* (YP 6)

In-person sessions

Some of the young people preferred to meet the interventionists for in-person sessions; these were sometimes at their home, school/college, family centre setting or, in some cases, as a walk and talk (some workers offered a walk and talk if the young people preferred to be outside). They liked having the options available, but they felt that in-person was more beneficial for them. When asked why, they said

It's easier ... easier to talk when you're with someone in person, innit? (YP7)

I just thought it would be more … I thought I would probably take more from it. Actually, being able to sit with someone and like speak to them properly. 'Cause … like, I feel, like, over the phone, it's still obviously better than doing nothing, but in person, I feel like you speak more, like, er like, honestly. (YP 10)

The interventionists also found that in-person sessions were easier for building trust and engagement. Trust and rapport were therefore considered a mechanism that triggered engagement with the intervention. The young people 'opened up' during walk-and-talk sessions, which were particularly effective for creating a relaxed and open environment.

The interventionists felt that physically meeting the young person enabled them to observe non-verbal cues, body language and general demeanour, which could inform the session approach:

I just think face to face is so much better ... for professional curiosity. Are they dressed well? Are they bruised? … All that kind of extra bit that you can do, and also, are they listening? You know, are they engaging? Are they benefiting from this? What vibe are you getting from them? (INT 3)

The importance of the session setting or context was also noted:

So, session 1. We sat in his living room and did the appointment, and mum was in the kitchen ironing, but the door was like open a crack and I think he was very nervous he'd been found with quite a lot of weed … He was quite a closed book in the first session, like only answering, like, yes, no kind of questions. So, the second session I was like, 'Why don't we go out?' Like, why don't we just go for a walk around, like instead of mum kind of listening? He was then disclosing loads of stuff around the people he hangs around with, where he goes, his relationship with weed … and there were lots of other substances that actually he had tried before, so we were able to speak about his experiences of those and dosages and harm reduction. (INT 2)

The young people all felt that the interventionists were engaging and friendly and that it was easy to talk to them, which led to meaningful conversations and helped reduce attrition.

Intervention content

The young people enjoyed the intervention content, and all the young people found the information they received useful and that it added to their knowledge. The session contents that were repeatedly highlighted were the exercise on the law, the Drug Triangle and the Drugs Grid, which promoted self-reflection and harm reduction:

> *I feel like the consequences aren't always worth it, to be constantly at risk of stuff, like, obviously, the police and stuff like that, even just the police as well, like, your health and stuff like that as well.* (YP 9)

The legal implications of being found in possession of illegal substances are addressed in the psychoeducation Drugs Grid session. This session explores the wider societal impacts of substance use, highlights associated risks and provides a supportive space for young people to reflect on consequences while developing the knowledge and confidence that enable informed choices:

> *She went through the, erm, like, the sentencing of, erm, like, if you were in possession or, like, dealing, and I thought that was, erm, it was quite like eye opening … kind of took all of it in and, like, subconsciously, you know, like, went it ... I did find the legal side quite interesting, that resonated with me a lot.* (YP 2)

Communication style

All young people said that the Re-Frame interventionists were friendly and really listened to them; they liked the non-judgemental approach. Communication was uncomplicated and easy to understand:

> *She was, she was easy to speak to. It was like, it was like, yeah, 'cause it was like when I was speaking to the police, you know, the police are there to do one job, where because she is not police or [a] teacher or family or nothing, it was like there was no judgement at all. No matter what I said, there was like, there was no sort of, like, there was no funny looks, you know what I mean? She was just open to everything that I said.* (YP 10)

> *I, honestly, I thought it was going to be like, erm, a counselling session, but in some respects, it is like that, but erm, it was more like advice, helpful advice. And that was a good thing, 'cause, you know, [it] just helps you feel safe and everything … I felt like it was quite, like, honest, so ... like, it was just authentic, I guess the word would be.* (YP 2)

The Re-Frame interventionists told us that, from the very first point of contact, they ensure that communication is clear and honest; this reflects the young people's experience of the positive communication from the very beginning of the intervention:

> *I think it's, like, from the start, I make a really conscious effort, even in that initial phone call, to try and put that young person at ease and be really clear about who we are, what the project is, why it's been set up … And I'm just really honest and really clear from the get-go about what's going to be covered. Check that that's all OK with them. Ask if there's anything else they would like to talk about. And then, obviously, use my skills, like active listening, counselling skills, using aspects of motivational interviewing, CBT techniques, to engage that young person. (INT 1)*

Police contact

The most common negative experience was the initial police contact. While this was in the pre-intervention stage, it is important to note because many found it to be uncomfortable and stressful. The experience of being stopped by the police was often expressed as a surprise or shock and appears to be a window of opportunity for a behaviour change intervention:

> *They put us in handcuffs … took all our details, called all our parents and then asked our parents, like, if we needed dropping home. Erm, I was honestly a bit scared, but also, I knew I was all right because it wasn't like a lot [of drugs]. Well, I wouldn't have a lot, but if I did have a lot, then I'd be scared … I felt, well, not comfortable, 'cause obviously you're getting arrested* ... (YP 14)

When reflecting on behaviour change, some of the young people reported being more cautious about smoking cannabis in public spaces following their experience of being found in possession by the police. Increased awareness of the potential consequences has influenced their decision-making and led to changes in behaviour. One young person explained that he now uses less cannabis and avoids smoking in public, as he is motivated to prevent further trouble with the police. He felt that if he were to be 'caught' a second time, it would be more challenging because of the process that he would have to go through (YP 14).

The intervention staff also felt that the first contact with police had been a key moment for the young people:

> *A lot of them are really scared. It's probably their first time [experiencing police contact] … like, some young people have told me how brazen they were with, like, walking down the high street, like, with a bong in their hand and stuff, like, I think just being stopped and spoken to by police definitely has got like, yeah, it definitely pulls a bit of a punch for them, I think.* (INT 1)

Exploring potential adaptations

The mechanism of change was explored using a mediation model approach and incorporating motivation, self-efficacy and expectancy at month 6, adjusted for baseline covariates. The allocated group was included as an interaction term. The mediation analysis is detailed in table 17 and indicates that only a small proportion of offending or change in the frequency of substance use in the six months after baseline was mediated by motivation, self-efficacy or expectancy.

The factors that impact the mechanism of change were assessed using regression analysis to model the relationship between pre-randomisation factors and observed outcomes at six months; the analysis for the primary outcome and for PDA from substance use were conducted separately. Interaction terms within the allocation arm were included in the analysis, and a significance level of 0.1 was used to determine which factors were included in the regression model. Pre-randomisation factors included gender, age, ethnicity, IMD decile, adverse childhood experiences, anxiety and depression and family cohesion.

Table 18 presents the results of this analysis for the number of offences in the six months post-randomisation; being aged 15–17 at referral was the only significant predictor. Table 19 presents the results for the frequency of substance use in the six months post-randomisation; there was only one significant predictor, family conflict, indicating that lower levels of family conflict predict increased frequency of use.

In addition to quantitatively understanding the mechanism of action, the qualitative analysis provided an opportunity to explore the perceptions of the intervention from the point of view of a variety of stakeholders. The analysis allowed us to explore which elements of the interventions were useful and which were unnecessary, issues around how the interventions were planned and implemented and the perceived barriers to or facilitators of implementation in usual practice.

Delays in intervention delivery and closure

The police, the participants and the intervention staff noted delays to delivery and police closure, which is a formal recording of an outcome. If a young person completed the diversion, they would receive an Outcome 22, which is a Home Office code used by the police when diversionary action has led to an NFA. It is an alternative to a formal out-of-court disposal, prosecution or further investigation and can be used without an admission of guilt. The outcome is not recorded until the diversionary activity, which addresses the root causes of offending and preventing offending, has been completed (National Police Chief's Council, 2022)

> *We can't even close the [crime] report our end unless we've got a closure report. Okay, so it's quite strict here, and this is where we then start getting our sergeants on our back because it's kind of like, 'You've still got this report in your pot from June,' and it's like, I haven't received the closing paperwork yet. So, we start getting in the neck at our end.* (PO 5)

The delay to police closure was primarily caused by a change in WithYou's management during the efficacy phase of the Re-Frame study. This transition led to issues that impacted the programme's efficiency and staff morale and resulted in delays for the young people receiving the sessions. It also impacted the timely sending of closure reports to the police. The intervention should occur within two weeks of the referral and be delivered within four weeks. However, the delay caused issues for officers, as they felt it reduced the impact of the intervention, raised concerns about responsiveness and caused some administrative frustration in regard to internal reporting.

Tailor session content to accommodate younger children

Interventionists suggested that tailoring intervention content materials for younger participants (e.g. 12–13 year olds) would be beneficial, as they felt these young people sometimes struggled with contextual thinking. This included simplifying the Drug Triangle to match the young person's developmental stage.

The young people told us they did not feel Re-Frame could be improved to make it more acceptable to young people, as it was 'already great.'

Tighten up referral and delivery times

It would be beneficial to streamline referral timelines and address delays in both police referrals and delivery times to ensure the young people are contacted closer to the incident, maintaining relevance and engagement.

Police officer training and education

The current training approaches, particularly the online modules, were described as 'too generic' and lacking relevance to officers' day-to-day roles. Several forces noted that existing training does not adequately equip officers with the practical understanding needed to apply diversion effectively. It was suggested that training

on youth diversion should be embedded in both initial officer recruitment programmes and ongoing professional development, to ensure a consistent and informed approach. Additional training suggestions included:

- A video or recorded presentation explaining youth outcomes and diversion processes
- A focus on Outcome 22 and its application in youth diversion
- Collaboration between police teams and diversion delivery teams to ensure accurate and comprehensive training on why police-led drug diversion should be used for young people found in possession of class B and C substances
- Strategies to engage young people and their families, as supportive families can enable positive engagement.

When considering both impact and acceptability, the interviewees shared aspirational, long-term ideas. These suggestions represent broader, strategic thinking aimed at significantly increasing reach and engagement, particularly among young people. While not immediately actionable, they hold the potential for greater impact over time and reflect a more ambitious vision for future development.

Policy to divert

A formal police policy to divert was raised to create police acceptability and increase impact, thus enabling a more consistent approach to police drug diversion for young people and potentially improving fairness and equity in how young people are treated. It was felt that this aligned with existing policies for children and young people and would frame youth diversion as a child protection issue, which could strengthen the case for making it a formal policy. Making diversion a policy could streamline the process for frontline officers, allowing them to quickly refer cases and reduce their workload. However, some officers felt that another policy was just another layer in an already complex system.

Expand referral criteria

Three of the four police sites told us they would welcome an expansion of Re-Frame to include a diversion for alcohol-related and antisocial behaviour, as a lot of young people came to their attention that way:

> *I've got two massive residential areas, and it's just jam-packed full of kids who just need to be cracked down on. So, if there was an expansion of Re-Frame for antisocial behaviour issues that we could start referring kids for, I have about 20 waiting I would happily refer tomorrow. And the more quick, easy tools you can give us, which is* [sic] *still slightly punitive but educational, I'm fully on board.* (PO 1)

> *If you ever do anything around alcohol and antisocial behaviour … We would be on board.* (PO 6)

Others suggested including possession of small amounts of class A substances to broaden the scope of the intervention.

Exploring the factors affecting implementation

Within the CJS, there is no central recording mechanism for recording informal out-of-court disposals and diversions. It is estimated that 40% of first-time youth entrants to CJS receive an informal diversion (Brodie et al., 2025). As part of the efficacy trial, we planned a survey of police forces in England to explore the

nature and extent of diversion for first-time substance use offences among young people, working in collaboration with colleagues with the police and senior staff involved in criminal justice at the OHID. This survey aimed to address the varieties of diversionary schemes employed, eligibility, referral mechanisms, numbers referred annually and sources of funding.

A number of factors hampered the conduct of this survey: significant changes within the OHID meant there was no formal oversight of criminal justice from a public health perspective; most police forces did not respond, and when they did, they had little detail on what diversion schemes were available in an ever-changing landscape. Nationally, where a police force uses a diversion scheme for young people found in possession of substances, it takes the form of referral to substance use services for education or brief psychosocial intervention. In the participating sites, only Kent had a substance use diversion scheme prior to the study, where young people were diverted to a multi-session, multi-component group intervention that addressed risk-taking behaviour in general.

What reasons do participants offer for their substance misuse and for their intervention responses?

The young people were able to identify and reflect on why they used drugs. The key themes identified were for the social environment and fun, as self-medication for neurodiversity (diagnosed and undiagnosed) and mental well-being, and as an escapism and coping mechanism. Intervention staff and the police interviews also identified and offered reasons for young people's drug use that were congruent with the young people's views.

The young people told us that drug use is often a social activity, with young people trying substances because their friends are using them. Many young people reported using drugs as part of social gatherings, saying that it was 'fun' and that they enjoy smoking weed with their friends, rather than alone. Some said they tried drugs out of curiosity or a desire to experiment with friends. The social activity of using drugs with friendship groups was commonly observed, with many expressing that the shared experience of using drugs with friends often made them feel closer to their friendship group:

> *I don't smoke on my own ... I smoke with friends, and it makes us all feel closer when we're having a laugh ... it enhances the social sort of feeling, err, well, it's almost like some sort of bonding thing.* (YP 1)

> *It was just, just recreational. It was just something fun to do with my friends on, like, the weekend.* (YP 14)

> *We don't want fights – we just we just get stoned instead.* (YP 6)

In some cases, drug use was normalised within the young person's social circle or community, making it appear more accessible and less stigmatised. Police and delivery staff also felt that the accessibility and normalisation of drug use (in particular, cannabis) is a reason why young people use drugs:

> *I think, I think a lot of them think that cannabis is just fine, probably because the parents are using it.* (PO 7)

> *We've got a culture across all classes now that it's OK to do drugs, 'It's OK. It's just a bit of weed.' I've heard professionals say that. I'm like, well, it's not just a bit of weed.* (PO 3)

Several young people said they used drugs, particularly cannabis, to manage the symptoms of ADHD, autism, anxiety and poor sleep. Cannabis was often referred to as a mood stabiliser. The young people said it helps them feel calmer and more focused, especially in school environments. This came across strongly in the interviews, particularly in relation to how the young people were navigating both diagnosed and undiagnosed neurodiversity, with some sharing that they smoked cannabis to self-medicate. They said that it helped to calm their minds and to reduce feelings of overwhelming anxiety and stress:

> *I felt a lot better when I did it basically. I just felt better in general … it just helped me cope with everything. I just forgot about everything when I was doing it… general[ly], I've not really got the best, like, mental health, so it was just, just that I felt a lot calmer and then, just better.* (YP 5)

One young person told us that he had been waiting for two years for a review of his ADHD and a medication review, and he felt that self-medicating with cannabis was helping him while he waited to be seen:

> *I smoke it because ... well, I self-medicate for ADHD 'cause the medication that they give me don't work. Well, it didn't work, and they stopped making it as well … It calms me down a lot.* (YP 6)

Others also mentioned waiting for appointments with child and adolescent mental health services (CAMHS) or assessments for ADHD.

Both the police and delivery staff interviews supported the young people's experiences of self-medicating with cannabis and the challenge of wait times for assessment in their areas:

> *Children are waiting for two to three years to be seen by CAMHS … They're using cannabis even before they've got a formal diagnosis. Yeah, they're quite open: I have ADHD. I don't take my medication. I self-medicate with cannabis. It's … very, very, very regular.* (PO 8)

> *A lot of our young people have got, like, special educational needs and stuff as well. And actually, a lot of them are talking about the benefits of cannabis for their ADHD in the sessions.* (INT 2)

> *I think a lot of the time it is just, 'Oh, my mate was doing it, and I got passed it and then I realised it really calmed me down.'* (YP5)

> *A lot of it is mood stabilising, a lot of [it is] ADHD, autism, can't sleep, poor appetite, and they just take this thing and then they can sit in school and not kick off, and they can listen to their parents telling them off and get on with their work.* (INT 4)

The young people have an opportunity during the Re-Frame intervention to discuss their mental well-being, and this can help them to reflect on the link between drug use and mental health, in particular, long-term well-being. One young person reflected that they use cannabis to self-medicate and was concerned about the long-term use of cannabis. They told us that they are currently awaiting a mental health referral and assessment for ADHD and, like others, had been told to expect to wait at least a year for an appointment:

> *I know a lot of people say weed's not bad, but it's bad, really, isn't it? … It's like, you shouldn't do any of it, but that's like probably the least harmful one out of all the drugs you can do … instinctively, you still feel that you shouldn't be self-medicating with it. So, I'll end up, it'll make it worse eventually. It might help it at the time, but then I'll end up getting addicted to it.* (YP 12)

The Re-Frame Intervention is designed as a brief intervention. If a young person in either the control or intervention group is found to need more intensive support, they are referred to appropriate local services.

The young people often referred to their drug use as a way to escape or cope with pressure and stress from school and college or with relationship issues they were experiencing. Some referred to difficulties with sleep and how this impacted their stress.

Several young people shared that they felt smoking cannabis 'slowed their brains down' and helped them with school or college work, as many linked this with the idea that cannabis helped them to sleep and, therefore, to focus the next day (YP7). One young person described how his mind felt when smoking cannabis:

> *So, it's sort of like, I'm always, like, 100 miles an hour – do you know what I mean? Like, some days I'll wake up, and I'll be, like … energetic. It's really, really weird to explain it. It's not anything specific … I can sit down and watch TV, but my brain will still be going, like* [whistles]. *Like, when I am smoking, I feel normal, just a bit more, like, relaxed … because I get anxious a lot as well, like.* (YP 12)

Escapism from adverse circumstances was identified in the police interviews as a suggested reason for young people's drug use, and while the young people did refer to 'escapism or coping', it was couched in a 'personal' context, whereas professional observations referred to escapism from family issues and/or wider structural contexts. Officers acknowledged that some young people face really challenging family situations and noted the presence of childhood trauma and poverty. Officers explained that when they first come into contact with a young person, they conduct initial background checks:

> *This could be the child's first involvement, but the whole family are involved in drugs and other matters.* (PO 6)

Do police perceive the intervention as impacting participants' offending?

During the police interviews, officers from all sites stated that the young people who participated in the diversion were less likely to appear in police systems or come to the attention of the youth panels for subsequent offences. There were several officers who observed that they were not seeing the same young people again for possession offences or other offences:

> *We've obviously seen some really good results where they've not come back. For kids, we have seen a reduction in being a second-time offender, which has been great. Proves the point, doesn't it, about getting those early interventions in.* (PO3)

> *So, I think it's got to be working … You sort of get a general sort of feel of that in the faces that you see – sort of, the people that come back on your radar? … It's not like, 'Oh God, they're back again' … I actually can't even recall ever saying, 'Diversion, didn't you work with this one?'* (PO7)

> *The success rates seem high, with many names not coming up again after referral for diversion.* (PO8)

Officers were positive and hopeful that the educational approach to drug use, alongside knowledge of the consequences of drug possession combined with the non-judgemental style of Re-Frame, could mitigate against reoffending.

They acknowledged that while the diversion itself is not punitive, it is a very minor, time-based punishment. It requires young people to attend sessions or risk being referred back to the police, creating an inconvenience that could deter future offending. One officer felt the enforcement element of the diversion might act as a deterrent because of the power exchange of the law:

> *I think the thing we've found with Re-Frame is because ... it's from the police, but it's external, so it has the enforcement. But then, once they've accepted that, they suddenly are met with somebody who's non-judgemental – not telling you, 'You can't do drugs' … That young person is allowed to say what they feel without any sort of fear of going to get into trouble for this … they* [the young people] *said, 'You know, I was a bit nervous, but as soon as I spoke to somebody, it was like, they, they didn't tell me off.' And so, there's this element where, with the police, [the young people] feel they've been caught and then they've, like … the power exchange is very scary for them.* (PO 7)

Officers felt that while the Re-Frame intervention was generally perceived, or hoped to be, effective, it would not work for all young people, particularly those already experiencing challenges in life and with entrenched drug use behaviours. Officers felt that some wouldn't change their behaviours regardless of intervention:

> *We can say and do everything, but you know that it's not going to change, and it's not a lack of effort on my part or [the Re-Frame workers'] part. It's just, you know, a young person can see me for an out-of-court disposal, and I know whether I'm going to see him again.* (PO 8)

> *I've got one young gentleman in particular, unfortunately – I think we're going to know him for quite some time. He thinks that, after speaking to Re-Frame … [he] regards himself as a drug expert … 'I know exactly what I can take without overdosing or getting myself into trouble. I know what I can carry, I know what I can't,' which is ludicrous. Personally, I think, generally, it's taken in quite well by young people.* (PO 5)

Police officers and senior management perceived Re-Frame to be a valuable tool that might help to reduce offending among young people, especially for first-time and low-level offenders. They felt that the educational and non-judgemental approach, combined with the focus on early intervention, had the potential to influence behaviour change. However, they acknowledged that an individual's circumstances and wider support would be vital to maximising the impact Re-Frame had on offending.

To explore beyond the realms of the research project itself, we conducted several qualitative focus groups with key stakeholders not involved in the study. These groups were comprised of six to eight individuals and were repeated until data saturation had been reached. This purposive sample included areas of low/high diversion activity, capacity and deprivation. Participants were identified through engagement with local authorities and young people's drug treatment services. Initial contacts were made via the Health Determinants Research Collaboration forum and through partner networks within the selected local authority areas. The focus groups explored views on organisational capacity, intervention delivery, eligibility, referral mechanisms, the optimum number of standardised measures required to monitor intervention delivery, minimum standards of experience for interventionists, delivery of training and ongoing supervision. These focus groups allowed us to develop a set of minimum standards, standard operating procedures for training and intervention delivery, and a training and intervention delivery manual, which would be employed if the intervention were found to be effective.

Feasibility of implementing the Re-Frame intervention

Assessing the feasibility of implementing the Re-Frame intervention within existing service structures was informed by the views collected across the areas the focus groups' participants represented. The assessment explored organisational capacity, partnership readiness and commissioner support alongside practical aspects of delivery, such as referral pathways, eligibility criteria, the number of standardised measures needed for monitoring, minimum experience requirements for intervention staff and the design and delivery of training and ongoing supervision.

Programme interest and potential

Overall, there was strong support for implementing the Re-Frame police-led drug diversion intervention. Stakeholders expressed enthusiasm for the ongoing evaluation and were keen to review future results. All agreed the programme had potential for adoption within their local areas. They acknowledged that, while most interventions are evidence-informed, they would integrate an evidence-based intervention into their practice if the evaluation demonstrated its effectiveness.

All focus groups felt the Re-Frame programme/diversion could be a useful addition to the current services they offered. In particular, the programme element of reflecting on *why* a young person used substances, combined with the context of *why* the offence occurred, would help identify and support underlying needs they felt might currently be missed during initial assessments.

Organisational capacity and infrastructure

The tiered approach to service was discussed in all focus groups, and all agreed that Re-Frame fits well with their tier 2 provision, which included the provision of alcohol- and/or drug-related information and advice, triage assessment, referral to structured alcohol and/or drug treatment, brief psychosocial interventions and harm reduction interventions.

Staff across all areas largely agreed the programme could 'slot in quite easily' to their current services without major structural change, although some areas acknowledged staffing shortages. Services already work in partnership with youth justice and the police, and most felt there is a collaborative culture across teams, meaning the groundwork for referral pathways already exists. However, while the services reported that they currently receive some Outcome 22 referrals, they acknowledged they are not consistent.

Partnership readiness

It was felt that effective implementation would be easier in areas that have strong collaborations between drug treatment services and relevant partner agencies, which may include youth offending services, CAMHS and other drug treatment services in the area, to reduce the possible duplication of services.

Building police partnerships was identified as a priority for enabling cross-agency referrals and coordinated support. Some areas felt their police partnership would need to be further developed and would be essential to the programme's success and referral optimisation. There are established communication channels, and some teams attend multi-agency boards (i.e. youth justice and multi-agency child exploitation panels), with communication routes that can support referrals and engagement.

Commissioner support

All areas felt they had good relationships with commissioners who support the commissioning of evidence-based interventions for young people. One commissioner shared that current drug treatment services for young people allow for service evolution and service redesign, where benefits to young people and partnerships are clear and based on emerging good practice. Existing conversations around the integration and adaptation of services would need to be ongoing.

Reducing pressure on services

Many felt Re-Frame could alleviate pressure on overstretched services by managing low-level issues, enabling other services to focus on more serious or complex cases. The programme provides a structured way to engage young people and escalate support if other needs are identified.

Perceived barriers to implementation

Need for policy alignment

Without a clear and embedded policy, police referrals may remain inconsistent. Areas where drug diversion to Re-Frame is not embedded may struggle. Continued reinforcement or policy clarity would ensure consistent referrals.

Capacity challenges

Staffing shortages and staff turnover were noted as possible barriers to implementation by some teams and areas. It is acknowledged that some teams would need to balance their current caseloads carefully and might need justification to recruit additional workers.

Potential overlap

It was suggested that youth justice services already provide some substance use education; therefore, there may be questions raised around the duplication of efforts.

Session structure

Some felt that two Re-Frame sessions might not be enough, especially as rapport and trust take time to build with young people. They suggested introducing a pre-engagement session before the planned sessions.

Overall, the focus groups identified clear pathways to implement the Re-Frame programme, which is contingent on strengthening police partnerships and formalising inter-agency working. Commissioner support is strong, and the programme aligns with strategic goals to provide supportive, care-led interventions for young people.

Monitoring of the current service offer

Practitioners outlined the current service for monitoring the requirements of young people referred for substance use support as:

- All young people are logged on internal systems to reflect caseload numbers and service activity.

- Subject to ongoing monitoring through well-being and intervention plans, care plans and risk assessments are reviewed at six-week intervals.
- Non-engagement is flagged automatically within systems that track missed appointments and failed contacts.

Monitoring Re-Frame participation

Practitioners considered and agreed that Re-Frame monitoring could be integrated into current service monitoring but highlighted current IT system and data challenges that would need to be acknowledged and processes that would need to be put in place to accommodate additional Re-Frame monitoring:

- Did the young person attend both Re-Frame sessions?
- Was the engagement within the expected time limit (typically two weeks)?
- Were completed sessions logged and reported?
- If a young person failed to engage, was this reported to the police promptly, ensuring timely follow-up or escalation?

Police reporting

Delivery partners (currently WithYou) share monthly adherence reports with police. These include:

- Referrals received and status updates
- Outcomes (e.g. completed, disengaged)
- Cases returned to police due to non-engagement.

System and data challenges

Practitioners raised queries about how Re-Frame referrals would be recorded separately from standard service clients because of their different nature and pathway. Suggestions to ensure Re-Frame monitoring included a dedicated Re-Frame identifier within the case management system, to separate Re-Frame participants from other caseloads.

Services reported using different case management systems, which, some reported, would be changing soon. It was suggested that internal data teams would need to set up tailored reporting mechanisms to track Re-Frame-specific monitoring requirements that integrate with external police-reporting formats.

Minimum standards for staff to deliver Re-Frame

The following text is suitable for inclusion in a training manual or implementation pack for the Re-Frame programme:

> This section sets out minimum standards for the Re-Frame programme delivery. The standards align with capabilities outlined in the NHS Capability Framework for the Drug and Alcohol Treatment and Recovery Workforce (NHS, 2025), specifically, section 5.2 on children and young people's drug and alcohol worker capabilities. These capabilities can be embedded into the programme's delivery requirements to ensure consistent, high-quality practice.

The focus group participants proposed a set of recommended minimum standards required for Re-Frame delivery within their current service offering. The minimum standards identified included relevant

experience, knowledge requirements, training and qualifications, delivery approach and practitioner values. These standards are designed to ensure high-quality, consistent delivery and effective engagement with the young people diverted for possession of a class B or C substance and referred via an Outcome 22.

Table 26: Minimum Standards Required for Re-Frame Delivery

Relevant experience	Experience working directly with young people, particularly in settings where trust, rapport and motivational engagement are essential.
	Background of working in drug treatment services/other relevant services and a basic understanding of the relationship between drug use and offending.
	Understanding or experience of the criminal justice system; this would ideally include police, youth offending services or other services/charities that work with similar groups of young people.
Knowledge requirements	Re-Frame workers should have a clear understanding of the following areas: • Drug education knowledge and drug-related harm • Substance use risk factors, which include health and social impact • Risk management and safeguarding training: the ability to raise concerns and escalate appropriately • The criminal justice system: Outcome 22 and its purpose.
Training and qualifications	Relevant qualification or certification in substance misuse, youth work, or criminal justice *(not essential but desirable*). Completion of mandatory internal training on: • Substance misuse awareness • Safeguarding • Risk assessment and management. For inexperienced staff lacking direct justice system experience, arrangements should be made for shadowing or spending time with: • Local youth offending teams

	• Police youth-/child-first approaches.
Delivery approach and values	Re-Frame workers should: • Deliver sessions confidently and consistently using the Re-Frame materials. • Adapt their communication style to meet the needs of diverse young people. • Build rapport and motivation, ensuring sessions are not experienced as punitive but as supportive • Approach delivery with enthusiasm, a non-judgemental attitude and a genuine interest in the young person's development.

Exploring the fidelity of the intervention delivered

We assessed fidelity by randomly audio recording 20% of intervention sessions, stratified by age group, interventionist and site, and independently scoring them using BECCI (Lane, 2002). 32 audio recordings were assessed, and the overall mean BECCI score for the intervention was 3.00 (95% CI = 2.93 to 3.08), indicating a high level of fidelity in the delivery of the intervention.

Usual practice for non-trial participants

Usual practice varied by site, depending on the nature of the offence. For less serious offences, such as being in possession of a small amount of class B or C substances for personal use and being a first-time offender, usual practice would involve a warning and NFA. More serious offences might result in an out-of-court community resolution, formal charging and an appearance in court. In the usual control arm of the study, the young person was given an out-of-court diversion and referred to the substance misuse service; those young people who did not attend the substance misuse service had their case referred back to the police, who took a decision on what further action to take. Prior to the study, usual practice in the intervention group was similar to usual practice in the comparison group.

One of the key issues in interpreting the results is disentangling the effects of diversion from the effect of the Re-Frame intervention; randomisation occurred only after diversion. There was no evidence of the efficacy of the Re-Frame intervention on key outcomes compared with that of the control group, but there were changes over time in both groups: the volume of self-reported delinquency decreased from a median of 5 (interquartile range [IQR] 1 to 13) to 2 (IQR 0 to 7), and the frequency of substance use decreased. It may be the case that the observations are a result of the diversion itself, something that was confirmed by interviews conducted with the young people.

Cost information

A list of cost items and their underlying assumptions is provided in table 26.

Table 26: List of items, including cost estimates

Category	Description
Staff	
Labour cost assumptions	Intervention staff salaries, including employer national insurance and pension contributions, was £26,150 in 2023–24. It was estimated that staff would work 46 weeks/year (£568/week) and 37.5 hours/week (£15.16/hr).
Interventionist training	Training to deliver Re-Frame took one working day for four interventionists: £454.40.
Intervention preparation	Preparation for the intervention, including reviewing the referral, contacting the young person and arranging an initial appointment, was estimated to take 30 minutes: £7.58.
Intervention delivery	Each session of the intervention took two hours to deliver; both sessions took four hours: £60.64.
Buildings and facilities	
None	The intervention was delivered in WithYou offices or online during the working day: no additional costs were incurred.
Materials and equipment	
Printing worksheets	Total cost of printing material at 2023–24 prices was £641: £3.48/participant.
Translation	A one-off cost of £100 was incurred for the translation of worksheets: 54p/participant.
Incentives	
None	No incentives for participation were offered.
Other inputs	
Referring outcome	Referring the young person's attendance to the police and ensuring records were up to date was estimated as taking 15 minutes: £3.79/participant.

The actual cost of implementing the Re-Frame intervention is provided in table 27.

Table 27: Actual cost of implementing Re-Frame by cost item

Price 2023–24 cost items	Upfront or recurring?	Delivery partner cost
Staff		
Interventionist training	Upfront	£454.40
Intervention preparation	Recurring	£1,394.72
Intervention delivery	Recurring	£11,157.76
Buildings and facilities		
None	–	0
Materials and equipment		
Printing worksheets	Recurring	£641.00
Translation	Upfront	£100
Incentives		
None	–	0
Other inputs		
Referring outcome	Recurring	£697.36
Total cost		
Set-up	–	£554.40
Recurring	–	£13,890.84
Total	–	£14,445.24
Cost per participant		
Number of participants	–	184
Set-up cost per participant	–	£3.01
Recurring cost per participant	–	£75.49
Total cost per participant	–	£78.50

Total upfront costs were estimated as £554.40 (£3.01 per participant) and recurring costs as £13,890.84 (£75.49 per participant). Total costs were estimated as £14,445.24 (£78.50 per participant).

Conclusion

Table 28: Key conclusions

Key conclusions
Re-Frame demonstrated **a moderate negative impact** on children's offending. Children who received Re-Frame were more likely to offend than children who did not receive Re-Frame. There is uncertainty surrounding the estimate. This result has **a moderate security rating**.
Re-Frame showed mixed results on secondary outcomes: a small positive impact on emotional regulation, beliefs about the risks of substance use and beliefs about benefits from drug use and a moderate positive impact on frequency of substance use, peer problems and self-efficacy. Re-Frame showed a small negative impact on hyperactivity/inattention behaviours, well-being and quality of life and a moderate negative impact on self-reported offences, prosocial and conduct behaviour, and motivation to change. These are secondary outcomes and should be treated with caution.
Re-Frame was well received by the participants and staff involved, and compliance was very high. The young people found the content informative and reported that the substance misuse workers were friendly and really listened to them in a non-judgemental way. Police officers and senior management perceived Re-Frame to be valuable, especially for first-time and low-level offenders.
The participants were relatively infrequent substance users of class B or C controlled drugs who did not perceive their use of the drugs as a problem. In qualitative interviews, many of the young people described cannabis as harmless or a substance they used to self-medicate the experience of neurodivergence.
Some staff thought that while the programme could slot in quite easily to current services without major structural change, two sessions might not be enough time to change substance use and offending behaviours.

Impact evaluation and implementation and process evaluation integration

Evidence to support the logic model

This study does not provide evidence that the Re-Frame intervention is effective at reducing offending or the frequency of substance use versus a non-active control. Interviews with the police indicated they considered the act of diverting young people from the CJS to be associated with reductions in offending in both the intervention and control group. Interviews with the young people and interventionists highlighted that the young people had benefited from the Re-Frame intervention. The sample included in the study were not prolific offenders, with 73% who had committed an offence not coming to the attention of police for offending in the six months prior to diversion, 93% coming to the attention of the police for offending no more than once, 74% not coming to the attention of police for offending in the six months after randomisation and 94% coming to the attention of the police for offending no more than once in this period.

The aim of the Re-Frame intervention was to reduce the frequency of substance use and, in turn, reduce the rate of offending among the target population. It aimed to achieve this through a psychoeducational and skill development approach. The Drugs Grid explores knowledge about substance use and the associated risk and knowledge about substance use norms, and the Drug Triangle explores the impact of substance use on the young person's wider network. In theory, an enhanced knowledge of substance use and the associated risk is associated with a less positive attitude towards the use of substances, greater negative expectancy and increased confidence in resisting substance use (i.e. self-efficacy; Alharbi et al., 2025; Carney et al., 2016; Fooladvand, 2020; Hua-Nguyen et al., 2025). These are key predictors of substance use behaviour change. Understanding the risks of substance use is associated with an increased motivation

to change. Our analysis found that these components mediated very little of the change observed in the number of offences or frequency of substance use.

At baseline, the PDA from substances in the 28 days prior was quite high in both groups (68% in control and 67% in the intervention group), and this increased by 10% in both groups in the 28 days prior to the six-month follow-up (79% control and 77% intervention). So, the population, while meeting the diversion criteria – being in possession of class B or C substances – were not frequent substance users and, as such, were less likely to need, or to benefit from, an intervention. The logic model would benefit from the inclusion of a formal substance-use screen so that a psychosocial intervention can be delivered to those with a substance use disorder.

The study could not disentangle the effect of diversion alone. When young people come to the attention of the police for relatively minor offences, they are often given an NFA outcome, often by a police officer in situ rather than at a police station. No formal record is made of the NFA, and we were unable to explore offences committed by those who may have been eligible for referral to the study but who were not referred. Interviews with the police were overall positive about diversion and its effect on reducing reoffending rates. More research is needed to explore the act of diversion on offending rates directly, possibly using a cluster randomised controlled trial design.

The participants in this study were less diverse than we anticipated, with some ethnic minority groups underrepresented in the population diverted. Our attempts to analyse this were thwarted by the lack of ethnicity data maintained by participating forces, despite the coding of ethnicity being a key tenet of the 2020 Police Race Action Plan.

Interpretation

Offending behaviour

The primary hypothesis of the study addressed the difference in the frequency of offences in the six months after randomisation between those allocated to receive the Re-Frame intervention and those allocated to a non-active control. Re-Frame demonstrated a **moderate negative impact** on children's offending behaviour. The difference in the rate of offending between those in the Re-Frame group and the control group was not statistically significant at a 5% level and should be interpreted with caution. When compliance with their allocated group was considered in the analysis, the difference between groups was still not significant.

Of note was the difference in offending rate by age group, with younger participants having a significantly higher offending rate than older participants. This echoes the finding in adolescent alcohol-using populations, where younger adolescents appear to have more disinhibitory characteristics, particularly conduct disorders (McArdle et al., 2022). The IRR of the number of offences coming to the attention of the police in the six months after randomisation was 1.41 (95% CI = 0.94 to 2.12) when comparing the intervention group to the control group. This effect, while not being significant at the 5% level as stated in the statistical analysis plan, was significant at the 10% level, and this may be interpreted as an indication that the Re-Frame intervention had some effect on increasing the number of police reported offences at month 6.

Caution needs to be applied when interpreting these results. First, there is no hypothesised logic model to explain why an intervention to reduce the frequency of substance use caused an increase in offending, particularly as there were no differences in the frequency of substance use at six months between the intervention and control group. Second, the number of offences at six months is the number of offences participating police forces were aware of, not the number of offences a young person may have committed. Examination of self-reported offending at month 6 using the SRDS and a similar negative binomial model indicates no differences between the intervention and control group (IRR = 1.11; 95% CI = 0.82 to 1.50, p = 0.491).

An examination of the distribution of offences in the six months after randomisation highlighted two participants, both in the intervention group, who were outliers. To test for the influence of these outliers, we reran the regression using a bootstrapping approach. Bootstrapping is widely used to assess the influence of high-value, low-frequency occurrences. It involves taking 1,000 samples of the data (with replacement), whereby the probability of high-value outcomes is associated with their frequency in the data set. The results of the bootstrapped regression indicate that the original results are more likely to be due to statistical artefacts than providing evidence of an effect (IRR = 1.24; 95% CI = 0.81 to 1.90; p = 0.316).

The study population were not prolific offenders, with three-quarters not offending in the six months before randomisation and a similar number not offending in the six months after randomisation. A key limitation of the study was that it was unable to assess the impact of diversion alone on the number of offences, as both groups received diversion. It was noted in the police interviews that they felt the policy to divert did impact on offending behaviour:

> *We've obviously seen some really good results where they've not come back. For kids, we have seen a reduction in being a second-time offender, which has been great. Proves the point, doesn't it, about getting those early interventions in.* (PO3)

> *So, I think it's got to be working … You sort of get a general sort of feel of that in the faces that you see – sort of, the people that come back on your radar? … It's not like, 'Oh God, they're back again' … I actually can't even recall ever saying, 'Diversion, didn't you work with this one?'* (PO7)

> *The success rates seem high, with many names not coming up again after referral for diversion.* (PO8)

This concurs with a systematic review (Wilson et al., 2018) that found that police-initiated diversion for low-risk youth offences reduced future delinquent behaviour – although, as the authors noted, no effects were observed by the type of diversion programme.

All the young people interviewed had a positive view of being diverted from the CJS, seeing the opportunity to avoid criminalisation that they considered would have a negative impact on their future prospects.

Frequency of substance use

In a similar manner, while the population were considered for diversion from the CJS after being found in possession of class B or C substances, they were, on the whole, not frequent substance users. The PDA increased in both groups between baseline and month 6 – 68.0% to 79.9% in the control group and 67.2% to 76.7% in the intervention group – indicating a significant reduction in the frequency of substance use in both groups, an effect size of 0.30 (95% CI =0.14 to 0.45) and a mean difference for intervention versus control of –0.02 (95% CI = –0.08 to 0.04; p = 0.480).

It could be argued that social desirability played a role in the self-report of substance use, particularly taking the form of under-reporting in the intervention group, because the young people believed they had received an intervention. The eliciting of self-reported substance use in both groups was undertaken by a trained researcher using an interview approach; the young people were reassured that what they disclosed was confidential and would not be relayed to the intervention provider or the police. We are confident that social desirability did not play a part in the self-reporting of the frequency of substance use; this view is supported by a number of studies that conclude that social desirability does not play a role in self-reported substance use (Kypri et al., 2016; McCambridge et al., 2019).

No differences were observed between the groups on any of the secondary outcome measures in the six months after randomisation: the volume of self-reported delinquency, emotional regulation, well-being, quality of life, situational confidence, motivation to change substance use behaviour and substance use expectancy.

The theory of change model, which hypothesised that reducing substance use would in turn reduce offending, was not supported. Only a small per cent overall change in offending occurred, and the frequency of substance use was mediated by changes in motivation, efficacy and expectancy. Systematic reviews of brief interventions that aim to address substance use in adolescents are mixed. Two major reviews found evidence of small effects for illicit substances (Steele et al., 2020; Tanner-Smith et al., 2015), but a further review found no evidence of the effect of brief interventions for any substance other than alcohol (Li et al., 2016).

It was noted that the frequency of substance use decreased by approximately 10% in both groups in the six months after randomisation, and this concurs with studies of low-risk adolescent alcohol users, where no greater effects were observed among the young people receiving multi-session intensive brief interventions versus those who received simple feedback (Deluca et al., 2020). It may also be the case that, as relatively infrequent substance users, the study participants were less susceptible to behaviour change interventions because they did not perceive their use of the substances as a problem. In the qualitative interviews, many of the young people described using cannabis as being harmless or as a substance they used to self-medicate the experience of neurodiversity.

Implementation

Within the CJS, there is no central system for recording police-initiated diversion, nor is there a standard framework for determining who is eligible for diversion. It was noticeable, in this study, that diversion pathways differed by police force, with one allowing direct referrals by police staff and the other three referring after consideration by a youth justice panel, who decided whether a diversion was appropriate. The panel approach was seen by the police as creating unnecessary delays in referral for diversion.

Focus groups with key stakeholders had a generally positive view of diversion to substance use services; this view is contingent on strengthening police partnerships and formalising inter-agency working. Commissioner support is strong, and the programme aligns with strategic goals to provide supportive, care-led interventions for young people.

Racial and ethnic disparities

Ethnic minorities, particularly Black boys, are disproportionately represented in offending statistics as both the victims and perpetrators of crime (YEF, 2024). Data from the Youth Justice Board in 2024 highlights that while 6% of young people in the UK aged 10–17 years are of Black heritage, they represent 20% of those stopped and searched, 12% of those arrested, 11% of those cautioned and 26% of those in custody. The reasons for this disproportionality are complex, but many ethnic minority groups are more likely to experience discrimination, poverty, neighbourhood deprivation or exclusion from school; have emotional and mental health needs; use drugs; or be less likely to have access to early intervention. All of these are key risk factors for offending.

The number of referrals for diversion in the current study of non-White young people clearly under-represent the numbers who should have potentially been eligible, particularly as Black boys are twice as likely to receive an informal diversion than White boys (Brodie et al., 2025), and this figure is similar to that for adult programmes of diversion from police custody to drug treatment, where the odds ratio of being diverted for Black adults was 0.69 (95% CI = 0.63 to 0.76) (Stevens, 2026) compared to White adults. Further investigation could not be conducted as part of the current study because the participating police forces could not provide the ethnicity of all those who came to their attention in possession of class B and C substances during the recruitment period. The lack of a recording of the ethnicity of all those who come to the attention of the police has also been highlighted in other reports exploring ethnic disproportionality in the CJS (Brodie et al., 2025).

Conclusion

The Re-Frame intervention was no more effective at reducing offending or the frequency of substance use in the six months after randomisation than the control intervention.

Limitations and lessons learned

It is clear from the participants included in the study that the population had a relatively low offending rate and were infrequent substance users. This may not be the appropriate target population and substance use interventions may be better targeted at young people who screen positive for a substance use disorder. We excluded young people found in possession of class A substances at the request of police, but their inclusion may have created a population potentially more likely to benefit from a structured brief intervention. The use of a non-active control may have impacted the results of the study; minimal interventions have been found to be as effective in reducing the frequency of substance use in low-risk populations and the control could be viewed as a minimal intervention (Newbury-Birch et al., 2014).

Our population was not ethnically diverse compared to the demographic profiles in the participating areas and the over-representation of black males within the CJS, and some ethnicities were under-represented in the study sample. While we monitored the ethnicity of participants recruited to the study, referrals to the study were out of our control. The lack of data on ethnicity meant that some aspects of our analysis (exploring the difference in potentially eligible but not referred participants versus those referred) could not be undertaken.

Future research and publications

Future research directions include:

- An exploration of the use of second-chance diversion alone, using a cluster randomised controlled trial to avoid any potential ethical issues
- An evaluation of more intensive substance use interventions for those in police custody who score positive for a substance use screen
- As alcohol use has a stronger relationship to violent behaviour, an evaluation of diversion and alcohol use intervention for those young people who screen positive for an alcohol use disorder
- An understanding of the relationship between the cultural appropriateness of substance use interventions and outcome, as this could provide a deeper understanding of why certain ethnic groups do not access substance use treatment
- Further research into why certain ethnic groups are excluded from formal diversion when they are over-represented in the population offered informal diversion
- An exploration of why the police are failing to record the ethnicity of all the young people who come to their attention.

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Appendix A: Changes since the previous evaluation[4]

Appendix table 1: Changes since the previous evaluation[5]

	Feature	Pilot to efficacy stage
Intervention	Intervention content	None
	Delivery model	At the end of the pilot study the order of delivery of the drugs grid and drugs triangle was reversed. This was because young people had a stronger relationship in the second session and were more open about what drugs they had used.
	Intervention duration	None
Evaluation	Eligibility criteria	None
	Level of randomisation	None
	Outcomes and baseline	Not applicable to pilots.
	Control condition	Not applicable to pilots.

[4] Please delete this section if it is not applicable.

[5] Delete columns from the table if they are not applicable or adjust titles as relevant.

Further appendices:

Appendix A: Changes since the previous evaluation[1]

Appendix table 1: Changes since the previous evaluation[2]

	Feature	Pilot to efficacy stage
Intervention	Intervention content	None
	Delivery model	None
	Intervention duration	None
Evaluation	Eligibility criteria	None
	Level of randomisation	None
	Outcomes and baseline	Dropped PHQ9 and GAD7 at the 6-month follow-up
	Control condition	None

Appendix B: Effect size estimation

Appendix table 2: Effect size estimation (effect sizes estimated using Cohen's *d*)

			Intervention group		Control group			
Outcome	Unadjusted difference	Adjusted difference	n (missing)	Variance of outcome	n (missing)	Variance of outcome	Pooled variance	Cohen'd effect size (adjusted)
Number of offences in 6 months post randomisation	0.1427	0.1297	3	0.0688	1	0.0482	0.0805	0.18
Percent Days Abstinent from substances at month 6	-0.1861	-0.1605	35	0.0223	36	0.0203	0.2256	0.10

Self-report delinquency – volume score at month 6	0.8855	0.7925	36	0.8346	38	0.6998	0.8826	0.13
SDQ total score at month 6	0.0456	-0.0083	37	0.3893	38	0.3574	0.5366	0
SDQ emotional regulation score at month 6	-0.1167	-0076	37	0.1504	38	0.1427	0.2070	-0.05
SDQ Conduct score at month 6	0.2607	0.1031	37	0.1306	38	0.1097	0.1711	0.14
SDQ hyperactivity score at month 6	0.0888	0.0612	37	0.1545	38	0.1670	0.2273	0.03
SDQ Peer score at month 6	-0.1871	-0.1299	37	0.1211	38	0.1230	0.1726	-0.11
SDQ Prosocial score at month 6	-0.1944	-0.1476	37	0.1518	39	0.1325	0.2017	-0.10
WEMWBS wellbeing score at month 6	0.1468	0.0022	37	0.3400	38	0.2973	0.4287	0.03
CHU9D quality of life score at month 6	0.0035	-0.0029	40	0.0085	41	0.0080	0.0117	0
Situational confidence score at month 6	4.4919	1.664	43	2.1419	46	2.1861	3.0688	0.17
Positive expectancy	0.9700	-1.0682	45	2.3007	45	2.1899	3.1841	-0.13

score at month 6								
Negative expectancy score at month 6	0.0442	1.5141	41	2.1447	39	1.8810	2.8650	0
Readiness ruler score at month 6	-0.2129	-0.1266	37	0.1315	38	0.1399	0.1928	-0.13

Appendix C: Recruitment documents

What is this study about?

You are being invited to take part in a research study of a new way of helping young people who have used drugs to manage the risks associated with their use. The study is taking part across many areas of England and will help us know if our new approach is better at helping young people.

This leaflet is for you to keep. Please read it carefully and take time to decide if you want to take part or not. Talk to other people about the study if you want to. Please ask the researcher if there is anything that you do not understand or if you would like more information about.

What will happen to me if I take part?

If you agree to take part, you will be asked to provide agreement in the form of a written consent. A computer will decide at random whether you should receive the usual treatment or whether you should receive the new intervention.

The Study

The new intervention will involve two meetings with an experienced young person substance use worker on a one-to-one basis to discuss your substance use, each of these meetings will take about one hour.

If you are not selected to receive the new intervention any support you receive will remain the same as usual and will usually involve meetings of a similar length.

All young people taking part in the study (e.g. individuals receiving the intervention and those receiving usual support) will be asked to fill out a questionnaire at the start of the study and again 6-months later. As a thank you we will give you a £20 voucher at each stage you complete questionnaires, one £20 after completing the baseline questionnaire and another £20 after completing the questionnaire at six months. The questionnaires explore substance use, any involvement in crime and your health. We will also ask to access any police records you might have six months after agreeing to take part. In order to get a clear understanding of what young people think about the new intervention we might ask you to take part in an interview with a researcher, before you do we will ask your permission and you can say no if you want to.

Do I have to take part?

No. It is up to you to decide.

We will describe the study, go through this information sheet with you and answer your questions. If you decide to take part in the study, you will be asked to sign a consent form.

You are free to change your mind at any time; you will not need to give a reason. If you decide not to take part in the study, any information you give will be destroyed.

If you decide to decline the offer of taking part in the study or want to withdraw your participation, it will not affect the support that you receive from “We are With you” or referrals to any other services.

Who will have access to my information?

All information collected about you during this research will be kept confidential. The only people who will be able to look at it will be the research team.

All information will be stored on a password protected computer, with written information stored at University of Kent for 5 years, and electronic data stored for 10 years. After we have conducted the 12-month follow-up interview we will remove any information that might identify you from our records. Data will be kept according to the rules of the Data Protection Act. At the end of the study data will be archived by the organisation who is funding the study, the Youth Endowment Fund.

You will be provided with a copy of the privacy notice for the study or alternatively you can access a copy of the notice online here:

https://research.kent.ac.uk/re-frame/

All staff and organisations involved in the research work to the same rules of confidentiality as doctors and nurses which can only be broken, without your consent, in very exceptional circumstances. **Usually this is if the researcher sees or is told something which raises serious concern for yours or someone else's personal safety.**

Could I be at risk by taking part?

The research staff and organisations and staff conducting this research have a lot of experience and we do not think that you will not experience any harm as a result of taking part in this research study. Any suggestions or complaints about the study or how you were treated will be dealt with by the chief investigator Professor Simon Coulton whose contact details can be found at the end of this leaflet.

Who is funding and organising the study?

The study is funded by the Youth Endowment Fund and sponsored by the **University of Kent**. The interventions are delivered by an experienced young people's service, "We are with you". Before we started the study we asked an independent body to look at what we planned to do to ensure what we are doing is ethical and good practice.

What happens to the results of the study?

We are keen to ensure that all young people involved in the study get an opportunity to help discuss and understand the results of the study, we will let you know of any opportunities as they arise throughout the study period. We are happy to send you a summary of the research at the end of the project. If you would like to receive this please email us using the details at the end of this leaflet. The study results will help us understand new ways to help young people in the future. No one will be identified in any of the information written about the study.

Will the research help me?

We cannot promise that this study will help you directly. However, the study may give you the chance to talk openly about substance use and risk taking.

Thank you…

For taking the time to read this leaflet. Please ask any questions or raise any concerns you may have about the project. If you decide to take part, please keep this leaflet for future reference.

Project staff

Nadine Hendrie, trial manager, University of Kent, 01227 827912, n.hendrie@kent.ac.uk

Professor Simon Coulton, Chief Investigator, University of Kent, 01227 824535, S.Coulton@kent.ac.uk

If you have any complains or concerns about the research project do not hesitate to contact:

Ms Nicole Palmer, Research Ethics and Governance Officer, University of Kent, 01227 82 4797, N.R.Palmer@kent.ac.uk

Appendix D: Privacy Notice

RE-FRAME Study Privacy Notice

We are carrying out a study of people taking part in the RE-FRAME study to try to find out how the service might help young people in the future. The study is being funded by the Youth Endowment Fund (YEF). At the end of the study data collected will be stored in a secure archive and used to follow-up on children's progress in the future. This will include, for example, assessing whether children who took part in YEF- funded projects were less likely to be excluded from school or get involved in crime in the future.

This privacy notice provides information about who we are, what we are doing, and why we are doing it. It also explains how we will use personal information we collect as part of the study.

1. Who are we?

This study is being organised by the Centre for Health Service Studies at the University of Kent (www.kent.ac.uk/chss)

When we collect and use participants' personal information as part of the study, we are the controllers of the personal information, which means we decide what personal information to collect and how it is used.

2. What are we doing?

We are evaluating a new way of managing young people who come to the attention of the police who are found to have illegal substances in their possession. Our study explores whether this new approach is better than the approach usually employed. Our research will inform us about what works best for young people and their families.

Contact details:

Project Lead – Professor Simon Coulton, s.coulton@kent.ac.uk, 01227 824535
Data Protection Officer – Laura Pullin, dataprotection@kent.ac.uk

The YEF, which funds this study, is dedicated to preventing children and young people becoming involved in crime and violence. Once we have finished our study, YEF-approved researchers will explore whether RE-FRAME, and other programmes funded by YEF, had an impact over a longer period of time, including whether they reduced involvement in crime and violence. This is explained in more detail below.

3. Who has reviewed this study?

This study has been reviewed and approved by the University of Kent Social Research Ethics Committee ref SRC 0498

4. How will we use the personal information that we collect?

Data protection laws require us to have valid reason to use [your child's/the child in your care] personal information. This is referred to as our 'lawful basis for processing'.

We rely on the public task basis to use their personal information. We will only use special category information (such as information about health, religion, race or ethnic origin, or any criminal offence information) if it is necessary for research purposes or statistical purposes which are in the public interest.

We will use the information they give us to evaluate how well RE-FRAME has worked and to write a report about our findings based on all of the questionnaires and/ or interviews we have carried out.

The final report and any other publications produced by the University of Kent will not contain any personal information about the people who took part in the study and it will not be possible to identify individuals from the report. The report will be published on the YEF's website.

Any personal information that [you/your child/the child in your care] gives us will be stored securely and kept confidential.

- We may share this personal information with another person or organisation if [your child/the child in your care] tells us something during the study that makes us concerned about them or about someone else. Our Safeguarding Policy has more information about steps that we might take if we have concerns about [your child's/ the child in your care's] wellbeing, or the wellbeing of another person.

- Once we have finished our study, we will share all of the information we have gathered about everyone who has taken part with the Department for Education (DfE). The DfE will replace all identifying information about the young people who have taken part in the study (their name, gender, date of birth, home address) with the young person's unique Pupil Matching Reference number in the DfE's National Pupil Database. Once this has been done, it is no longer possible to identify any individual young person from the study data. This process is called anonymisation.

- Once information is transferred to the DfE to be anonymised, we hand over control to the YEF for protecting your personal information. The DfE will transfer the anonymised information to the YEF archive, which is stored in the Office for National Statistics' Secure Research Service. The YEF is the 'controller' of the information in the YEF archive. By maintaining the archive and allowing approved researchers to access the information in the archive, the YEF is performing a task in the public interest and this gives the YEF a lawful basis to use personal information.

- Information in the YEF archive can only be used by approved researchers to explore whether RE-FRAME, and other programmes funded by YEF, had an impact over a longer period of time. Using the unique Pupil Matching Reference numbers added to the data by the Department for Education, it will be possible to link the records held in the YEF archive to other public datasets such as education and criminal justice datasets. This will help approved researchers to find out the long- term impact of the projects funded by YEF because they'll be able to see, for example, whether being part of a project reduces a child's likelihood of being excluded from school or becoming involved in criminal activity.

5. How is information in the YEF archive protected?

The YEF have put in place strong measures to protect the information in their archive. As well as the pseudonymisation process described in section 4, the YEF archive is protected by the Office for National Statistics' 'Five Safes' framework. The information can only be accessed by approved researchers in secure settings and there are strict restrictions about how the information can be used. All proposals must be approved by an ethics panel. Information in the YEF archive cannot be used by law enforcement bodies or by the Home Office for immigration enforcement purposes.

You can find more information about the YEF archive and the Five Safes on the YEF's website [insert this link if you are working on a YEF Launch Grant Round Project: [insert link to the YEF guidance for participants relating to the grant round relevant to your project, available from the YEF archive web page: https://youthendowmentfund.org.uk/ evaluation-data-archive/]. We encourage all parents and guardians to read the YEF's guidance for participants before deciding to take part in this study.

Once information goes into the YEF archive it can no longer be deleted as that would affect the quality of the archived data for use in future research.

6. Retention and deletion

The University of Kent will keep [your/your child's/the child under your care's] an anonymised copy of the data for a period of five years after the end of the study. Once the collection and quality assurance of data for the final participant has been collected and the data transferred to the YEF data archive all personal identifiable information will be removed from the dataset. At this point no individual will be identifiable using the data held by the University of Kent.

The YEF will keep information in the YEF archive for as long as it is needed for research purposes. Data protection laws permit personal information to be kept for longer periods of time where it is necessary for research and archiving in the public interest, and for statistical purposes. The YEF we will carry out a review every five years to assess whether there is a continued benefit to storing the information in the archive, based on its potential use in future research.

7. Data protection rights

[You/You and your child/You and the child in your care] have the right to:

- ask for access to the personal information that we hold about them;
- ask us to correct any personal information that we hold about them which is incorrect, incomplete or inaccurate.

In certain circumstances, you also have the right to:

- ask us to erase the personal information where there is no good reason for us continuing to hold it – please read the information in section 5 about the time limits for requesting deletion of your personal information;
- object to us using the personal information for public interest purposes;
- ask us to restrict or suspend the use of the personal information, for example, if you want us to establish its accuracy or our reasons for using it.

If you want to exercise any of these rights during the study period, please contact our Data Protection Officer using the details provided earlier. We will usually respond within 1 month of receiving your request.

If you want to exercise any of these rights after the study has finished (i.e. after the point when information has been shared with DfE), please contact the YEF. Further information and their contact details are available at hello@youthendowmentfund.org.uk.

When exercising any of these data rights, we may need to ask for more information from [You/You and your child/You and the child in your care] to help us confirm their identity. This is a security measure to ensure that personal information is not shared with a person who has no right to receive it. We may also contact you to ask you for further information in relation to your request to speed up our response.

8. Other privacy information

Categories of personal information

- First name
- Surname
- Date of Birth
- Home address
- Alternative address (if appropriate)
- Telephone number
- Email address
- Social media contact (if willing to provide)

Sharing their personal information

We only ever use [your/your child's/the child in your care's] personal information if we are satisfied that it is lawful and fair to do so. Section 4 above explains how we share data with the Department for Education and the YEF. If you decide to take part in the study, we may also share their personal information with the police who will provide any interactions they have had with the young person over a 12-month period, 6 months prior and 6 month after agreeing to participate in the study.

Data security

We will put in place technical and organisational measures in place to protect [your/your child's/the child's in your care] personal information, including:

- Limiting access to specific named researchers who require access to conduct the study, such as contacting young people for follow-up.
- Keeping personal details such as name and address separate from all other data and linking these using a unique identifier.
- Keeping data on a secure encrypted server and ensuring data is regularly backed up for security purposes.

International transfers

We will not transfer your personal data outside the UK.

9. Feedback, queries or complaints

If you have any feedback or questions about how we use personal information, or if you want to make a complaint, you can contact the lead researcher or Data Protection Officer using the details provided earlier.

We always encourage you to speak to us first, but if you remain unsatisfied you also have the right to make a complaint at any time to the Information Commissioner's Office (ICO), the UK supervisory authority for data protection issues: https://ico.org.uk/make-a-complaint/ .

Appendix E: Information Sharing Agreement

Information Sharing Agreement

1. Introduction

1.1. This Information Sharing Agreement ("ISA") provides a commitment by the signatories to ensure that a framework is in place that facilitates the sharing of personal information between the Parties and respects the individual's right to privacy as part of the Re-Frame project. Re-Frame is a restorative programme being delivered in Cornwall, Kent, Lancashire and Sefton with the aim of diverting young people from the criminal justice system. The ISA will be valid for the duration of the project until October 2024.

2. Parties

2.1. The Parties to this ISA are:

a) MERSEYSIDE POLICE
b) UNIVERSITY OF KENT
c) We Are With You, a charitable company limited by guarantee incorporated in England & Wales with company no. 02580377 and registered charity number 1001957 (England) and SC040009 (Scotland), whose registered office is at Part Lower Ground Floor, Gate House, 1 -3 St. John's Square, London, England, EC1M 4DH. ICO Registration number: Z7376908

3. Purpose and Objectives

3.1. The Re-Frame project supports young people aged 10-17 years old who are referred to With You for a diversionary appointment. The young people (Data Subjects) are referred to With You after they have come to the attention of the police for possession of a Class B or C substance. The aim of the project is to reduce criminalisation of young people and offer them support and another chance. Concurrent to the delivery of the interventions The University of Kent (UoK) will be undertaking an evaluation of Re-Frame through a randomised control trial.

3.2. The sharing of information between different organisations of the public and the private healthcare sector is often necessary to ensure the highest quality of care from integrated services. The successful management of information is fundamental to ensure coordinated, secure and 'seamless' care for young people ("Data Subjects").

3.3. This ISA is set up to facilitate the sharing of Data Subjects' personal information between the Parties and will be routinely reviewed and updated as necessary (see also "Scope and Duration" below).

3.4. This ISA requires each of the Parties to designate a senior professional (e.g. Principal Investigator, Data Protection Officer (if one is appointed), or Head of Information Governance, or Caldicott Guardian etc.) who will be responsible for:

3.4.1. Agreeing who within each organisation will have access to the shared information.

3.4.2. Agreeing any future amendments to this ISA.

3.4.3. Ensuring appropriate monitoring and oversight arrangements are in place.

3.5. Data Subjects' personal information may be shared between the Parties for the purposes defined below:

3.5.1. **Healthcare** - includes all activities that directly contribute to the diagnosis, care and treatment of an individual and the audit/assurance of the quality of the healthcare provided. It does not include research, teaching, financial audit or other management activities.

3.5.2. **Medical** - these include, but are wider than, healthcare purposes. They include preventative medicine, medical research, financial audit, management of healthcare services and, where the Health and Social Care Act 2001 is applicable, includes social care.

3.5.3. **Social Care and Youth Offending Teams** - support provided to vulnerable people (adults, children and those with disabilities and sensory impairments). This excludes 'pure' health care (hospitals) and community care (e.g. district nurses) but may include respite care. There are no clear demarcation lines between health and social care, and social care will also cover services provided by others as commissioned by CSSRs (Councils with Shared Responsibilities).

3.6. The Information Sharing Protocol, which forms part of this ISA, provides the details of the purpose, or purposes, and the process for the sharing of Data Subjects personal information between the Parties to this ISA.

3.7. The objectives of this ISA are:

3.7.1. to define the specific use and purpose of the shared information;

3.7.2. to set out the principles and procedures for obtaining, holding and sharing personal information about individuals;

3.7.3. to provide a framework for the secure and confidential management of the shared information;

3.7.4. to recognise that this ISA complements and supports the policies and procedures of each Party regarding data security and confidentiality, and it is not designed to supersede them;

3.7.5. to define how the ISA will be implemented and how the shared data will be published, monitored, reviewed and looked after.

3.8. Any transfer/sharing of any other information will fall outside the scope of this ISA and will require the review of this ISA and the approval of each Party's Data Protection Officer on a case by case basis.

4. Duration

4.1. This ISA will commence from the date on which it is signed by the last of the Parties and will apply to all employees, workers, officers, representatives, contractors, subcontractors, advisers, agency/charity workers and volunteers of all parties involved in the Re-Frame project.

4.2. The Parties agree that this ISA will remain in effect for the duration of the Re-Frame Project from the commencement date. The duration of this ISA can be extended on request with agreement from all Parties.

4.3. Where necessary, this ISA will be supplemented by policies, procedures and guidelines, agreed between the Parties to further define the information management arrangements.

5. Applicable Laws and Regulations

5.1. Each of the Parties will have adequate procedures in place to ensure the sharing of Data Subjects personal data under this ISA is lawful.

5.2. In particular, any processing of personal data under this ISA must comply with all applicable data protection and privacy legislation in force from time to time in the UK including the retained EU law version of the General Data Protection Regulation ((EU) 2016/679) (UK GDPR); the Data Protection Act 2018 (DPA 2018) (and regulations made thereunder) and the Privacy and Electronic Communications Regulations 2003 (SI 2003/2426) as amended, The Human Rights Act 1998 and all other applicable law about the processing of personal data and privacy, including where applicable the guidance and codes of practice issued by the Information Commissioner's Office (all as amended from time to time).

5.3. All the above will be referred to as "Data Protection Legislation" hereinafter.

5.4. The Parties signing up to this ISA will ensure they have adequate technical and organisational measures in place to address the security of the information (e.g. physical security, access controls, information security and confidentiality training).

6. Responsibilities of the Parties

6.1. The Parties agree that each is a Data Controller in relation to personal data exchanged under this ISA. Each Party must comply with its obligations as a Data Controller under the Data Protection Legislation.

6.2. Where the personal data being processed under this ISA is Special Category Data or Criminal Offence Data as defined in the Data Protection Legislation, the Parties must only process the data in line with the Data Protection Legislation, and as described in the Information Sharing Protocol where they comply with the conditions for processing and/or the law enforcements principles.

6.3. When one Party is transferring personal data to the other Party under this ISA, the disclosing Party must ensure that any personal information that is transferred:

6.3.1. has been collected in compliance with the Data Protection Legislation; and

6.3.2. The disclosing party's privacy notice given to Data Subjects entitles the receiving Party to process such personal information for the purposes set out in this ISA.

6.4. All Parties must manage personal information confidentially and all relevant staff must be made aware by their employer of the 'common law' duty of confidentiality and Data Protection Legislation requirements to which they are subject (via contracts of employment, codes of conduct or applicable policies and procedures).

6.5. Each Party must review its data protection processes annually and will maintain up to date registration with the Information Commissioner's Office ("ICO").

6.6. Each Party must maintain policies which:

6.6.1. Identify staff with responsibility for ensuring the quality of shared personal data (including that it is not updated, inaccurate or deleted inappropriately);

6.6.2. Make arrangements for:

6.6.2.1. informing Data Subjects of the sharing of their personal information with other Parties;

6.6.2.2. if consent is required to process data dealing with circumstances in which

a Data Subject is unable to give consent;

6.6.2.3. if consent is required to process data recording whether consent is granted or withheld by Data Subjects;

6.6.2.4. dealing with complaints relating to the handling of data;

6.6.2.5. handling Subject Access Requests made by Data Subjects; and

6.6.2.6. implementing, monitoring and revising the policies and procedures designed to support secure data sharing.

6.7. Each Party warrants that, to the extent permissible under Data Protection Legislation, they have informed all Data Subjects, by means of a Privacy Notice, of the reasons why their personal data is collected, processed, shared (including details of the internal and external parties with whom their personal data will be shared), stored or disposed of (including when), as well as of their rights under Data Protection Legislation, including but not exclusive of:

6.7.1. Right to Object: Article 6 (1)(e) Public Task gives lawful basis for processing data if it is in the public interest to do so or exercising official authority includes data that is necessary for which is laid down by law a) the administration of justice b) the exercise of a function conferred on a person by an enactment or rule of law, c) the exercise of a function of the Crown, a Minister of the Crown or a government department. Subjects have the Right to Object to Processing.

6.7.2. Right to File a Complaint: they have the right to lodge a complaint about a Party's practices with respect to their personal data with the supervisory authority in the United Kingdom, the Information Commissioner's Office (ICO): https://ico.org.uk/make-a-complaint/your-personal-information-concerns/

6.7.3. Requirement to consent to participate in an evaluation: Participants (young people) who meet the stated eligibility criteria will be offered an opportunity to participate in the research evaluation. Those who wish to participate will provide full explicit informed consent including consent to have their treatment decided at random. Those participants who do consent will have the right to withdraw consent at any time.

6.8. All Parties must ensure that:

6.8.1. personal data is shared under this ISA in line with, and in full compliance of, the Data Protection Legislation.

6.8.2. If a Data Subject wants their personal data to be withheld from a specified Party (who might otherwise have received it), each Party must consider the request on a case-by-case basis and must disclose information only if it is in accordance with the Data Protection Legislation, taking into account the Data Subject's applicable rights over their personal data. Each Party must also make every effort to explain to the Data Subject the consequences of non-disclosure for care and planning.

6.9. Unless the personal data needs to be identifiable in order to achieve the purposes for which it is shared under this ISA, it will be anonymised by the Party who acts as a Data Controller of such data before it is shared with, or otherwise processed by, any other Party.

6.10. Each Party is responsible for the quality of personal data processed by its staff.

6.11. Information management will also be subject to such further policies, procedures and guidelines as are agreed between the Parties.

6.12. A Party receiving personal information must ensure that it is only processed for the purposes identified in the Information Sharing Protocol.

6.13. Each Party must provide all necessary information and assistance to each of the other Parties in order to verify their compliance with the obligations under this ISA and the Information Sharing Protocol, and the Data Protection Legislation.

7. Data Protection Impact Assessment (DPIA)

7.1. The Parties acknowledge the obligations imposed by the Data Protection Legislation on Data Controllers and Data Processors in relation to the requirement to conduct a DPIA whenever the processing of Data Subjects personal data is likely to result in a substantial risk to the rights and freedoms of individuals.

7.2. The Parties also acknowledge that risk in this context is about the potential for any significant physical, material or non-material harm to individuals, considering both the likelihood and severity of any potential harm to individuals whose personal data is being processed under this ISA and the Information Sharing Protocol.

7.3. To comply with the requirements under the Data Protection Legislation, and prior to commencing any processing of personal information, the Parties must collectively conduct a DPIA to assess if the processing of personal information under this ISA is high risk, or likely to result in harm to individuals.

7.4. A copy of the DPIA (Appendix 6), agreed and signed by the Parties, must be attached to, and form an integral part of, this ISA.

8. Signatories, Publication and Review

8.1. This ISA must be signed on behalf of each Party by its Data Protection Officer (DPO). Where one is not appointed, the ISA must be signed by the Head of Information Governance (or equivalent), or the Caldicott Guardian.

8.2. This ISA will be available to any authorised representative of any of the Parties (and to other individuals in accordance with the terms of the Freedom of Information Act 2000 or Environmental Information Regulations 2004).

8.3. This ISA will be subject to formal review at least once a year (no later than the anniversary of the commencement of the ISA) when the Parties must take into account:

8.3.1. Non-compliance with the ISA, logged and reported by each Party (including complaints arising from information sharing);

8.3.2. Non-compliance with any supplemental policies, procedures and guidelines, logged and reported by each Party (including complaints arising from information sharing under this ISA); and

8.3.3. General difficulties encountered in applying the ISA, logged and reported by each Party.

9. General

9.1. Governing law and jurisdiction

9.1.1. This ISA is governed by and must be construed in accordance with the laws of England and Wales, and the Parties agree to submit to the exclusive jurisdiction

of the courts of England and Wales.

9.2. Variation, extension or revocation

9.2.1. No variation, extension or revocation of this ISA must be effective unless it is made in writing and signed by the authorised representatives of each Party.

9.3. Third organisation rights

9.3.1. A person who is not a Party to this ISA has no right under the Contracts (Rights of Third Organisation) Act 1999 to enforce any term of this ISA.

9.4. Entire ISA

9.4.1. The Information Sharing Protocol and any other Schedule(s) form part of this ISA and have effect as if set out in full in the body of this ISA. Any reference to this ISA includes therefore the Information Sharing Protocol and any Schedule(s).

9.4.2. This ISA contains the entire understanding and agreement of the Parties in respect of the sharing of information in relation to the purposes set out in the Information Sharing Protocol and supersedes all prior oral or written communications and agreements. In entering into this ISA, no Party has relied on any representations other than those expressly made in this ISA.

9.5. Waiver

9.5.1. No omission or delay on the part of any of the Parties in exercising any right under this ISA operates as a waiver by that Party of any right to exercise it in future or of any other rights of that Party under this ISA.

9.5.2. No waiver of any provision of this ISA is effective except to the extent made in writing and signed by the Party giving the waiver.

9.6. Invalidity

9.6.1. In the event that any provision of this ISA is determined by any court of competent jurisdiction to be invalid, unlawful or unenforceable to any extent, such provision is, to that extent, be severed from the remainder of this ISA, which continue to be valid to the fullest extent permitted by applicable law.

9.7. Execution in Counterparts

9.7.1. This ISA may be executed in counterparts, each of which is deemed to be an original document but all of which taken together constitute one single ISA between the Parties.

10. Liability

10.1. Each Party will indemnify the other Parties in respect of any claims, direct or indirect costs, losses, damages, expenses (including legal expenses) and other outgoings sustained by or incurred by the other Parties as a result of or arises out of the first Party's breach of this ISA.

10.2. To the extent permitted by applicable law and notwithstanding anything to the contrary in this ISA, each Party's total aggregate liability arising out of or in connection with this ISA for all claims of any kind will not exceed £10,000 (ten thousand Pounds).

10.3. The general cap will not apply to liability for:

10.3.1. fraud, gross negligence or wilful misconduct;

10.3.2. death or personal injury.

We, the undersigned, accept that the procedures laid down in this Information Sharing Protocol, together with the associated Information Sharing Agreement ("ISA"), will be adhered to by all Parties, and will provide a secure framework for the sharing of Data Subjects personal information between the Parties in a manner that ensures compliance with any applicable statutory, regulatory and legal requirements.

1. Purpose and Method of Information Sharing

1.1. Purpose

1.1.1. This ISA has been developed to ensure effective care for those patients/clients/service users ("Data Subjects") accessing Police and We Are With You's services.

1.1.2. By sharing Data Subjects personal information, all relevant organisations who are Parties to this ISA aim to deliver a more effective and informed service to Data Subjects.

1.2. Process

a) The police will complete a referral (including consent) form and send it to With You, securely via CJSM account to the Re-Frame single point of contact CJSM account or by post. This will include the young person's personal information, special category data and criminal justice data detailed in Appendix 1.

b) With You will record the referral on Nebula (With You's database) and make contact with the young person, via their preferred method of contact.

c) With You will seek consent from the young person to engage in University of Kent's Randomised Control Trial (RCT). They will be given the RCT consent form and information leaflet (Appendix 2 and 3), and the With You Privacy Notice (Appendix 4)

If the young person does not consent to the RCT, With You will engage with them for a ' Relationship between Students' Self-Efficacy and Preparedness for Addiction

d) as usual' session and feed back to the police (detailed in g).

e) If the young person consents to engage in the RCT, personal details will be shared with the University of Kent via secure CJSM email. The University of Kent will contact the young person via their preferred method of contact. With You will offer them up to 2 sessions.

f) When the sessions have concluded, With You will report information on the young person's engagement to the Police via CJSM using the closure form (Appendix 5).

1.3. Method of Information Sharing

1.3.1. All personal information shared between the Parties will be transferred via:

1.3.2. Secure email (CJSM)

1.3.3. Secure File Transfer using SharePoint

1.4. In the circumstance where there are small amounts of personal information in hard format (paper) to be transferred, the relevant authorised representative of the Parties

will agree a suitable secure process that enables this to take place.

1.5. The Parties warrant that any process or processes put in place to transfer Data Subjects personal information under this ISA are compliant with the provisions for the transfer and sharing of personal data under the Data Protection Legislation[3] and in line with any relevant guidance issued by the Information Commissioner's Office (ICO) from time to time.

2. Lawful Basis for Sharing

2.1. Where the Party is a **public body, entity or authority**, the applicable lawful basis for the processing of Personal Data under this ISA is provided for in the UK General Data Protection Regulation ("UK GDPR"), article 6 (Lawfulness of Processing), specifically article 6.1 (a) and (e) as well as article 9 (Processing of Special Categories of Personal Data), specifically article 9.2 (a), (h) and (i).

Article 6.1

(a) the data subject has given consent to the processing of his or her personal data for one or more specific purposes;

(e) processing is necessary for the performance of a task carried out in the public interest or in the exercise of official authority vested in the controller; [...]

Article 9.2

(a) the data subject has given explicit consent to the processing of those personal data for one or more specified purposes, except where Union or Member State law provide that the prohibition referred to in paragraph 1 may not be lifted by the data subject;

(h) Processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3;

(i) Processing is necessary for reasons of public interest in the area of public health, such as protecting against serious cross-border threats to health or ensuring high standards of quality and safety of health care and of medicinal products or medical devices, on the basis of Union or Member State law which provides for suitable and specific measures to safeguard the rights and freedoms of the data subject, in particular professional secrecy;

(j) Processing is necessary for archiving purposes in the public interest, scientific or historical research purposes or statistical purposes in accordance with Article 89(1) based on Union or Member State law which shall be proportionate to the aim pursued, respect the right to data protection and provide for suitable and specific measures to safeguard the fundamental rights and the interests of the data subject.

2.2. To ensure that the processing is lawful, the Party must identify an article 6 basis for processing, and an article 9 basis if processing special category data. In addition, the Party can only process criminal offence data if the processing is either:

2.2.1. under the control of official authority; or

2.2.2. authorised by domestic law. This means the processing needs to meet one of the conditions in paragraphs 1 to 37 of Schedule 1 of the Data Protection Act 2018.

2.3. Where the Party is a **private organisation**, the applicable lawful basis for the processing of Personal Data under this ISA is provided for in the UK General Data Protection Regulation ("UK GDPR"), article 6 (Lawfulness of Processing), specifically article 6.1 (a) and (f) as well as article 9 (Processing of Special Categories of Personal Data), specifically article 9.2 (a) and (h).

Article 6.1

(a) the data subject has given consent to the processing of his or her personal data for one or more specific purposes;

(f) processing is necessary for the purposes of the legitimate interests pursued by the controller or by a third party, except where such interests are overridden by the interests or fundamental rights and freedoms of the data subject which require protection of personal data, in particular where the data subject is a child.

Article 9.2

(a) the data subject has given explicit consent to the processing of those personal data for one or more specified purposes, except where Union or Member State law provide that the prohibition referred to in paragraph 1 may not be lifted by the data subject;

(h) Processing is necessary for the purposes of preventive or occupational medicine, for the assessment of the working capacity of the employee, medical diagnosis, the provision of health or social care or treatment or the management of health or social care systems and services on the basis of Union or Member State law or pursuant to contract with a health professional and subject to the conditions and safeguards referred to in paragraph 3; [...]

2.4. Where the Personal Data processed under this ISA is Criminal Offence Data as defined in the Data Protection Legislation; and the Party is a private organisation, the processing shall be lawful if it is authorised by domestic law. This authorisation in law is set out in the conditions listed in Schedule 1 (18) of the Data Protection Act 2018 '*Safeguarding of children and individuals at risk'*.

2.5. Notwithstanding, the Partner Organisation must also identify an article 6 basis for processing.

3. Access to Personal Data and Security

3.1. All Parties are required to maintain policies governing levels of access and security and ensure they are adhered to. These policies should be made available to other Parties on request.

3.2. Parties must not disclose personal data to any third-party organisation in any circumstances except as required or permitted by this ISA and the Information Sharing Protocol.

3.3. Staff must only have access to personal data on a need-to-know basis, in order to perform their duties in accordance with one or more of the defined purposes of this ISA and the Information Sharing Protocol.

3.4. All Parties are required to ensure they have in place the mechanisms to enable them to address the issues of physical security, access control, security and confidentiality, awareness training, and security management as mandated under the Data Protection Legislation and ensure they are adhered to.

3.5. Where applicable, all Parties will comply with the assertions of the NHS Data Security and Protection Toolkit or have a robust action plan in place to achieve the assertions.

3.6. All Parties must implement and maintain appropriate technical and organisational measures to protect Data Subjects personal information against unauthorised or unlawful processing and against accidental loss or destruction of, or damage. These measures must be regularly tested by each Party to assess the effectiveness of the measures in ensuring the security, confidentiality, integrity, availability and resilience of the personal data and each Party must maintain records of the testing.

3.7. When no longer required for the purpose of this ISA/Information Sharing Protocol, personal data that has been shared between the Parties should be securely destroyed (see "Deletion of personal data" below).

3.8. When transferring personal data between Parties by email, the transmission must use a secure method. It is the responsibility of the sender to ensure that the method is secure and that they have the correct contact details for the receiver.

3.9. Any exchange of personal information must be part of an agreed process. This means that both those sending and receiving the information know what is to be sent, what it is for and have agreed how the information will be treated. The receiver should only access the information from a secure device which is managed to the standards outlined in the National Cyber Security Centre (NCSC) End User Device Security Guidance.

3.10. Devices must not be left unattended unless they are locked so that the personal data is protected in the event of the device being lost or stolen.

3.11. Each Party must maintain a policy which concerns the security of personal data, and which must be made available to each other Party upon request save where such disclosure could itself compromise the security of the personal data.

3.12. The policy must include provisions for:

3.12.1. the backing up of personal data

3.12.2. physical security

3.12.3. security awareness and training

3.12.4. transporting of confidential information procedures

3.12.5. security management

3.12.6. systems development and system specific security policies.

4. Deletion of Personal Data

4.1. Unless otherwise required by law, each Party must, upon termination or expiry of the ISA for whatever reason, or at the request of the disclosing Party or Parties, either securely

delete or return all shared personal data to the disclosing Party or Parties.

4.2. If required by law to retain a copy of the shared personal data, each Party must inform the other Parties what data is being retained and the lawful basis provided for in the Data Protection Legislation that justify such retention.

5. Personal Data Breaches

5.1. Each Party must notify the other Parties promptly of any known security incident, namely any breach of technical and organisational security measures where the breach has affected or could have affected personal data transferred under this ISA/Information Sharing Protocol ("Personal Data Breach"). Such breaches by members of staff will be dealt with under the employing Party's local disciplinary policies where appropriate.

5.2. In the event of a Personal Data Breach, each Party must consult with one another in respect of whether a notification to the ICO is required and the content of the notification. In the event agreement cannot be reached regarding the notification, each Party may notify the ICO as they wish.

5.3. All Parties are responsible for maintaining adequate records of all Personal Data Breaches, in line with the record-keeping requirements under the Data Protection Legislation[4].

5.4. All concerns raised by Data Subjects about the processing of their personal data should be addressed by the Party who is the Data Controller of such data, and by following their own internal procedures and inform other parties to this agreement that a concern has been raised.

5.5. Each Party must report promptly to every other Party any finding by the ICO that they are likely to have breached any provisions under the Data Protection Legislation in respect of personal data shared under this ISA/Information Sharing Protocol.

6. Information Requests

6.1. Requests may be received from Data Subjects (or their representatives) under the Data Protection Legislation. When a request for information which has been shared under this ISA and the Information Sharing Protocol is received, the Party which receives the request must inform the other Parties and request their views about the disclosure or otherwise of the information.

6.2. In the event of:

6.2.1. **Subject Access Request (SAR)** - the Party who has received the request must notify the other Parties promptly. The other Parties must provide reasonable assistance to allow the Party who has received the request to respond to the Data Subject within the timescales set out in the Data Protection Legislation.

6.2.2. **Request for rectification or erasure of personal data or restriction of processing** - the Party who has received the request must determine whether such request is valid under the Data Protection Legislation. In the event that the Party which has received the request determines that the relevant personal data should be rectified or erased or that any processing must be restricted, it must notify the other Parties promptly. The Party receiving the notification must rectify or erase the personal data or restrict its processing (as applicable) promptly.

6.3. On receipt of any request or enquiry from a Regulator that relates to personal data

transferred under this ISA/Information Sharing Protocol, each Party must notify the other Parties and must provide the other Parties with all reasonable assistance to allow the Party in receipt of the request to respond.

6.4. Each Party must bear its own costs incurred in completing, or assisting other Parties to complete, any of the requests referred to in this clause.

6.5. Requests for disclosure of information received under the Freedom of Information Act 2000 or the Environmental Information Regulations 2004[5] are not concerned with individuals' personal data. As such, none of the provisions under the Data Protection Legislation are applicable.

6.6. In the event that any such request is received, the receiving Party must consult with the other relevant Parties[6] before responding to that request (if applicable). Each relevant Party agrees that the decision on whether any exemption applies to a request for disclosure of recorded information is a decision solely for the relevant Party who is the Data Controller of the requested information.

Appendix F: Interview Topic Guides

Re-Frame: Young People Interviews

1) Can you tell us what led to you being referred to Re-Frame?
   - Prompt: What happened?
2) How was the Re-Frame explained to you and who did this?
   - Prompt: Did they explain what to expect?

     Did you understand what they told you?

     Did you have the chance to ask questions? (If not why?)
3) Did you feel the decision to be part of Re-Frame rather than CJS was yours?
   - Prompt: Did you have a chat with your parents?
   - Could you have said no?
4) Were you worried about anything to do with Re-Frame before you joined it?
   - Did you feel assured when you started Re-Frame?
5) Did anything happen to delay your joining the programme?
   - Prompt: If yes, what was it?
6) Was the programme what you expected it to be?
7) What if anything would you recommend should be changed about how people join the programme?
8) Do you think the programme was helpful for you?
   - Prompt: How was it helpful /not helpful?

     What could have improved helpfulness of the programme for you?
9) Do you think that taking part in Re-Frame will enable you to change any of your behaviour in the future?
   - Prompt: What behaviour?

     In what way?
10) Do you think Re-Frame is a good idea?
    - Prompt: If not for you, for others?

      Why do you think this?
11) What would you say were the best parts of Re-Frame? What were the worst?
    - Prompt: Please explain.
12) How would you improve Re-Frame?
13) Are there other people you think would benefit from joining Re-Frame?
14) Were you tempted to leave Re-Frame at any point?
    - Prompt: What stopped you?
15) What were the Re-Frame workers like?
    - Prompt: What did you like about them?

      What did you not like about them?
16) What was good about how they worked with you? What wasn't? Why?

17) Thinking about your experience with drugs and alcohol, were there any parts of the programme that really made sense to you? Were there any parts that didn't make sense? Why?
18) Do you feel that you made the right choice to accept Re-Frame rather than the alternative (CJS)?
    - Prompt: Why was is right/wrong for you?

Re-Frame WAWU Staff Interviews

1) Do you think the Re-Frame referral process works?
- Prompt: If not, why not?
- Could the police make things easier? How?
- What barriers have you experienced with the referral process?
- What has facilitated the referral process?

2) How is the programme being explained to young people? Do you think this is working well?
    - Prompt: Why do you think it is/isn't working well with the referral process?
3) Are there any logistical issues delaying young people coming on to the programme?
    - Prompt : Contact details etc., parents, process
4) What if anything would you recommend should be changed about how young people join Re-Frame?
5) Do you think staff efficiency on the programme is high or low?
    - Prompt: Why is this?

      What factors do think affect this?

      Are staff enthusiastic about and engaged with Re-Frame?

6) Do you think Re-Frame is helpful for young people in terms of changing their drug & alcohol use?
    - Prompt: How is it helpful/ not helpful?

      How could this be improved?

7) Do you think that taking part in the programme will enable change any of the young people's behaviour in the future?
    - Prompt: What behaviour?

      In what way?

8) Do you think Re-Frame is a good idea?
    - Prompt: Why? Why Not?
9) How could the Re-Frame be improved?
    - Prompt: Elements to disregard / introduce
10) What do you perceive are the barriers to this improvement? What may facilitate the improvements?
11) Is there anything you feel you need to enable you to work more effectively on Re-Frame?
12) What would you say are the best aspects of the programme? What are the worst?
    - Prompt: Please explain your answers.
13) Are there other people you think would benefit from joining the programme?
14) Is their retention of young people between session 1 & 2?
    - Prompt: If retention is good, what do you think the reasons are? If not, why?
15) Would you say that young people are / are not engaged with the Re-Frame content?

16) What elements of Re-Frame do young people seem to enjoy – Have you any examples?

Police: Staff Interviews

1) Please can you tell me your role and the area you work?

2) How did you first hear about Re-Frame?

1) Referral to Re-Frame: Can you explain the referral process?
    a. Prompts: how do people come to the attention of the programme?
    b. What are the criteria for being considered/excluded?
    c. Do you think the programme reaches the young people it should reach?

2) Is the referral process clear and easy to follow? Is there anything that would make it easier/quicker/clearer?
    - Prompts: The form, the information for YP etc

    How easy is it to explain to the YP & parents?

    Paperwork process /time consuming/workload?

3) Do you perceive any external or logistical issues as impacting referral to Re-Frame?

4) Do you feel that Re-Frame is understood and accepted in your area?

5) Do you feel it is offered enough?
    - Prompt: Are there occasions when Re-Frame is not offered?

6) Do all police staff know they can refer into Re-Frame?

7) Who declines/refuses to take part in Re-Frame (YP)?
    - Prompts: What reason do they give?

    Do parents get involved with the decision?

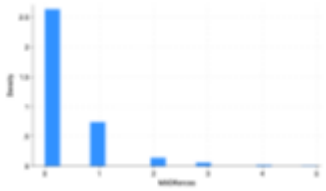
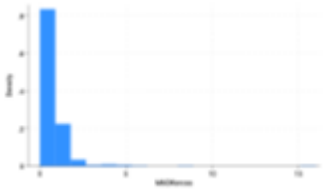
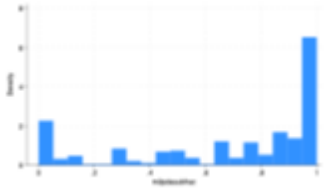
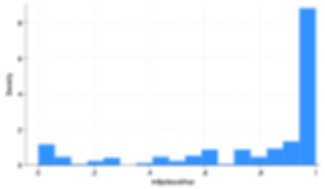
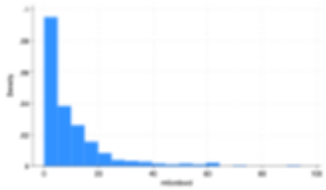
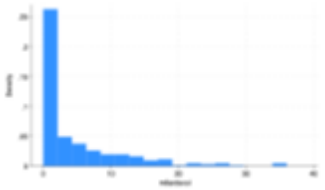
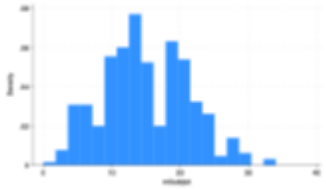
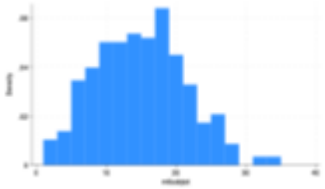
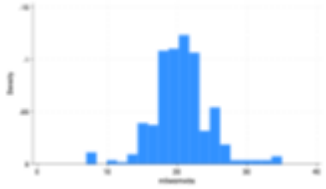
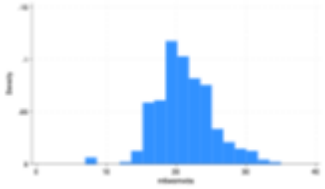
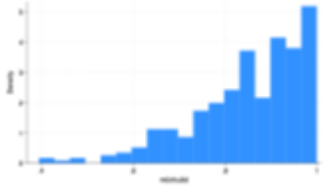
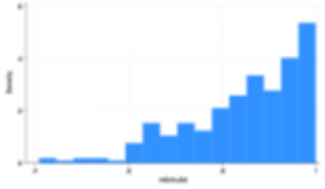
    Why do you think a YP would refuse diversion?

    What happens if they refuse? (CJS)?

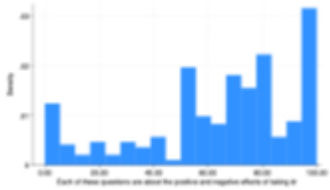
8) How do YP & parents respond to being offered Re-Frame

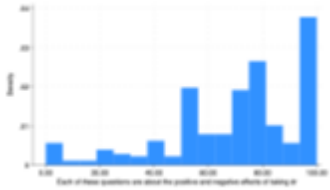
9) Do you think that Re-Frame can impact young people's offending behaviour?
    - Prompt: If so, why? If not, why? Have you any examples?

Appendix G: Distribution of outcomes

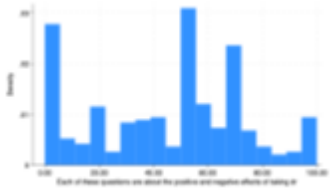
Month 0	Month 6	
		Number of offences – negative inflated with overdispersion – negative binomial regression
		Percent days abstinent from substance use- Fractional outcome, proportion bounded by 0 or 1 – fractional regression
		Self-reported delinquency - negative inflated with overdispersion – negative binomial regression
		SDQ total score – Normal distribution – linear regression
		Wellbeing WEMWBS score – Normal distribution – OLS regression
		Quality of life CHU9D – non-normal distribution – Kernel density of the regression indicates residuals normal distribution – OLS regression

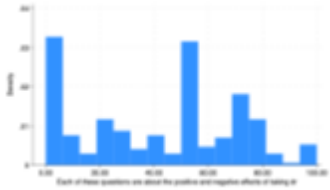
Situational confidence SCQ – non-normal distribution – Kernel density of the regression indicates residuals normal distribution – OLS regression



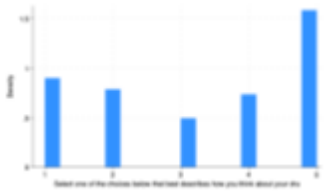


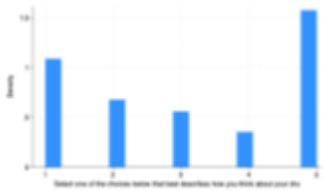
Negative expectancy – non-normal distribution – Kernel density of the regression indicates residuals normal distribution – OLS regression





Positive expectancy – non-normal distribution – Kernel density of the regression indicates residuals normal distribution – OLS regression





Readiness to change – non-normal distribution – Kernel density of the regression indicates residuals normal distribution – OLS regression

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Appendix C. YEF Security Rating

Rating	Design	MDES Outcome: Threshold*	Attrition	Initial score		Adjustments		Final score
5	Randomised design	Offending: <=0.1 SDQ tot: <= 0.3 Other: <= 0.2	0-10%	3				
4	Design for comparison that considers some type of selection on unobservable characteristics (e.g. RDD, Diff-in-Diffs, Matched Diff-in-Diffs)	Offending: 0.11 – 0.19 SDQ tot: 0.31 – 0.39 Other: 0.21 – 0.29	11-20%					
3	Design for comparison that considers selection on all relevant observable confounders (e.g. Matching or Regression Analysis with variables descriptive of the selection mechanism)	Offending: 0.2 – 0.29 SDQ tot: 0.4 – 0.49 Other: 0.3 – 0.39	21-30%					**3**
2	Design for comparison that considers selection only on some relevant confounders	Offending: 0.3 – 0.39 SDQ tot: 0.5 – 0.59 Other: 0.4 – 0.49	31-40%					
1	Design for comparison that does not consider selection on any relevant confounders	Offending: 0.4 – 0.49 SDQ tot: 0.6 – 0.69 Other: 0.5 – 0.59	41-50%					
0	No comparator	Offending: >= 0.5 SDQ tot: >= 0.7 Other: >= 0.6	>50%					

*MDES requirements vary by outcome measurement. Offending: Offending data collected through self-report or admin data; SDQ tot = SDQ total difficulties score; Other: all other outcomes, incl. SDQ externalising and internalising