Local drug prevention - From policy to practice

A qualitative case study of policy makers, outreach social workers and at-risk youths

Olin Blaalid Oldeide

Thesis for the degree of Philosophiae Doctor (PhD)
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Scientific environment

This PhD project is affiliated with the research group Social Influence Processes on Adolescent Health (SIPA) at the Department of Health Promotion and Development (HEMIL), Faculty of Psychology, University of Bergen. The doctoral education was carried out at the Graduate School of Human Interaction and Growth (GHIG) and in the doctoral program at the Faculty of Psychology, University of Bergen. The project was financed by the University of Bergen.

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Abstract

The overall aim of this thesis is devoted to understanding a local drug prevention strategy and its implementation through the eyes of policy makers, outreach social workers and at-risk youths. In Norway, municipalities are responsible for many of the services that are important in promoting healthy lives among children and youths. While there has been an evolution in policies towards addressing the social determinants of health and the intersectoral collaboration required to address those issues, there remains a need to investigate how these policies coincide with the structures in the municipalities. This thesis is inspired by theoretical perspectives from both the fields of health promotion and governance. It relies on findings from a qualitative case study which investigated a local drug prevention strategy and follows how that strategy is implemented throughout the municipal organization of Bergen, Norway. Through interviews with policy makers, advisers and the service providers interacting with youths, the thesis provides powerful insights into the structures of local policy implementation that are at play when designing policies that include many policy sectors. In addition, youths participated in focus groups to discuss how they received the overall drug prevention strategy. The thesis consists of three published articles, with the findings summarized and discussed in a synopsis.

Article 1 draws on the findings from policy makers and advisers in the municipality of Bergen to provide insights into the structures for collaboration and integration with complex public health challenges like drug prevention. The findings reveal that – even though collaboration was crucial – there was limited actual integration for drug prevention. The policy makers experience diverging perceptions of ownership of drug prevention as a policy field, while the advisers experience a lack of mandate for collaboration. These findings indicate that the structures within the municipal organization are siloed and that integrating boundary-spanning policies is challenging.

Article 2 combines the perspectives of policy makers and practitioners in a local outreach prevention service, to investigate the local structures for drug prevention. The findings reveal a drug prevention strategy which, aims to create good living conditions

and promote protective factors for the youths, all in line with a health-promoting perspective. Although the drug prevention strategy is impeded by the siloed organization of the municipality, the outreach service describes an ability to create collaborations. The findings highlight the structures surrounding street-level bureaucrats and their ability in the vertical structure of the municipality to "overcome" structural constraints to provide at-risk youths with the services they need.

Article 3 provides insight into how the overall drug prevention strategy is received through the eyes of at-risk youth. The findings are complemented with data from the outreach social workers to broaden the analysis. The findings show that the youths experience the services of the municipality as fragmented and rely on the outreach service to navigate a complex bureaucracy. The outreach service also has a resource approach, which is contrasted to other services' more deficit-oriented approach. These findings support the notion that the outreach service acts as a safety net for youths who fall between the cracks of the system and demonstrates the need for empowerment-oriented approaches aimed at at-risk youths.

Based on the findings in the three articles, I have identified elements in the horizontal and vertical structures in the municipality which limit and promote integration in complex public health policies. While there is limited collaboration across policy areas to address the social determinants of health, the outreach social workers in the vertical structures can counter fragmentation and act as a safety net for the youths. The outreach service demonstrates empowering practices and places the needs of the youths at the centre of their collaborations with other services. The thesis reaffirms the need for policy sectors in the horizontal structures to address the social determinants of health. Without a reorientation of policies, the strategies will continue with selected and indicated strategies to address at-risk youths and consequently not move upstream to promote health. The thesis also advocates for awareness of the structures needed to translate policies into practice on a local level.

List of Publications

Oldeide, O., Fosse, E., & Holsen, I. (2019). Collaboration for drug prevention: Is it possible in a "siloed" governmental structure? *The International Journal of Health Planning and Management, 34*(4): e1556-e1568. https://doi.org/10.1002/hpm.2846

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Contents

1. Introduction

Illicit drug use among young people has been a growing concern in Western societies since the 1960s. There are many strong opinions regarding the appropriate policy response (Midford, 2010). One response is to focus on the individual level and use education and personal development to encourage the individual to realize the harms of misuse (Spooner, 2009). There has been a push in the field of drug prevention to add environmental factors as part of the explanation behind illicit drug use. As a consequence, illicit drug use among youths is explained through a complex interplay between the individual and environmental factors from early childhood to adulthood. Another consequence is that a problem behaviour such as illicit drug use is one of a range of many problems that share antecedents. Having a narrow focus on a single behaviour may not lead to any clear resolution, as one problem behaviour can be replaced with another (Spooner, 2009). Therefore, it is important to not focus merely on the arena where the problems present themselves; rather, it is an essential part of drug prevention to direct attention "upstream" of the problem and promote healthy child and youth development (Catalano et al., 2002; Spooner, 2009).

This research project originated in a municipality's intervention in one of the largest open drug scenes in northern Europe. Bergen, Norway's second-largest municipality, had a high overdose fatality rate, and the drug scene was the epicentre for considerable damages to both the users and the surrounding community (Bergen Municipality, 2017; Lundeberg & Mjåland, 2017). In 2014, the municipality initiated a comprehensive, large-scale action plan against the open drug scene. The strategy involved several key stakeholders such as the municipality, police district, local hospital, social services, and multiple non-governmental organizations (NGOs). The evaluation of the strategy showed that the action plan effectively decreased drug-related activity in the city centre. The strategy against open drug scenes attracted considerable focus from both the research community and the municipality. While there was a substantial effort from the municipality devoted to the visible expression of drug use in the open drug scene, the question of what was being done by the

municipality to prevent young people from becoming future illicit drug users was raised.

This thesis builds on a broad-based understanding of drug prevention, where the youths' environment is the key to both understanding and dealing with the problem of illicit drug use. In Norway, municipalities are responsible for many of the services important for promoting healthy lives among children and youths. By investigating one municipality's strategy for drug prevention aimed at youths, we can come closer to understanding how the complex role of the environment is addressed through a policy response. Furthermore, we can learn how policies are implemented and experienced by the key stakeholders. This thesis combines the viewpoints of policy makers, advisers, and service providers at different levels in the municipality that represent the structures in place to prevent illicit drug use among youths. Notably, the thesis is also built on the experiences of at-risk youths themselves as the focus of the overall drug prevention strategy. In combination, these perspectives provide an in-depth analysis of local drug prevention and its supporting structures.

1.1 Drug prevention and health promotion

The thesis expands on developments in the drug prevention field to move towards a broader understanding of drug use by introducing core concepts from the health promotion discipline. Catford (2001) acknowledges that drug prevention has for too long operated in isolation from broader health promotion initiatives: "a broader-based health promotion approach is urgently needed" (p. 107) for preventing illicit drug use. While the two disciplines share a targeted focus on society's impact on health, the origins of the disciplines are dissimilar and lead to different approaches. The drug prevention field is based on a pathogenic approach of deterring disease and illness, reflecting the biomedical disease model. This model has been criticized for having a reductionist focus on risk factors (Baum, 2000). The strong focus on predicting risk and identifying precursors led to an emphasis on causality, potentially at the cost of understanding the complexity of risk behaviours. The intensive focus on problem behaviour has been also criticized for leading to a culture of *blaming the victim*

(Catalano et al., 2002). The growing criticism of the biomedical disease model underlying prevention paved the way for what Baum (2000) calls a new era of public health that culminated in the first international conference on health promotion in 1986. The conference resulted in the development of the ground-breaking Ottawa Charter, which laid the foundations for the health promotion discipline (Green & Tones, 2010).

Health promotion is based on a salutogenic approach, which focuses on what creates health and the positive resources that exist in people and communities (Mittelmark et al., 2017). Health promotion is defined as "the process of enabling people to increase control over and to improve their health" (World Health Organization, 1986, p. 1). The definition has strong ties to the empowerment approach, where individuals and groups are portrayed as able to present their concerns and participate in decision-making through a social, cultural, psychological, or political process (Nutbeam & Harris, 1998). This development can also be understood as a distancing from the biomedical model, where experts traditionally prescribe strategies on behalf of a target group (Green & Tones, 2010). In addition, the Ottawa Charter advocated for a settings approach to health promotion, which reflects an ecological model of health (Dooris, 2013). Kickbusch (1996) describes the settings approach as a shift from a previous deficit model of disease to the "health potentials inherent in the social and institutional settings of everyday life" (p. 5). Many countries have developed policy frameworks to address the settings which influence health and the needs of people at different levels and sectors of government, at both the national and local levels (Kickbusch & Behrendt, 2013).

Internationally, Norway and the other Nordic countries have been cited as leaders in developing such health-promoting policies due to the similarities between the key principles of health promotion and the traditional concepts of the Nordic welfare state (Raphael, 2014). Norwegian public health policies have followed the evolution of health promotion, echoing the principles from the Ottawa Charter in government white papers (Fosse & Helgesen, 2017). The enacting of the comprehensive Norwegian Public Health Act represents the clearest example of this development (Ministry of

Health and Care Services, 2011). The act is built on the principles of Health in All Policies (HiAP), which requires a high degree of intersectoral collaboration to ensure that every sector in government is working to promote health (Fosse & Helgesen, 2017). The act outlines the responsibility of each municipality for devising health promoting policies which take account of the social determinants of health (Fosse et al., 2019). The municipality in Norway, therefore, plays an important role in addressing the structures for preventing youths from engaging in illicit drug use.

1.2 The municipality as an arena for drug prevention

Norway has 356 municipalities, over half of which report that illicit drug use is their most important public health challenge (Helgesen & Hofstad, 2012). In Norway and the other Nordic countries, the provision of public services is channelled through local governments (Baldersheim & Ståhlberg, 2002). In addition to being local decision-makers in their own right, municipalities are agents of the welfare state and thus must strike a balance between national objectives and local autonomy (Baldersheim & Ståhlberg, 2002). The relationship between Norway's national government and its municipalities has undergone some changes, with a shift in administrative policy that political scientists have called "the new municipality" (Bukve & Offerdal, 2002; Ramsdal, 2004). The new municipality is characterized by the national government steering municipalities towards national goals; as long as the municipalities reach those goals, they are free to organize efforts and initiatives as they see fit (Ramsdal, 2004). Ramsdal (2004) points out that this administrative policy conflicts with the political trend of adopting broad efforts and initiatives, demonstrating that the policy areas which are adapted to the new administrative policy are characterized by constraining their focus. Ramsdal (2004) warns that "borderless" policy fields such as mental health, where the target groups are ambiguous and it is hard to reach quantifiable goals, risk losing leverage compared to more specific policy areas (Ramsdal, 2004; Vike et al., 2002). A report reviewing local drug policy planning processes in Norwegian municipalities revealed that the ambitions of drug policy plans had to give way to the municipal economy, local business interests, liberal politicians,

and the tendency to focus more on concrete efforts than on visions and goals (Baklien & Krogh, 2011). Although the national government recommends a focus on universal drug prevention in municipalities, client-oriented work addressing experienced drug users receives the most attention in municipal drug plans (Baklien & Krogh, 2011). This highlights some of the structures facing drug prevention in Norwegian municipalities today. Although local governments have been described as instrumental for developing policies best suited for local needs, the research literature has primarily been devoted to national-level drug prevention policies (MacGregor et al., 2014; Tieberghien, 2016). Several researchers have advocated addressing policies to the local government level because that is the level tasked with the implementation and development of these policies (Fosse et al., 2019; Sellers & Lidström, 2007). In chapter 2, empirical studies addressing the role of municipalities in drug prevention are explored in detail.

Addressing a complex societal issue such as drug prevention aimed at youths within a municipal structure reflects the boundary-spanning potential of the topic. National Norwegian policies emphasizes that drug prevention requires both collaboration between municipalities and NGOs and collaboration within each municipality (Det kongelige barne- likestillings- og inkluderingsdepartement, 2013). Drug prevention is relevant to several municipal departments and, in line with the HiAP approach introduced in the Public Health Act (Ministry of Health and Care Services, 2011), there needs to be collaboration between the different departments. The present study provides insights into how the relevant municipal departments collaborate on a boundary-spanning topic such as drug prevention. In addition, the thesis explores the viewpoints of the different stakeholders in local policy development: from policy makers to service providers to the at-risk youths to whom the efforts are directed.

1.3 Bergen Municipality's structures for drug prevention

Within each municipality, the different ways of organizing departments and services are influenced by, among other political decisions, local prioritization, and national

policies (Bukve & Offerdal, 2002). In the municipality of Bergen at the time of data collection, the key departments were organized as shown in Figure 1:

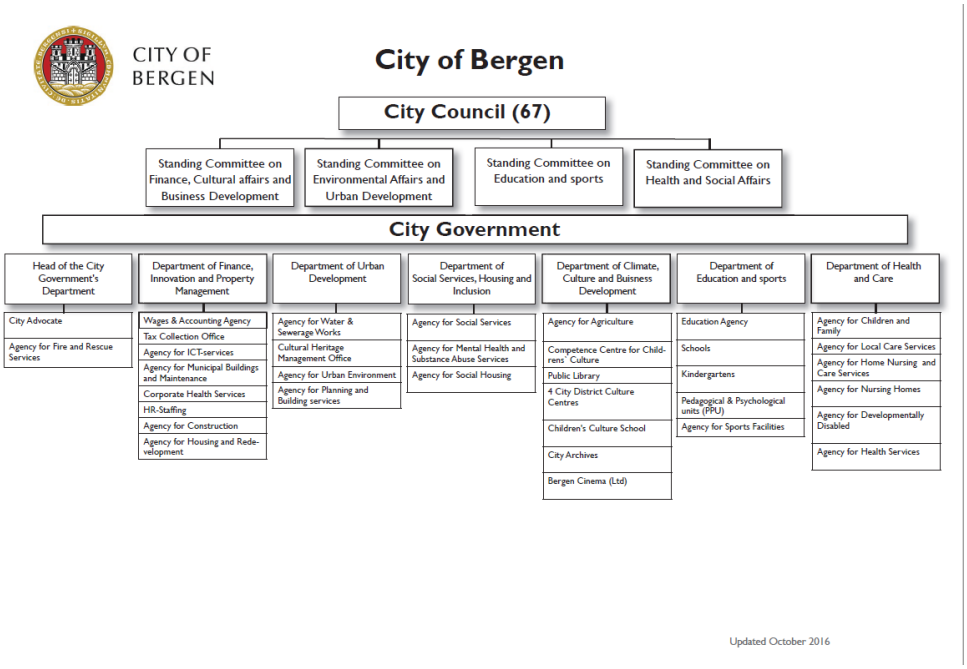

Figure 1: Illustration of the municipal structures of Bergen municipality at the time of data collection (Bergen Municipality, 2016).

Bergen is one of three municipalities in Norway governed through a parliamentary model. The city council consists of 67 publicly elected officials who elect a city government, in much the same way as a national government answers to a national parliament. The parliamentary governing model is characterized by majority rule overseen by the top political leadership; consequently, that political leadership is more visible (Bukve, 1996). As opposed to the more common aldermanic model, where there is one political leader, the parliamentary governing model has a political leader at the top of every department (Bukve, 1996), which may serve to highlight the structural silos between policy areas within a municipality. The parliamentary model also serves to highlight political polarizations, with clear demarcations between the political parties that typically follow national political party lines (Saxi, 2018).

Drug policies have been a priority issue for Bergen's city government, which was made especially clear with the creation of an action plan to address the open drug scene (Bergen Municipality, 2012). The increased attention on drug policies was also reflected financially. In the years after the action plan to address the open drug scene Bergen has spent 58% more on its budget for services offered to people with drug problems, compared to the other major municipalities in Norway (ASSS, 2018). The beneficiary of this increase has to a significant extent been the services connected to established and senior drug users, through initiatives such as an injection room, an overdose team and opiate maintenance programs. The municipality has developed several drug policy plans, often spanning four-year periods, which have mainly been organized by the Department of Social Services, Housing and Inclusion. Drug prevention initiatives, however, have often been organized by a different municipal department, the Department of Health and Care. The municipality's drug and crime prevention coordinators (SLT-Coordinators[1]) are located in that department and tasked with coordinating prevention initiative for the municipality as a whole. The Department of Health and Care also houses the outreach service. Outreach social work has long played an instrumental role in drug prevention and is cited in the proposed drug reform as an important prevention agency, which targets at-risk groups in danger of involving themselves in drugs and crime and developing mental health issues (NOU 2019: 26). The outreach service targets groups that are often considered hard to reach by using outreach methodologies that are voluntary for the users and in which social workers can be flexible (Henningsen et al., 2009).

While the majority of Norwegian youths show positive development concerning risk behaviours such as less alcohol consumption and smoking than previous generations (Bakken et al., 2018), there are reasons to believe that the divide between the ones who are able to cope and those who cannot is increasing (Haug et al., 2020). Every year, the local outreach service in Bergen meets over 100 youths who need aid. These youths often require services from different welfare agencies simultaneously. Youths who are characterized as having *complex needs* typically have some difficulties with mental

[1] In Norwegian: "Samordning av lokale rus og kriminalitetsforebyggende tiltak"

health, with or without a psychiatric diagnosis, and are exposed to various risk factors, such as difficulties in completing education, unemployment, out-of-home care, substance abuse and juvenile delinquency (Almqvist & Lassinantti, 2018). It should be noted that the group is heterogeneous and, since the outreach service is a low-threshold service, it offers its services to youths who to varying degrees experience these risk factors but are united in their need for aid from that service.

1.4 Outline of the thesis

The topic of the thesis is drug prevention aimed at youths within a specific municipality, and the topic is discussed through a health promoting theoretical lens throughout the three included articles. The thesis is structured around the three key entry points of the local policy process, which illustrate the inner structures of drug prevention in the municipality: from the collaboration between the municipal departments in developing policies aimed at youth to address drug prevention, to the collaboration between policy makers and service providers in the implementation of the policies, and finally how the youths at the centre of the policies experience the structures surrounding them in leading healthy lives.

The thesis consists of two main sections. The first is a synopsis which elaborates the foundations of the research project, and the second presents the three articles. In combination, these sections answer the research questions which form the basis of the thesis. In Chapter 1, I have provided a short introduction to the rationale for developing the research project and current developments in both public health and drug prevention at the municipal level in Norway. Chapter 2 provides an updated review of the literature on how the role of municipalities has been addressed in the research on drug prevention. Chapter 3 describes the unifying research questions for the thesis. In Chapter 4, the theoretical underpinnings are explored, with a focus on the health promotion approach. Chapter 5 offers an in-depth description of the case study which unifies the three articles and the ethical considerations involved in the project. In Chapter 6, the three individual articles are briefly reviewed. Chapter 7 presents a

discussion of the key findings from those articles, while concluding remarks make up Chapter 8.

2. The role of the municipality: A review of the literature

Laverack and Labonte (2000) identify two prominent discourses in health promotion. The first is characterized by illness prevention through health behaviours and the second by social justice through community empowerment and advocacy. These discourses can be said to represent top-down and bottom-up approaches, respectively, in their way of addressing the community. In the first, the community is a setting for health behaviour programs, while in the second the community is the starting point from which to change broader policy and practice. The literature concerning the municipality's role in drug prevention follows a similar dichotomy. The municipality is often described either as an arena for drug prevention initiatives or as a research subject in and of itself, where the goal is to highlight its internal structure and address a broader approach to prevention.

In studies where municipalities are viewed as arenas for interventions, they have been found to be suitable for a range of initiatives, from HIV prevention by distributing condoms at health care centres (Hjorther et al., 1990) to providing more Hepatitis C virus patients with treatment after close collaboration with both municipal stakeholders and peer-group members (Lygren et al., 2019). The literature on drug prevention in municipalities has increasingly focused on the role of the municipality, emphasizing especially the active engagement of key stakeholders if a drug prevention program is to be successful (Danielsson & Romelsjö, 2007; Nilsson et al., 2018; Norrgård et al., 2014).

The drug prevention literature is also focused on identifying the structures within municipalities which are at play when administering policies or projects aimed at drug prevention. Three studies from Sweden direct attention in different ways at how municipalities address their new responsibilities regarding drug prevention; Sweden had adopted a similar approach to that found in Norway. An evaluation of a community-based prevention program in six Swedish municipalities used surveys and interviews with six to eight participants in each municipality, including political and

administrative decision-makers relevant to drug prevention and teenagers and parents of teenagers and representatives of NGOs (Andréasson et al., 2007). The evaluation indicated that the communities were positive about a policy move from narrow prevention directed at individuals towards a broad approach aimed at the entire population. However, they were not initially aware of the challenges associated with reorienting their prevention efforts, such as the need to document success, or competing with treatment alternatives (Andréasson et al., 2007). In addition, the evaluation showed that the municipal leadership's commitment to drug prevention varied. The effects of the same program were presented in an article by Hallgren and Andréasson (2013) that was based on a cross-sectional survey of youths compared to control municipalities. The study revealed few significant improvements in the trial communities, when compared to controls, which was attributed to a lack of evidence supporting the strategies the municipalities had chosen (Hallgren & Andréasson, 2013). However, the study did indicate that interventions addressing the availability of drugs and alcohol and where risk factors were locally identified were more likely to succeed than programs directed solely towards individuals (Hallgren & Andréasson, 2013).

Similar to the results of Hallgren and Andreasson, a study of local drug strategies in six Norwegian municipalities showed that the universal and selective programs initiated did not have a documented effect (Rossow & Baklien, 2011). The lack of evidence for programs was also addressed in a study by Spak and Blanck (2007), who interviewed project representatives in 49 municipalities and conducted in-depth case studies of four representative municipalities. Their results showed that community alcohol prevention had been strengthened, but evidence-based practice was still lacking. Many municipalities are striving for broad prevention efforts, where collaboration is a key issue. However, collaboration between the relevant stakeholders was limited. Based on the same data collection, Blanck et al. (2007) elaborated their analysis in a separate publication to identify the ideology involved when the civil servants discussed prevention at the local level. The study indicated that local alcohol prevention is characterized by limited collaboration between stakeholders and, although young people were mentioned as important for prevention work, there was

little indication of any dialogue with those young people; indeed, youths were often identified as problems rather than possible resources (Blanck et al., 2007). A study by Valderrama and colleagues (2006) combined policy-level and youth perspectives to understand prevention needs in small municipalities in Spain. The data for the policy level are based on a survey of 206 municipalities and in-depth qualitative analysis with focus groups, observations, and interviews in 8 representative communities. The study showed that mandated prevention was not adequately covered in the municipalities (Valderrama et al., 2006), while the qualitative analysis revealed that the youths experienced the limited prevention actions as ineffective. This was supported by the professionals in the municipalities, who also added that there was limited coordination between professionals and the organization's drug prevention activities.

The role of collaboration in prevention is also explored on the local level in work by Bulling (2017) and Bulling and Berg (2018). They studied the role of low-threshold services of family centres in three Norwegian municipalities to meet the needs of families requiring different levels of assistance, ranging from universal interventions to children and youths with particular needs. These family centres unite different professions relevant for families to bridge some of the separate services offered by the welfare system. Bulling's 2017 study was based on interviews and focus groups with the professionals and parents using the centre and showed that a low level of bureaucracy was essential for the users; the parents also stressed the need to be met with respect and for professionals to have collaborative competence (Bulling, 2017). In Bulling and Berg (2018), the data are based on interviews and focus groups with professionals and the managers of the centre (Bulling & Berg, 2018). This study showed that intersectoral collaboration was crucial for developing high-quality support for users, but the professionals found that collaboration was under constant pressure of being squeezed out. The professionals experienced that health promotion across sectors was mandated by national policy but regulations or guidelines on how the policies should be implemented or the efforts evaluated were lacking. Bulling and Berg (2018) conclude that intersectoral collaboration should be reframed from a problem-solving approach to a form of collective learning, which may lead to a setting in which diversity is more valued. The study points to the difficulties that front-line

workers in the municipality experience when tasked with prevention efforts directed at people with complex needs. Although they suggest reframing intersectoral collaboration, there is limited attention to the overall structures within the municipality, possibly supporting a sectorized system.

The literature described above highlights the role a municipality can play as either a setting for a drug prevention intervention or a research subject with the goal of identifying the inner structures of municipalities to address a broader approach to prevention. The present study builds on knowledge from previous research and seeks to combine the perspectives of different key stakeholders, who together provide richer picture of the structures of the municipality regarding drug prevention.

3. Aims and research questions

Municipalities play an important role in promoting healthy lives for children and youths, as they are the organizers of many of the essential welfare services and surrounding structures that youths interact with every day. According to The Public Health Act in Norway, municipalities should work across policy sectors to promote health (Ministry of Health and Care Services, 2011). Therefore, the municipality has not only an important responsibility but also a unique opportunity to help these youths. However, drug prevention is a complex and boundary-spanning issue that may be limited by structures within the municipality. To gain more insight into how these overarching policies coincide with the structures of the municipality and the needs of youths, the following research aim has been proposed:

The thesis aims to provide a contextual and in-depth investigation of the organization of drug prevention at a local level. This prompted the overall research question:

> *How are local drug prevention strategies implemented in Bergen municipality through the eyes of local policy makers, outreach social workers and at-risk youths?*

The research question is answered by empirical data from a case study which combines three focal points representing the local policy process:

- The local policy makers from departments tasked with developing drug prevention policies
- The service providers at an outreach service aimed at preventing youth maladjustment and illicit drug use
- The at-risk youths as recipients of municipality's policies in addressing drug prevention

The thesis is inspired by theoretical perspectives from both the health promotion discipline and the field of governance, which inspired a theoretical framework addressing both the drug prevention policies and the structures for implementing those policies within the municipality. The overall research question is further operationalized and answered in three separate articles. The three articles and the research questions are illustrated in Figure 2.

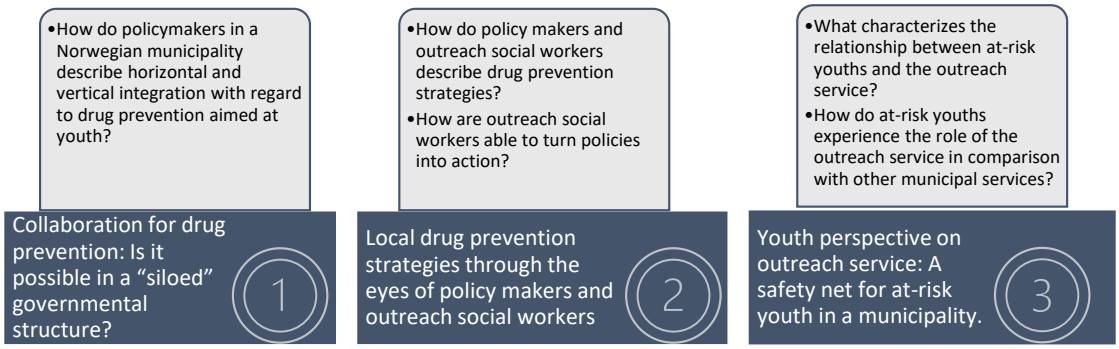

Figure 2: Illustration of the three articles with titles and research questions.

Together, the three articles combine the different perspectives from the local policy process on drug prevention. Article 1 presents the views of policy makers from different policy areas on the horizontal and vertical integration of drug prevention policies. Article 2 provides insight into how policy makers and outreach social workers describe the drug prevention strategies and the role of outreach social workers in translating them into policy. Article 3 combines the perspectives of outreach social workers and at-risk youths to describe the outreach service as a drug-prevention initiative and to shed light on how drug prevention strategies are understood by the youths themselves.

While the municipality plays a central role in local drug prevention, other actors like NGOs and government services such as hospitals and police are important stakeholders. Though these actors collaborate with municipalities, this thesis focuses on the internal structures of the municipality and therefore does not include actors outside the municipal government.

4. Theoretical framework

The thesis is based on the health promotion discipline, and some of the key theories used in health promotion have inspired the theoretical framework of the thesis. Health promotion is an interdisciplinary field which draws on theories from fields such as political science, social science, and psychology to offer insight into the ecological nature of health. In this chapter, I present and elaborate on the main theories which make up the theoretical framework of the thesis and how the theories relate to and complement one another. In addition to presenting the overall theoretical framework behind the thesis, I present the theoretical tools used in the three articles and describe how they are connected.

4.1 An ecological approach to health

One of the most foundational ecological theories in health promotion is the social determinants of health (SDH) model by Dahlgren and Whitehead (1991). SDH describes some of the complexity that can affect an individual's health (Figure 3).

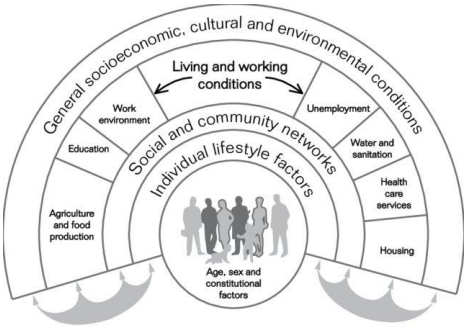

Figure 3: The main determinants of health (Dahlgren & Whitehead, 1991).

The model describes individual constitutional factors, individual lifestyle factors, social and community networks, living and working conditions and general socioeconomic, cultural, and environmental factors as important for health. The SDH model is frequently used in health promotion and cited in white papers at both the national and global levels. It highlights how an individual's health can be affected by surrounding structures such as environmental factors. It also illustrates the

interrelations between the surrounding structures and thus outlines the need for intersectoral collaboration of different policy sectors, as health is also created outside the health sector.

In the development of the thesis, the model played an important role in highlighting the need to examine the structures surrounding the youths. Traditionally, drug prevention and public health have been focused on individual lifestyle factors, particularly on risky behaviours (Baum, 2000; Green & Tones, 2010). In line with the health promotion discipline, this model inspired a broad and multisectoral approach to the topic of drug prevention aimed at at-risk youths and served as a useful aid in directing attention towards the surrounding structures, such as the outreach service and the municipality itself.

Over the years, the SDH model has been used frequently, even by scholars outside health promotion. Although the model has a strong footing within that discipline, most SDH studies have been found to have an epidemiological starting point and a focus on diseases; for example, health is often discussed and defined as life expectancy (Holt, 2016; McQueen et al., 2012). Some have argued that SDH is rooted in an epidemiological epistemology (McQueen et al, 2012) and builds on the premise that SDH captures the causality that social factors have on health, which contrasts to some extent with the constructivist position (Holt, 2016). The criticism of SDH reflects some of the tensions which exist between different approaches to health promotion (Baum, 2000). One mode of health promotion focuses on disease prevention, using models of behavioural change linked to positivist biomedical methods and measures of effectiveness. In this mode, the SDH model can be understood as a framework of correlative causality. In the other mode of health promotion – in which this thesis is positioned – the focus is on tackling the social and wider determinants of health (the causes of the causes) linked to a moral and political approach with its own structuralist methods and measures. This view reflects the radical roots of health promotion, roots that continue to challenge the individual-focused medical model and its related health care delivery systems (Baum, 2000). The constructivist position of this thesis reflected as a holistic case study is inspired by the ecological nature of the model and is further

explored in the methods chapter. The SDH model remains a useful tool in identifying and addressing the structures which influence health.

The ecological approach to health inspired the design of the study and served as a theoretical tool in the articles. Following the rationale proposed by the SDH-model, the structures surrounding the youths, such as the services offered by the municipality, play an instrumental role in their development of health, and therefore warrant a closer investigation. In the articles, the ecological perspective is also used as a theoretical tool to analyse the findings from the participants.

4.2 Healthy public policies and collaboration

The ecological approach described in the previous section demonstrates that many factors influence health and is often contemporaneously mentioned with the well-known phrase, “health is largely created outside the health sector” (De Leeuw, 2017, p. 329). This standpoint contrasts with the common supposition under which the health sector is tasked with the social ownership of health issues (De Leeuw, 2017). Following the logic proposed by the ecological approach and the SDH model, other policy areas both affect and bear responsibility for health issues. The recognition of SDH-inspired policy movements such as HiAP and intersectoral collaboration are significant for both the development of the overall thesis and serve as analytical frameworks in the articles. The present section demonstrates the consequences of the theoretical position of recognizing the impact of a social-ecological perspective on health.

A natural consequence of identifying that health is determined using an ecological model is to reaffirm the focus on public policies. One of the main proponents of a political and systems-level solution to the medicalized health care system was Milio. Milio, who (simultaneously with Hancock) developed the term “healthy public policies,” which had a lasting effect on the Ottawa Charter for Health Promotion (De Leeuw, 2017). Healthy public policies are summarized as follows:

> Characterized by an explicit concern for health and equity in all areas of policy, and by an accountability for health impact. The main aim of healthy public policy is to create a supportive environment to enable people to lead healthy lives. Such a policy makes healthy choices possible or easier for citizens. It makes social and physical environments health enhancing (Nutbeam, 1998, p. 359).

The healthy public policy perspective has been criticized for merely identifying the structures of government and not doing much to mobilize action (Fafard, 2008; Marmor & Boyum, 1999). While the principles reflected in healthy public policy is idealistic, De Leeuw (2017) argues that it may represent the idealistic zeitgeist surrounding the creation of the Ottawa Charter and that the visionary perspective of the Charter may have enhanced the appeal of the health promotion discipline. The healthy public policy approach enhanced the focus on the role of government in health promotion.

The recognition that health determinants also lie outside the health sector has led to repeated calls for intersectoral action (De Leeuw, 2017). The contribution of other sectors to health and development has led to intersectoral health being advocated for several decades. Intersectoral action has also received increased awareness due to increasingly diverse and complex societies. Modern society is characterized by hyperspecialization, organizational silos and a lack of cross-silo engagement (De Leeuw, 2017). Different approaches have been introduced to reform the public sector to adapt to the changes in society. New Public Management (NPM) reforms are often characterized by decentralized accountability, in which smaller units work based on performance measure and competition. This way of organizing can result in a limited understanding of the whole system and consequently lead to fragmented services (Eriksson et al., 2019). Due to NPM's "production-esque" mode of efficiency in internal processes' input and output, it is not viewed as compatible with complex issues involving different actors (Eriksson et al., 2019). Since the development of NPM, new paradigms have emerged in policy administration to address the need for integration, such as the governance paradigm (Hill & Hupe, 2014). Governance refers

to “the challenge of steering and co-ordinating a complex range of organisations via a control system constructed upon a multiplicity of linkages” (Flinders, 2002, p. 51). Governance is managed through tools such as coordination, accountability, and power (De Leeuw, 2017; Flinders, 2002).

Since the first significant effort to document and change other sectors’ involvement in health 30 years ago, there has been a substantial growth in rhetoric to describe the problem (De Leeuw, 2017). A key foundation in the concepts developed for integration about complex topics is the belief in governance. The topic has been described using different terminology, such as joined-up government, whole-of-government, integrated governance, horizontal and integrated government, multisectoral action and intersectoral action (De Leeuw, 2017; Exworthy & Hunter, 2011; Hunt, 2005; WHO, 2013). The most prominent approach in the health promotion field is HiAP**.**

HiAP aims to increase the responsibility for public health at all levels of the policy process and requires high degrees of collaboration within the government, which needs to be supported by the leadership (Carey et al., 2014; Ståhl et al., 2006). One of HiAP’s main characteristics is to enhance population health by introducing health considerations into non-health sectors (Ståhl et al., 2006). As previously stated, Norway has been described as a leader in developing health-promoting public policy (Raphael, 2014). Norway has embraced the principles of HiAP; indeed, the HiAP approach is one of the five founding principles of the Norwegian Public Health Act (Hofstad, 2016). Municipalities in Norway are the primary implementers of population health policies, and the Public Health Act plays a significant role in policy development.

At The 8th Global Conference on Health Promotion in Finland in 2013, the goal of HiAP was formulated as follows: “to better health, health equity and well-being by stimulating positive determinants of health and hamper the negative ones” (Ståhl et al., 2006). HiAP has remained a popular approach within health promotion to highlight the need for intersectoral action and has enjoyed considerable attention from researchers

and policy makers (Leppo et al., 2013). Critics of HiAP point to the paradoxical role of "health" in HiAP. Some researchers have pointed out that starting a collaboration with a health argument may be counterproductive (De Leeuw, 2017). This has been further explored on a local level by Holt et al. (2018) in Danish municipalities and by Synnevåg et al. (2018a) in Norwegian municipalities. Their findings have argued that placing public health issues at the forefront and expecting other policy sectors not only to adjust to the health perspective but also to initiate intersectoral action based on that premise is a sign of *health imperialism*. Alternative terms such as *social sustainability* and *living conditions* have been suggested as possible concepts to bolster cross-sectoral action on social inequities (Hofstad & Bergsli, 2017; Holt et al., 2018; Scheele et al., 2018; Synnevåg et al., 2018a). Another point of contention with the HiAP approach and similar concepts is their limited focus on the existing science of governance, policy, and implementation. De Leeuw (2017) warns that the terminology surrounding HiAP and other concepts conflate policy with action and encourages grounding cross-sectoral engagement in a multilevel governance perspective. The present thesis uses a similar perspective, drawing on theoretical frameworks from the public administration field to better illuminate the structures of multilevel governance.

4.3 The structures of governance

According to the Public Health Act (Ministry of Health and Care Services, 2011) and the principles of HiAP, all sectors should band together to discuss health concerns, but this raises the issue of identifying the structures a municipality operates under. Implementation studies in operational governance distinguish between top-down and bottom-up approaches. The traditional perspective, represented by the work of Pressman and Wildavsky (1984), is top-down, based on a rational model in which policy sets goals and implementation research is concerned with what interferes with the achievement of those goals (Hill & Hupe, 2014). Lipsky (2010) is considered the founder of the bottom-up perspective, which describes the structures surrounding street-level bureaucrats, the ones who are tasked with the translation of policy into action. The introduction of street-level bureaucrats represents a normative shift from

the top seeking to exert its will, to bottom-up implementation (Hill & Hupe, 2014). Lipsky (2010) points to the paradoxes of street-level work, where bureaucrats at that level can experience, they are cogs in a system and oppressed by the bureaucracy, even though they often appear to have a great deal of discretion, freedom, and autonomy. Lipsky's (2010) theory inspired the need to investigate the role the implementers have played on policy formation and serves as a theoretical tool to describe outreach social workers role in the implementation of policy.

Drawing on research into inter-organizational integration in public health and other welfare services, Axelsson and Axelsson (2006) developed a conceptual scheme which combines the ideals of HiAP with a focus on governance structures. Integration is defined as "the quality of the state of collaboration that exists among departments that are required to achieve unity of effort by the demands of the environment" (Lawrence and Lorsch, 1967, p. 11). The conceptual scheme of different forms of integration laid the foundation for the analysis in article 1 and serves as a framework for the discussion in the thesis as a whole (Axelsson & Axelsson, 2006). The conceptual scheme distinguishes between vertical and horizontal integration. Vertical integration takes place between different levels of a hierarchical structure, while horizontal integration takes place between units on the same hierarchical level (Axelsson & Axelsson, 2006). The combination of these dimensions forms a conceptual scheme illustrating the degrees of integration within these dimensions, as illustrated in Figure 4.

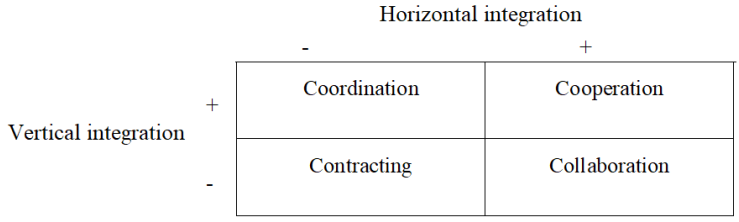

Figure 4: Conceptual scheme of different forms of integration (Axelsson & Axelsson, 2006).

The conceptual scheme illustrating degrees of integration serves as a theoretical tool to describe how the structures following horizontal and vertical lines in the municipality's policy making coalesce around the goals of drug prevention. The HiAP ideals underlying the conceptual scheme aligns with the policy shift in Norway and addresses the growing need to consider the structures of governance in municipalities.

Integration and collaboration have become the buzzwords in public health (Kvarnström, 2011), but the shift towards integration is not without its critics. Kaehne (2017) criticizes the inter-professional focus of integration, arguing that although integration appears to be a part of a wider trend to adopt a patient-centred perspective, it actually deals with the staff: "The difficulty arises that integration, however, remains an inter-professional endeavour, not a patient-orientated one" (p. 272). This concern raised the need to look more closely at how the users at the end of the policy chain experience the services of the municipality. Axelsson and Axelsson (2013) suggest viewing the challenges connected to integration from the of the various key stakeholders involved; management, professionals, and users. The focus on combining perspectives of different stakeholders is in line with the rationale of the present thesis.

4.4 Theoretical perspectives on at-risk youths

This thesis is inspired by the health promotion discipline, not only in the ecological approach to health but also in the approach used to describe the centre of the policies. In the thesis, the youths are described as both recipients of the policy and as actors. When describing the youths as actors, health-promoting concepts such as *agency* and *empowerment* are used. Empowerment is used as a theoretical tool to describe the youths' agency. The notion of empowerment has been the flagship model in health promotion, describing individuals' ability to take control of their own lives (Nutbeam, 1998). Some have argued that empowerment has lost its radical roots (Woodall et al., 2012), that individual empowerment tends to remain at a superficial level and not include an actual transformation of power. Staples argues that "individual empowerment is not now, and never will be, the salvation of powerless groups. To attain social equality, power relations between *haves*, *have-a-littles*, and *have-nots*

must be transformed. This requires a change in the structure of power" (1990, p. 36). Another challenge when using the concept of empowerment is confusion surrounding the concept itself (Drydyk, 2013); researchers have identified 30 different definitions of empowerment (Ibrahim & Alkire, 2007). It was, therefore, necessary to specify the term *individual empowerment* when describing the findings. The role of *power* in empowerment is further discussed in the discussion chapter of the thesis.

In two of the articles, Gordon's classification framework (1983) is used to describe the policies developed to reach the youths at the centre of the thesis. In prevention science, Gordon's classification is often used to structure the different target groups of prevention initiatives. The intended application of *universal* preventive measures is across a population, irrespective of risk; these are measures targeted at a general population. *Selective* measures are aimed at members of a sub-group in which risks are higher. *Indicated* measures are preventive strategies targeted towards individuals who are found to manifest a risk factor (Gordon, 1983). The framework originates in prevention science, which searches for what causes illness and how to prevent or reduce the consequences of illness. Prevention science is based on community epidemiology and aims to identify empirically verifiable precursors that affect the likelihood of undesired health outcomes (Catalano et al., 2002). Childhood and adolescence became a focal point for interest as it is theorized that early risk exposure and not meeting developmental challenges may lead to additional exposures to risk (Catalano et al., 2002). While the focus in Gordon's classification framework is solely on risk, the present thesis combines the risk focus with a health promotion reorientation towards the youths' individual resources. The inclusion of both the prevention and promotion perspectives reflects a modern adaptation in which it is not a question of either-or but of having a complementary perspective (Naidoo & Wills, 2016). Within prevention science, there has also been a growing interest in reorienting the focus to include more traditional health-promoting concepts such as well-being (Biglan, 2014) and the significance of the environment (Foxcroft, 2014).

The ecological approach to health requires looking beyond the individual to understand the complex structures behind illicit drug use among youths. By including

a wide range of individuals involved in the municipal structures and the implementers of policy as actors, we see a fuller picture of the complex structures of policy making. Inspired by the empowerment concept in health promotion, the thesis also gives a voice to the youths at the centre of the policy in question. Using empowerment as a theoretical tool in this context may serve to illustrate the contention regarding the concept of empowerment in health promotion. While empowerment can be used to describe the youths' experiences, it does not address the social determinants of health and therefore does not constitute full empowerment, according to Woodall and colleagues' (2012) understanding of empowerment.

To summarize, the thesis is inspired by theoretical concepts and frameworks from healthy public policies such as the HiAP approach in that drug prevention aimed at youths is considered a health issue which requires the involvement of different policy areas. This necessary integration across policy sectors is reflected in Figure 5 as the horizontal line inside the municipal structure.

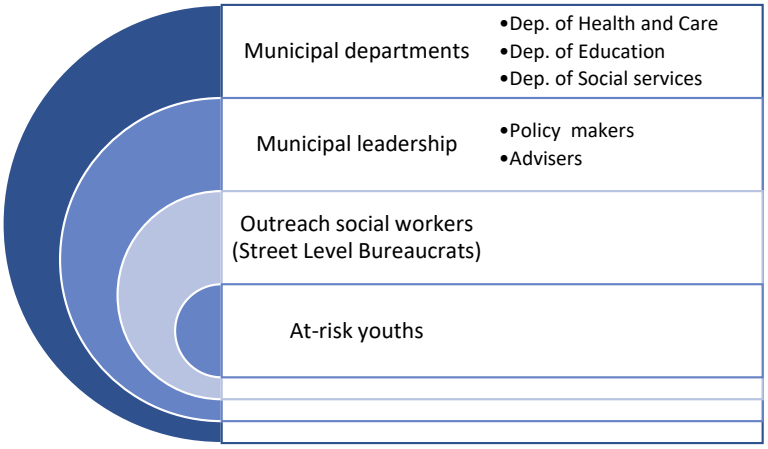

Figure 5: Theoretical entry points for the project.

In addition, the thesis is inspired by the governance structures highlighted by the bottom-up perspective in implementation studies, such as Lipsky's (2010) focus on street-level bureaucrats. This can be reflected as a vertical line of governance structures from policy makers to street-level bureaucrats. In addition, the thesis

includes the views of the target group itself, responding to the need for a client-centred perspective as suggested by Kaehne (2017) and others. The following chapter offers insights into how the case study data were generated following the entry points indicated by the project's theoretical assumptions.

5. Methodology

Many research projects are presented as final products in which the methodologies are neatly outlined and followed, with less attention paid to the decision processes that led to the approach ultimately chosen (Lauckner et al., 2011). This chapter highlights some of the important methodological decisions that have affected the project and the consequences of those decisions, starting by highlighting the underlying assumptions of the research project. The project is based on the view that truth is shaped by context and thus tends towards the constructivist paradigm, focusing especially on how the different participants understand and describe drug prevention inside the municipal structure. In the following section, I describe how the case study was developed and how the data representing the different perspectives were generated. All researchers engage in different procedures and techniques to demonstrate the trustworthiness of a study (Creswell & Miller, 2000). Due to the epistemological assumption that reality is subjective and thus experienced differently by each individual, qualitative studies have been described as challenging to evaluate critically (Cronin et al., 2008). The two cornerstones in establishing quality in qualitative research have long been transparency and reflexivity. The present chapter is devoted to demonstrating transparency by clarifying the choices and consequences of the research process. To demonstrate reflexivity and describe how my role as researcher affects the study, "I" (the researcher) appears more frequently in the present chapter than in the articles. In addition, section 5.5. (Methodological considerations about quality) offers a deeper dive into the reflections to ensure the trustworthiness of the study.

5.1 Case study

The thesis uses a case study design to highlight the internal structures shaping municipal policy. Case studies can be placed in either the positivist/post-positivist or interpretive/constructivist paradigms (Lauckner et al., 2011). The flexibility of case studies as a research methodology has led several researchers to highlight the importance of clearly describing the paradigmatic and theoretical position when using a case study design (Hyett et al., 2014). In the early stages of the project, Yin's (2009)

understanding of case studies informed many of the decisions with regard to rigour and protocols for data collection. Yin is therefore referenced in the first article concerning case selection. However, Yin's (2009) approach to case studies is based on the ontological belief that there is an *objective* reality that can be probabilistically apprehended, placing it in the positivist/post-positivist paradigm (Lauckner et al., 2011). In contrast to Yin's understanding of case studies is the qualitative case study approach described by Stake (1995) and Merriam (2009), which falls within the interpretive/constructivist paradigm. Stake's (1995) description of case studies explicitly seeks out the multiple perspectives of those involved in the case, aiming to gather collectively agreed upon and diverse notions of what occurred. In this instance, the ontological belief is that reality is local and specifically constructed (Lauckner et al., 2011). As I was working on the thesis, the epistemological assumptions of reality as constructed from different perspective grew in importance. I gradually found the project gravitating towards Merriam's and Stake's understandings, using both of their views of case studies to structure the steps taken in this project. Creswell (2013) argues that interdisciplinary practice calls for even clearer methodological descriptions than other methodologies. A description of how the case study design has inspired the project follows.

5.2 The case of Bergen municipality

The most pressing question in any case study research is, "What is this a case of?" There are different types of case study designs. The present project is an instrumental case study in which the goal is to provide insight into an overarching object of interest (Stake, 1995). Thomas (2011) distinguishes between the subject and object of a case study. The subject in the present case is the municipality's structures, from the politician to service providers to user groups, all in the context of local drug prevention policy. The overarching object of interest is drug prevention policies and how they are implemented through the eyes of the key stakeholders in a local government. To investigate a complex social problem such as drug prevention, the instrumental case study design is useful, as it captures the complexity of a case while

also offering a manageable framework to structure the study. The instrumental case study provides insight into an issue, with the case carefully selected to advance the understanding of the object of interest (Hyett et al., 2014). I wanted to understand how drug prevention was perceived and negotiated by key stakeholders following a policy chain perspective. Therefore, I selected relevant parts of the municipal structure in Bergen as the case, with three focal points: policy makers, service providers and youths in the target group. Framing the project as a case study and not merely as an interview study contributes to a clearer focus on the internal context of the municipality, specifically the relationship between policy makers, service providers and the target group. In addition, case studies have previously demonstrated their value as an approach to examining such policy processes in drug policy literature (Lancaster & Ritter, 2014). Stake defines a case study as a "study of the particularity and complexity of a single case, coming to understand its activity within important circumstances" (Stake, 1995, p. xi.). This definition highlights some of the most central characteristics of case studies. The next two subsections present two key characteristics of case studies.

5.2.1 Holistic characteristics of case study

Stake describes a case study as holistic, which means it considers the interrelationships between the phenomenon of interest and its context. The holistic characteristics of the case become apparent when describing and discussing the overarching structures of the municipality's drug prevention, such as public health developments and the Public Health Act that serves as the backdrop to the thesis. By placing the case in a larger context, it is possible to extend the findings of the articles beyond that one case. However, it should be noted that the true purpose of case studies is not to create generalizations; rather, the goal is rich particularization of the case. That may include knowledge of how cases differ from each other, but the emphasis is on understanding the case under examination itself (Stake, 1995). Figure 6 illustrates the interrelationship between the case and its context. The holistic characteristics of the case highlight the interrelationship with the external context and may serve to highlight the case itself and the three focal points as a bounded system.

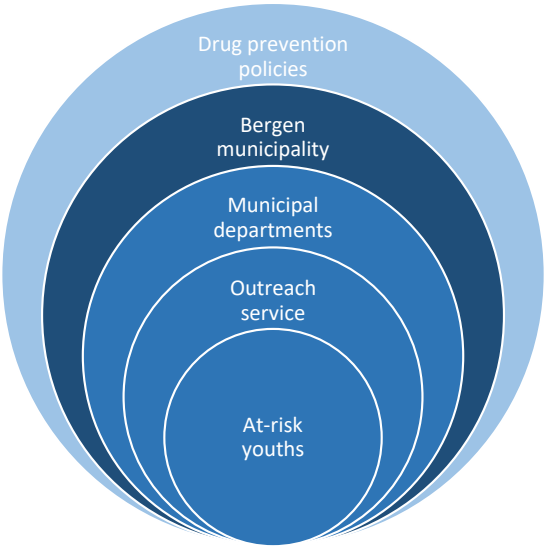

Figure 6: Illustration of the interrelationship between the different focal points of the case study and its context.

Stake (1995) encourages clarifying what is common and what is particular to a case, which involves careful and in-depth considerations of the nature of the case, its historical background, the physical setting, and other institutional and political factors (Stake, 1998). The important factors of the context of the case that are included in the analysis of the articles are described below.

Bergen, as noted in the introduction, had one of the largest open drug scenes in Norway, which led to a comprehensive strategy against open drug scenes. Attention from the municipality, the media and researchers led to a substantial focus on experienced drug users, at the potential expense of drug prevention initiatives aimed at youths. Bergen follows a parliamentary governing system, which can serve to reinforce the municipality's structural silos. In addition, the municipality adheres to a drug and crime prevention coordination model, employing a prevention coordinator who is responsible for coordinating prevention initiatives. The municipality also has a large outreach service with approximately 70 employees. The strategy to counter the open drug scene, the parliamentary model, an awareness of drug prevention and

having a large outreach service are some of the distinctive traits of Bergen municipality.

5.2.2 Emphatic characteristic of case study

Stake also characterizes case studies as emphatic, which means they reflect the different experiences of the participants from their subjective perspective. The thesis is structured around the three focal points in the data generation, which have three different positions and subjective lenses. A key aspect of this project has been to come closer to the different perspectives inside a municipal structure. By providing room for different perspectives, the case has become enriched. The rationale behind including policy makers from three key departments and outreach social workers was developed in close collaboration with a gatekeeper at the municipality, in keeping with the emphatic approach that seeks to capture stakeholder perspectives. Encouraging participants from the municipality to influence the design of the present study brought with it insight into which structures are considered relevant for these stakeholders and which are not. The present case follows policy makers across three identified departments and an outreach social service devoted primarily to at-risk youths. The policy makers offered insights into overall policy making and the intersectoral collaboration between the relevant policy areas. The outreach service providers in one aspect represent service providers from the municipality in that they are on the front lines of the municipal organization and provide services directly to the youths. However, it should be noted that the outreach service does not represent the *general service providers* of the municipality. While the outreach service provides valuable information as to how policies are implemented by the municipality, it is a unique organization, and its distinctive qualities lay the groundwork for the analysis in articles 2 and 3 while deepening the understanding of the vertical structure for drug prevention in the municipality. The case study design opens the door to studying the interrelationships between the different focus areas, which are represented through the different ways of generating data, as described in the next section. Figure 7 illustrates the case. While working on this project, I came to think of Bergen municipality as a building with different focal points operating on different floors in the policy process. The policy makers were on the top floor, developing plans for the service areas. The

outreach service was on the second floor, tasked with implementing policies, and the target group was on the first floor. Figure 7 includes an elevator to reflect how I metaphorically travelled between the different focus areas, taking on the perspectives of the different participants throughout the study. When generating the data, it was important to identify each of the vicarious experiences between the floors and within each floor. Therefore, the analysis in article 1 is based on the diverging descriptions offered by advisers and leaders on the top floor of the municipal leadership. Below is the illustration of the case with its three main focal points (Figure 7).

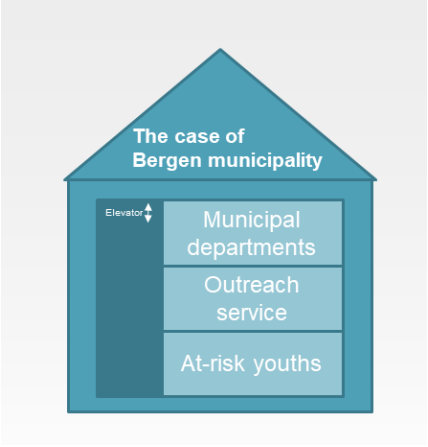

Figure 7: Illustration of the case and the three focal points.

5.3 Generating the data

To reflect the different experiences in the policy chain of local policy development, I primarily generated data through face-to-face interviews with individuals and through focus group interviews. In addition, I followed the proceedings of several city council meetings, read local policy documents, and engaged in informal conversations with people at the municipality to develop an understanding of local policy processes. The different data sources feed into the overall understanding of the case study, enabling a detailed analysis of the issue of local drug prevention. The subsections below provide

a detailed description of how the participants were recruited and the methods used to generate the data.

Before I started communicating with the municipality, I received approval for the data security routines described below from the Norwegian Centre for Research Data (see approval letter in appendix A). Before data collection began, I formally advised the top political leaders in the three relevant city departments (see approval letter from the municipality in appendix B).

5.3.1 Policy makers

The sampling of the participants followed two main strategies. the first and most prominent was done in a collaboration involving me as the researcher, the supervisors, and a gatekeeper from inside the municipality with detailed knowledge of drug prevention as a topic and the municipality as an organization. Based on the participants' roles in the municipal organization and the relevant departments, we charted possible participants in line with a purposeful sampling strategy, where participants would be selected for their ability to provide information-rich data (Patton, 1990). During the interviews, the participants were asked whether there were additional participants I should interview. I, therefore, followed Merriam (1998) suggestions regarding sampling: “Purposive or purposeful sampling usually occurs before the data are gathered, whereas theoretical sampling is done in conjunction with data collection” (p. 66).

I conducted interviews with a total of 11 policy makers; all who were asked to participate agreed. The gatekeeper in the organization assisted in recruitment by placing me in direct contact with the participants. The policymakers held different positions within the municipal organization:

- Commissioner: Political leader of a department
- Chief Executive Officer: Administrative leader of a department
- Advisers: Executive officers who develop policy documents

These policymakers were recruited from the three departments of the municipal organization with primary relevance for drug prevention: The Department of Education, the Department of Social Services, Housing and Inclusion and the Department of Health and Care. The interviews took place in 2016 and lasted between 45 and 120 minutes. After the 11th interview, I experienced theoretical saturation; the interviews had ceased generating new themes or topics.

5.3.2 Outreach social workers

The interviews with the employees of the outreach service took place in the autumn of 2017. I recruited three participants from among the senior staff with considerable experience at the outreach service. The interviews lasted between one and two hours; before the interviews, the participants signed informed consent forms. The interviews were conducted in the offices of the outreach service. Participants were recruited through contact with the leader of the outreach service (Figure 8).

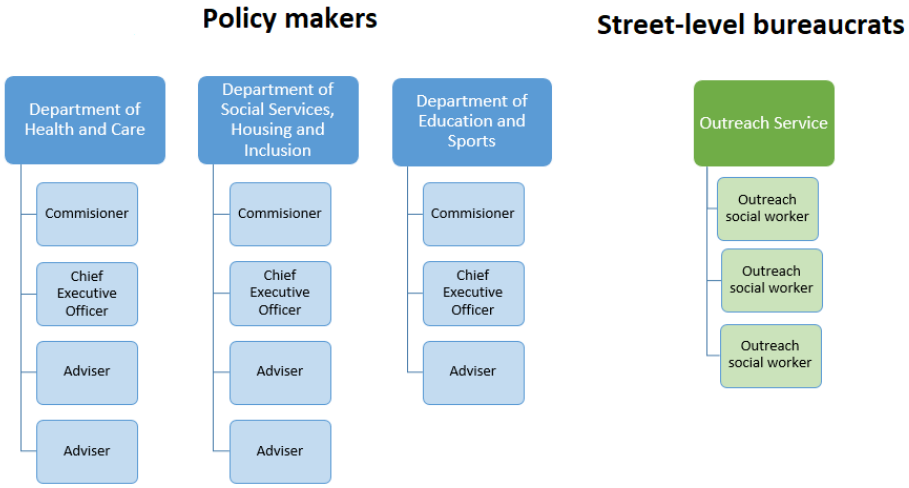

Figure 8: Illustration demonstrating the participants from the individual interviews.

5.3.3 At-risk youths

At any given time, the outreach service is in contact with approximately 100 youths between 13 and 25 years old. Through the help of outreach social workers, we recruited 21 participants who took part in the one of 3 focus group interviews, each of

which had between 6 and 8 participants. The youths were informed before the focus group began that participating in the study was not connected to their relationship with the outreach program in any way and that their participation in the focus group interviews was voluntary. The fact that the outreach service was instrumental in their recruitment, however, has certain obvious consequences. It is possible that youths who had and expressed negative feelings about the outreach service were excluded from the study; therefore, it is important to specify that the aim was not to provide an objective evaluation of the outreach service but to provide insight into which mechanisms are working when the youths describe that service. All the youths described the outreach program in positive terms, and the analysis follows their experiences. Youths who experienced negative encounters with the outreach program would, arguably, not experience the outreach service as promoting empowerment in the same way. Therefore, these experiences are from those who benefited from the outreach service.

Of the 21 participants between 16 and 24 years old who participated in the autumn of 2017, there were 6 males and 15 females. The participants were chosen based on criterion-based sampling. The main inclusion criteria for participants were that they be 16 and above, that they could give consent without parental or guardian clearance and that they had experience with the outreach program. The nature of those experiences differed; some had been familiar with the outreach service for several years, while others started their contact a couple of months earlier. The youths came into contact with the outreach program in different ways. Social workers had approached some on the streets and some at school, while others had sought out the outreach program on their own. Some participants already knew each other, which aided in giving the focus group discussions a familiar atmosphere. The participants were somewhat homogenous. Most were in their late teens, from the Bergen metropolitan area and born in Norway. However, there were some exceptions; some of the youths were immigrants, a few lived in smaller neighbouring villages and some were older. The homogeneity in a group can aid the interaction, but too little diversity increases the danger of unwelcome psychological phenomena like groupthink (Janis, 1982).

5.3.4 Individual interviews

Kvale and Brinkmann (2009) note that the interviewer is both a traveller discovering knowledge and a producer of knowledge, with the interviews acting as an arena of producing knowledge. This harmonizes with the epistemological reflections guiding this project, in which knowledge is generated in the interview situation between the researcher and the participants, highlighting the need for both a reflexive researcher and transparency in describing the interviews to provide a reliable analysis. The approach was inspired by Kvale and Brinkmann's (2009) thoughts on semi-structured research interviews, where the goal is to gain an understanding of people's experiences, perspectives, and interpretations of their everyday lived worlds. Individual interviews were used to ensure in-depth information about the participant's role related to their position in the municipality. The individual interview also allowed for disclosure of any possible challenges related to the different professionals or other stakeholders, which would be uncomfortable or precarious to divulge in a group context. Following the rationale proposed by Kvale and Brinkmann (2009), the semi-structured interview facilitates a natural conversation, while the interview guide provides structure and themes for the interview, ensuring that important topics are covered. There are underlying power relations in any interview situation, where the researcher among others has defining power as to what themes will be covered. As I was cognizant of the underlying power relation, I felt it important to start the interview with a short briefing about the study and by describing the ground rules for the interview with regard to informed consent (see informed consent for individual interviews in appendix C).

Before conducting the interviews, I piloted the interview guide with the policy makers. The goal was to test and improve the data collection instrument regarding both content and procedure (Stake, 1995; Yin, 2009). The participant in the pilot interview was not a part of the study, as that individual was not employed in close proximity to the drug prevention area but was an insider in the municipal organization and aided in adapting the questions to fit a bureaucratic context. Following the pilot, some changes were made to the wording and order of interview questions.

The interviews were generally conducted in the participants' offices, with exception of one that took place in a university office. The interview guide provided some structure to the interviews, but the role of the guide changed as data generation progressed. Because the participants were from different backgrounds and had different roles in the organization, interesting new themes that arose were added to the guide. Therefore, the attached interview guide can now be understood more as a collection of themes and topics that grew organically through the interviews rather than a stone tablet with immutable questions. Each interview was customized for the participant, so the interview guide functioned as a collection of questions and themes that could be used (or omitted) in a given interview. Some questions in the interview guide were irrelevant for some interviewees; for example, a new employee would not be able to describe a change in the municipality's policy in sufficient depth (see appendix D and E for examples of interview guides for policy makers and outreach social workers).

The development of the interview guide can also serve to demonstrate the flexibility of the interviews. As an interviewer, I sometimes took detours from the guide when the participants showed an interest in a specific topic, and those detours would spark new areas of interest and generate new questions, which I then added to the interview guide. After completing each interview, I transcribed the material to review my role as a researcher and review the interview techniques. This led me to identify two main techniques: probing and silence, which were used intentionally throughout the remaining interviews. Silence proved to be among the most powerful tools in the interviews. Although it was uncomfortable to sit in silence, the participants would often offer some new or alternative ways of describing a theme when they had been given the opportunity to think more thoroughly about it. When the participants approached a topic I felt was relevant, I would probe and ask them to either specify what they meant, describe it another way or illustrate it with an example. This produced thick descriptions of particularly interesting themes. The text box below is an excerpt from an interview to exemplify the two key techniques of probing and silence:

Interviewer: Is it your impression that there is good collaboration across the different municipal departments with regard to drug prevention?
Participant: Yes, I think it is very limited.
Interviewer: You think so?
Participant: Yes, it's my impression that there is little collaboration, yes.
Interviewer: Yes.
Participant: Yes.
Interviewer: Can you elaborate? [Probing]
(Silence)
Participant: (draws a breath)
Participant: Eh. So…
Participant: (Sighs)
Participant: I…
(Silence)
Participant: No. (Laughs)
Interviewer: (Laughs)
Participant: So, I think… I can, actually…, I can… I can… I shouldn't really, but… But, I think it is about getting a collaboration across these silos. Because we are all… There are many municipal departments, which, which, work in their area. Right? We have this silo division. And that, that is a structural thinking that is necessary to have some authorization power and organizational lines; but who is responsible for what? – And so on? I think we are so dependent on that in our system. … It can lead to our not being able to work together because some don't have a line over to that municipal department right next door or on the floor below, right? So you are within your field. So there are probably some barriers to the system. Both in this field and others. So it would be exciting to get tighter collaboration between the municipal departments, which natural fits to have more collaboration.

5.3.5 Focus group interviews

The aim of a focus group interview, as opposed to an individual interview, is to generate a perspective from participants on a group level. Focus group interviews are an organized discussion on a topic involving a selected group of individuals to gain information about the views and experiences of that group. The interaction between the participants is thought to trigger responses that may not have appeared in individual interviews (Skovdal & Cornish, 2015). The dynamics of group processes may strengthen and enrich the information that arises from the discussion. In the literature, there is a distinction between focus group interviews and focus group discussions, although the terms are often used interchangeably. The main difference is the role of the moderator. While in an interview the moderator is present and guides the discussion towards the topic of interest, in a group discussion the role of the moderator is more like a fly on the wall. In the present project, the data gathering method can be described as a combination of the two methods; I as moderator was actively present throughout the interviews, both by moderating the discussion to stay somewhat on topic and by reinforcing participation. For example, I might notice people nodding and ask, "I see that you are nodding Patricia, do you agree with what is

being said?" However, the goal throughout was for participants to discuss things between themselves.

To explore the experiences of at-risk youths involved with the outreach program, three focus group interviews were organized in fall 2017 with youths who had experiences with the outreach service. Figure 9 offers an illustration of the three focus groups and their participants (Figure 9):

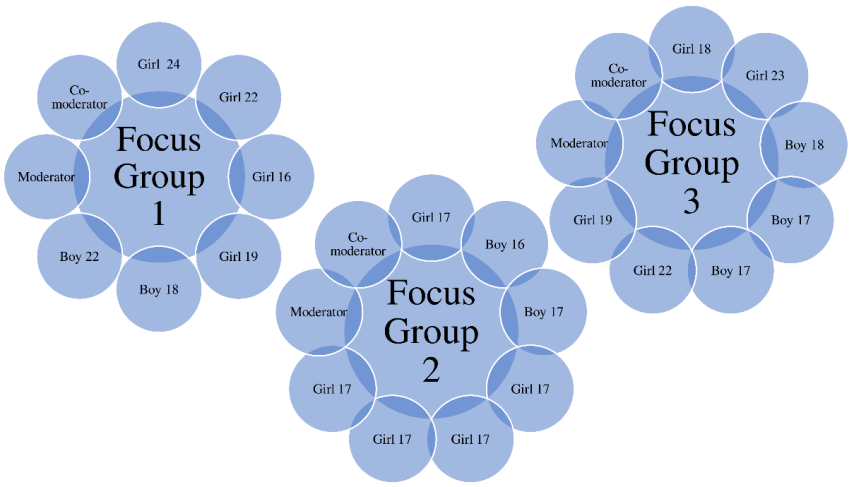

Figure 9: Illustration of the participants in the three focus groups.

Before conducting the focus group interviews, I and two students from the master's program in health promotion piloted the thematic guide in a focus group discussion with three youths who were not in the target group. We constructed a thematic guide that covered topics like the outreach service and youth life in general, mostly using open-ended questions on a general level to prevent the discussion from becoming too personal for the participants (see appendix F for an example of the thematic guide). Focus group interviews have previously demonstrated their value as a research method in several research projects (Porcellato et al., 2002; Tanner et al., 2011). They have also been used in similar projects whose aim was to obtain the perspectives of youths on a group level (Peterson-Sweeney, 2005).

During the focus group interviews, I was the main moderator, with the two students assisting as co-moderators. The data generated from the focus groups were used in the article 3 and in their master's thesis, which analysed the experiences of the youths using salutogenic theory (Lilleng & Ask, 2018). Before the focus group interviews began, we introduced ourselves and stressed that participation was voluntary and would not affect the relationship with the outreach service in any direct way, as well as assuring participants that their contributions would be treated anonymously. Each focus group interview lasted around three hours. The participants received 200 NOK (approximately 20 euros) in compensation to cover transport. After the three focus group discussions, I found that the data became saturated and concluded I had a sufficient selection of participants to study how these youths experienced the outreach service. The focus group interviews were recorded and transcribed verbatim. Every participant signed an informed consent form (see appendix G for the informed consent for focus groups). In the data analysis, the participants were assigned a pseudonym in place their name to ensure anonymity.

5.4 Analysis

All individual interviews and the focus group interviews were audio recorded on an Olympus Digital Voice Recorder. I transcribed most of the audio recordings of the individual interviews, except for a few cases on which the two research assistants helped with that work. The research assistants signed a confidentiality agreement. To ensure the reliability of the transcripts, I listened to the audio recordings while reading the transcripts prepared by the research assistants. The interviews were transcribed verbatim but did not include pauses and incomplete words that were not relevant for the analysis. In order to understand the context and for the transcripts to make sense, I included in parentheses descriptions of some of the events that may not have been relevant to the study itself but did change the rhythm of the interview. For example, situations such as (Phone rang), (Coughing) or (People knocking on the door). The two master's students transcribed the material from the focus group interviews under my supervision and additional checks to see that the audio recordings and the transcribed

material matched. The transcribed interviews were entered into the NVivo software package as a tool to aid in further analysis.

The data generated from the methods were given different roles in the articles. In articles 1 and 2, the data came from interviews with policy makers and outreach social workers and are presented in parallel. In article 3, the focus groups are given substantially more weight to reinforce that article's focus on the voices of the youths, while the interviews with the employees of the outreach service are presented to support the findings from the focus groups. The transcribed interviews were analysed in three rounds, one for each of the three different articles. The frameworks that guided the analysis differed for the different research questions and data. The subsections below provide a description of the two main frameworks that inspired the analysis.

5.4.1 Thematic framework analysis

The method of thematic analysis was developed in connections with applied policy research in the 1980s and has since gained popularity among qualitative researchers (Ritchie & Lewis, 2003). The method is associated with having concepts developed before the analysis starts, inspired by either a theoretical framework or research questions. The next steps of analysis include familiarization with the data, identifying a thematic framework, indexing, charting, mapping, and interpretation (Ritchie & Lewis, 2003). Following this framework, the data have a hierarchal structure that has developed transparently, which allows the analyst to move between different levels without losing sight of data. This framework was useful in both articles 1 and 2, where the roles of the participants were used as a level in the analysis. Each participant was marked with key attributes, such as position and departmental connection, that were compared and contrasted with the other participants. Throughout the process, there was constant movement between an inductive and a deductive approach by *letting the data talk* and attempting to analyse the data through different theoretical lenses. During this process, I continually discovered new codes, revised existing codes, and organized themes. Especially during the analysis for the first article, I tried different ways of analysing the data, such as different conceptualizations for drug prevention and including a document analysis that did not elevate the material. However, when I

utilized Axelsson and Axelsson's (2006) conceptual framework of integration and the position of the participant to guide the analysis, I saw a new dimension emerging from the data. In the second article, I followed the framework analysis by including Lipsky's (2010) theoretical underpinnings of the analysis of the different positions held by policymakers and the outreach social workers as street-level bureaucrats. Although making sense of the data relies on the method or tool used when analysing the data, Ritchie and Lewis (2003) highlight the role of the analyst and the degree of rigour, clarity and creativity associated with the study. Throughout the analysis, I discussed potential themes and theoretical frameworks with my supervisors.

5.4.2 Thematic Network analysis

In the third article, the data from the focus group interviews and some of the individual interviews from the outreach social workers were analysed under the thematic network analysis approach (Attride-Stirling, 2001). The purpose of the thematic network analysis is to reveal prominent themes on different levels by illuminating the structures through three different levels: basic theme, organizing theme and global theme (Attride-Stirling, 2001). While the thematic framework analysis provided a structured format for considering the roles of the participants, the thematic network analysis provided a structure that enabled a closer investigation of the relationship between the different themes on an even foundation. This aligned with the idea of letting the youths' voice come through clearly in the analysis. The data from the outreach social worker interviews were used to provide more depth to the topics discussed by the youths.

5.5 Methodological considerations about quality

All researchers strive to demonstrate the credibility of their studies. However, there are many different and conflicting ways of describing validity in qualitative research. Creswell and Miller (2000) suggest moving beyond describing the specific procedures taken to demonstrate a study's validity and instead acknowledge the lenses employed in a study and the epistemological assumptions at the base of the research (Creswell & Miller, 2000). This section describes the measures taken to ensure the validity of the

study from the viewpoint of both the researcher and people external to the study by referring to the epistemological assumptions of this project.

According to Creswell and Miller (2000), providing thick and rich descriptions aids in demonstrating credibility through the lens of people external to the study. Thick descriptions help provide context to demonstrate the contextualization of the participants and provide as many details as possible. This is in line with the holistic characteristic of case studies, according to Stake (1995), where attention is paid to the interrelationship between the phenomenon studied and the content. Therefore, considerable space in the articles, the introduction and the methods chapter of the overall theses is devoted to the context of the case (section 1.3 and 5.2). These rich descriptions invite the reader to make decisions about the applicability to other contexts and to follow the analysis.

To demonstrate validity through the lens of a researcher and the discretion of the individual researcher's decision about the data in a constructivist paradigm, it is important to search for alternative perspectives when regarding the data, which is referred to as disconfirming evidence (Crewell & Miller, 2000). The expressed goal is not to debunk the initial finding but rather to illuminate the different realities present in the data. This harmonizes with Stake's (1995) description of the emphatic characteristic of a case study, where the goal is to reflect the vicarious experiences of the participants. Throughout the research process – and especially when analysing data – I have sought out divergent views to challenge assumptions. Diverging views can illuminate and provide new ways of understanding the original themes (Bazeley, 2009). For example, in the reporting on the focus groups, one participant diverged from the rest of the group by stating that she had a positive relationship with her psychologist, which contrasted with the group's reflections of a more problematic deficit focus on the part of the psychologists expressed by the rest of the group (Oldeide, Holsen, & Fosse, 2020)

Following the case study design proposed by Stake (1995), research described as a researcher-subject interaction falls within the constructivist paradigm (Stake, 1995).

Therefore, it is also important to discuss how my role as a researcher interacts with the participants of the study, which is known as the reflexivity of the researcher. Reflexivity is often narrowly viewed as analytical attention to the researcher's role in qualitative research (Dowling, 2006). However, Dowling (2006) explains that reflexivity operates on multiple levels (Etherington, 2004) and acknowledges that the researcher is involved in both the process and the product (Horsburgh, 2003). In this section, the focus is primarily on my interaction with the participants, although these characteristics also influence the design, analysis, writing up and all other parts of the research project, in line with the constructivist underpinnings that guide it.

At-risk youths are a marginalized group for which research has predominantly and importantly focused on the problematic aspects of youth life (Follesø, 2015). One of the underlying principles of the health promotion perspective is to appreciate the strengths and resources each individual holds (WHO, 1986). These underlying principles are manifested in the development of the project, in the topic guide questions and in my interaction with the youths. The goal was to have the youths describe and provide insight into their positive experiences. Therefore, when asking questions and in my interaction with the youths, I was always careful not to focus on their suffering or any problems the youths experienced while still keeping the door open if a youth wanted to share such experiences. When interacting with the youths, I grew aware that in their eyes I was an adult woman without a story similar to theirs. To them, I might be considered somewhat of a "square" or at least as conservative. For example, all the youths described using drugs as a negative experience. By sharing a similar upbringing or history as these youths, I might have been privy to more intimate stories and they might have shared more positive aspects of illicit drug use. Thus, my positionality limited their stories to the normatively *correct* descriptions of drugs as *being bad*.

The interviews with the policy makers can be characterized as expert interviews because those individuals have expert roles in the social setting being investigated, by, for example, working for years in policy development for the municipal organization (Gläser & Laudel, 2009). The expert positions held by the participants led me to have

a somewhat subservient role in our interactions, during which all the participants appeared eager to inform and educate me about the inner workings of the municipality. This was a generous position in which to operate as a researcher. On the other hand, if I were an insider with experience in municipal organizations, I would perhaps be given access to more details and would also have earned more trust when it came to sensitive topics about the municipality's inner workings. My contact with the outreach service can also be described as a type of expert interview; the participants were eager for me to understand the details of social work, the outreach service, and at-risk youths. Although I would have probably obtained richer and more detailed information as an insider, the external role may also have given them the chance to view their daily activities with an external gaze when interacting with me. Several participants ended the interviews saying something like the following: "I was a bit anxious about talking about drug prevention because it's not my main field, but after talking to you about it, I see that a lot of what I do is precisely that".

5.6 Ethical considerations

Anyone conducting research is sure to encounter ethical dilemmas, and there is a need to reflect on one's personal ethical attitudes and come to a well-founded decision between conflicting interests (The National Committee for Research Ethics in the Social Sciences and the Humanities [NESH], 2016). Below, I highlight two main discussions with implications for the study. The first ethical consideration is related to the conceptualization of at-risk youth, while the second was the decision to name the case at the centre of the study and forgo the traditional ethical modus operandi of case anonymity.

5.6.1 At-risk concept

According to NESH's own section on vulnerable groups, "Individuals in a vulnerable group might not want to participate in the research because they fear the group as a whole might be portrayed in a bad light" (NESH, 2016, p. 24). The youths participating in this study might not want to be associated with the notion of *at-risk youths*, as the term is larded with negative connotations and, on a group level, can lead

to increased *othering* and stigmatization of the group. On the other hand, some youths may appreciate the chance to speak out about their situation. This reflects the balance needed to not portray vulnerable groups in a bad light and respond to society's legitimate interest in mapping the living conditions for these groups (Tangen, 2010). Even though the consequences of being associated with at-risk behaviours are not created by research, the present study actualizes some of the difficult aspects of a youth's life (Ulvik, 2005). While using a stigmatizing concept such as *at-risk youth* is associated with some negative outcomes, other concepts may fail to describe the seriousness of the youths' situations. Concepts such as "youth with complex needs" (Almqvist & Lassinantti, 2018), "young person not in employment, education or training (NEET)" (Lögdberg et al., 2018), "youth in flight" (Follesø, 2015) and many more aim to capture the group of youths who fall into the category of at-risk youth. While these concepts also come with their own set of consequences, I believe that using the term *at-risk youth* best captures the vulnerabilities on a group level, which is in line with the prevention logic of Gordon (1983). It should be noted that references to at-risk youth apply only at the group level. Throughout this project, I was careful not to portray the youths negatively and, although the at-risk concept is used, it is always done in an attempt to increase our understanding and focus on the positive dimensions, such as the inclusion of concepts like agency and empowerment. While acknowledging the values built into the concept of at-risk youth, I hope this study – by focusing on the resources that these youth have – can expand the understanding of "at risk", moving from a deficit focus to a broader understanding of the concept.

5.6.2 Naming the case and anonymity

The study has an interdisciplinary approach which draws on methods and theories from health promotion, political science, organization theory, sociology, and other fields; each has its own epistemological foundations. During the project period, some of the tensions between the different disciplines appeared more clearly than others. Naming the case was one such tension. Anonymity is a key ethical principle and a necessity when researching sensitive topics. In a sociological approach, for example, it is typical with nameless case studies to make wider generalizations (Nespor, 2000). However, this conflicted with several of my convictions and illustrated my *walking the*

tightrope between doing what felt right and what was expected under professional ethical codes and by the academic profession (Van Den Hoonaard, 2003). A key reservation I had about not naming the municipality was the possibility of not being able to disseminate the findings with a rich contextual description. The project was designed to ground the organizations in their historical, geographical, and cultural context (Tilley & Woodthorpe, 2011). Naming the municipality and referring to unique and common traits of the case may enable other municipalities to compare and contrast their situations with the one in Bergen. Ensuring anonymity would thus have been counterproductive, as the contextual dimensions were essential for the analysis.

As I chose to identify the municipality, it was important that all the participants were aware of that decision and understood its implications. Therefore, before each interview, I went through the informed consent, which stated that the municipality was identified but that individual participants would not be readily identifiable. The participants on the policy level in the outreach service were instructed that every attempt would be made to ensure confidentiality. The participants were advised through informed consent that they could, in theory, be indirectly identifiable, while the youths participating in the study would be treated anonymously, which meant removing or obscuring the names of participants and omitting information that might lead to participant's being identified (Walford, 2005). The participants at the policy level and outreach service are in theory identifiable since it is possible to identify members of the administration and leadership within the municipality in the time period of the study. I therefore took steps to ensure confidentiality. There are no direct quotes connected to a single participant; rather, each quote is connected to the position the person held in the municipal administration. I ensured that there were three people from the same position category, meaning that each quote could have come from any one of three individuals. In other words, while an individual quote cannot be connected to only one person, it remains in theory possible to identify the participants. This was made clear to the participants. It should also be noted that the overall theme of the study is not traditionally known as a sensitive topic, and being frank with the participants about naming the municipality made it possible to keep the analysis at a certain overall level. If I could have guaranteed anonymity in every regard, the

findings might have included more tensions and conflicts. This was, however, not a key research area within the scope of the study. Tilley and Woodthorpe (2011) argue that the core principles of anonymity may not be consistent with the aims and scope of all qualitative research, particularly with regard to the need to disseminate. In the present study, the need to ensure rich contextual data and promote knowledge transfer was among the motives for naming the municipality and may well add to the ongoing debate of revising the concept of anonymity as an overarching guiding standard of social research.

6. Findings

6.1 Article 1

Oldeide, O., Fosse, E., & Holsen, I. (2019).

Collaboration for drug prevention: Is it possible in a "siloed" governmental structure?

The International Journal of Health Planning and Management, 34(4): e1556-e1568.

The research question for this article is, "How do policymakers in a Norwegian municipality describe horizontal and vertical integration with regard to drug prevention aimed at youth?" The article provides insights into the structures of integration in a local government regarding drug prevention aimed at youths from the perspective of policy makers and advisers in the relevant municipal departments. The article contributes to the ongoing debate about collaboration and integration in the face of complex public health challenges.

The findings show that collaboration between the relevant departments was viewed as important to successfully address drug prevention. The policy makers describe difficulties with integration in terms of confusion regarding the ownership of drug prevention among the different departments and the perceived lack of a mandate for collaboration among lower-level actors. Following the conceptual scheme of different forms of integration developed by Axelsson and Axelsson (2006), the article discusses both how higher-level actors may promote horizontal integration among lower-level actors and the important role that those lower-level actors play in a welfare bureaucracy.

The article demonstrates that the municipal organization is characterized as siloed and highlights key challenges related to both the horizontal and vertical structures. The article concludes that integration of drug prevention in a siloed structure requires the departments to appreciate their respective roles in drug prevention and room in the vertical structure to collaborate across the policy areas.

6.2 Article 2

Oldeide, O., Fosse, E., & Holsen, I. (2020).

Local drug prevention strategies through the eyes of policy makers and outreach social workers.

Health & Social Care in the Community.

The article is a further investigation of the structures for drug prevention aimed at youths within a municipality and combines the perspectives of social workers in a municipal outreach service and municipal policy makers from the relevant policy areas. The research question of the study is twofold: "1. How do policy makers and outreach social workers describe drug prevention strategies? 2. How are outreach social workers able to turn policies into action?" By combining the perspectives of both the vertical line from policy makers to practitioners and the horizontal structure of collaboration between the different policy areas, the article provides a fuller picture of the governance structures in place for drug prevention aimed at youths.

The findings reveal a drug prevention strategy which has a health-promoting perspective, as the universal strategies are described as creating good living conditions and promoting protective factors around the youths. In line with this perspective, the findings show the need for collaboration across relevant policy sectors to promote health and prevent illicit drug use. However, they also reveal that the implementation of policies is hindered by a siloed organization. The outreach service, here representing the vertical structure of the municipal organization, report that they are able to create collaborations with other essential service providers across policy areas. This serves to illustrate the role of bottom-up processes from a governance perspective. The article follows the rationale proposed by Lipsky (2010), which highlights the important role street-level bureaucrats play in implementing policies. The findings reveal that the structural determinants surrounding the outreach service are crucial in the implementation of the drug prevention strategy. The key structural determinants discussed in the article are resource orientation adopted by the outreach service, which motivates them to seek collaborations with other stakeholders in combination with their flexible role in the organization.

The findings suggest that, while the structures of drug prevention implementation are siloed, the outreach service workers can navigate these structures due to distinct structural determinants and play an important role as implementers of the drug prevention policy.

6.3 Article 3

Oldeide, O., Holsen, I., & Fosse, E. (2020).

Youth perspective on outreach service: A safety net for at-risk youth in a municipality.

Children and Youth Services Review, 116: 105234.

In this article, we explore the relationship of at-risk youths and the outreach service by asking how youths experience the role of the outreach service in comparison with other municipal services. The aim is to give a voice to the youths as recipients of the municipalities' drug prevention policies and provide insight into how the municipality's drug prevention strategy is applied. The article builds on focus group interviews with the youths and is supported by individual interviews with outreach social workers. The twofold research question is, "What characterizes the relationship between at-risk youths and the outreach service? How do at-risk youths experience the role of the outreach service in comparison with other municipal services?"

The youths describe the outreach service as trustworthy and as having a resource-oriented approach, which was contrasted to the deficit orientation of the other services on which these same youths rely. The resource-oriented approach was discussed in relation to the growing literature embracing the effects of empowerment-oriented practices targeted at at-risk youths. The findings in the article suggest that the youths experience services as fragmented, leaving them without the services they need. The outreach service is consequently understood by the youths as a service which both understands the kind of assistance they require and agents who can help the youths navigate the bureaucratic system. This analysis leads to a discussion of viewing the outreach service as a safety net for youths who otherwise fall between the cracks of the system. This discussion serves to highlight both the fragmented drug prevention

strategy in the municipality with youths not receiving the services they need and the opportunities of actors such as the outreach service to counter those negative aspects.

6.4 Synthesizing the findings

Together, the three articles present the three focal points of the case, illustrating the local policy process from policy makers to service providers and, finally the user group to give insights into how drug prevention strategies are implemented in Bergen municipality. The first article centres on policy makers at the top of the municipal structure and reveals that collaboration between the relevant policy areas is crucial for drug prevention, but that the organization is described as siloed and with limited integration. The first article uses the conceptual scheme of integration offered by Axelsson and Axelsson (2006) to analyse the findings, which reveal that integration is limited both by the lack of a mandate for collaboration from the top of the municipality but also by the important role that lower-level actors play in the municipal organization. The second article further explores the role of those lower-level actors, using Lipsky's (2010) theories and the role street-level bureaucrats play in policy implementation. The article combines the perspectives of the policy makers with the outreach social workers to provide insights into how drug prevention policies are understood and implemented from the top of the organization to the service providers who actually carry out the interactions with at-risk youths. Following the focal points of the local policy process, the articles reveal that drug prevention strategies are apparently consistent at all the levels of the policy chain, revealing an initiative based on health-promoting perspectives. The drug prevention policies described are in line with the healthy public policies and HiAP approach, where the goal is to create good living conditions and promote protective factors around the youths. In line with this perspective, integration between the policy areas is an essential part of these policies. While the organization is mostly described as siloed, the article identifies some features that counter this fragmentation. The findings demonstrate that the outreach service plays a vital facilitating role in the implementation of the drug prevention policies, which shows how important service

providers are in the vertical line of governance. The outreach service's resource-oriented philosophy and its flexible role in the municipality are discussed as the key structural determinants that make them a safety net in the face of broader service fragmentation. The third article is written largely from the perspectives of the youths as recipients of the overall drug prevention strategy. Their views are combined with those of outreach service workers, providing insight into the mechanisms of integration in a municipal organization as experienced on the ground. The youths' description of difficulties in navigating the bureaucratic system coincides with a description of fragmented services in the municipality and limited collaboration regarding at-risk youths. The youths point to the role of the outreach service as aiding them in navigating the system, reinforcing its status as a safety net in the wider municipal organization. The youths emphasize that the outreach service's resource-oriented approach stands in contrast to other services' deficit-oriented focus, which is discussed using the empowerment concept. These findings illustrate the special role the outreach service plays in the lives of the youths and as policy implementers. Taken together, the findings from the three articles reveal the dynamic and complex structures which characterise the local drug prevention policy from policy to practitioners to target group.

7. Discussion

The overall research question of this thesis is, "How are local drug prevention strategies implemented in Bergen municipality through the eyes of local policy makers, outreach social workers and at-risk youths". The findings presented in this thesis reflect the fact that local drug prevention strategies have a broad approach and a health-promoting orientation. They are therefore in line with the HiAP approach and healthy public policies that call for integration between policy sectors to create good living conditions. However, there are discrepancies between the intended policies and the structures for their implementation. Inspired by Axelsson and Axelsson's (2006) conceptual scheme of integration, I use the horizontal and vertical constructs of the conceptual scheme to highlight the structures of the municipal government and discuss the key findings of the thesis. As to horizontal structure, the findings reveal a lack of ownership for drug prevention and the absence of a mandate to collaborate across policy sectors. In the vertical structure, the findings demonstrate that the outreach service counters this fragmentation thanks to key structural determinants that enable it to play the role of safety net against this fragmentation. The youths' perspective furthers the bottom-up perspective on the implementation of drug prevention strategies, revealing fragmented services and the importance of an empowerment-oriented approach from the outreach service. In this chapter, I first discuss the key characteristics of local drug prevention policies and then address how the strategy is implemented in the context of the horizontal and vertical structures of the municipal organization. Finally, I turn to the youths' perspective as recipients of the overarching drug prevention policy.

7.1 Local drug prevention strategies aimed at youths

The drug prevention strategies described by the participants in different positions in the municipality all convey the health-promoting dimension of its drug prevention efforts. The policy makers describe the main strategy as creating supportive environments through universal efforts, while the outreach social workers describe promoting protective factors around the youths. These findings align with the key

strategy in health promotion of creating supportive environments and healthy public policies (WHO, 1986). These findings support the notion that health-promoting principles have firmly taken root in the local government's policy development processes (Hagen, 2020; Synnevåg, 2019; Weiss et al., 2016). The literature indicates that, although the principles from health promotion are embedded in policy development, there appears to be a gap between what is preached and what is practiced. A study by Andréasson et al. (2007) found that moving towards broad prevention efforts was popular among local policy makers, but that there were challenges with practical implementation, such as the need to document success and competition with treatment alternatives for limited resources. In a related study on social inequities in health, Hagen and colleagues (2016) found that less than half of Norwegian municipalities had clear policies addressing the social determinants of health. The municipalities which were able to address those determinants reported making use of intersectoral collaborative working groups and had employed public health coordinators to facilitate the collaboration (Hagen, 2020). The existing literature and the findings from the present study suggest that the ability to create supporting structures for drug prevention in a municipality plays a key role in the success of the implementation of policies. The collaboration between policy sectors has proven especially important when implementing policies of a boundary-spanning nature, such as health promotion and drug prevention. The discussion below highlights some of the key conditions following both the horizontal and the vertical structures of the municipality.

7.2 Collaboration between different policy areas for drug prevention: The role of the horizontal structure

The findings in this thesis highlight that there are siloed structures within Bergen municipality creating difficulties for the collaboration between different sectors needed to achieve integration for drug prevention (Oldeide et al., 2019). A key hindrance to integration was identified as the diverging perceptions of ownership from key policy areas. Achieving unified action requires a common awareness of the root causes of illicit drug use and for each department to take responsibility for its

contribution (Oldeide et al., 2019). However, this is not as straightforward as it might appear. Synnevåg et al. (2018b) identified several challenges involved in planning intersectoral policies, such as the HiAP approach, for public health. A central challenge is the difficult task policy makers face in balancing different approaches to planning for intersectoral policies. The policy makers in Synnevåg et al. (2018b) study struggled between promoting quantitative expert knowledge and structures which rely on instrumentally defined targets on the one hand and relying on promoting qualitative, experience-based knowledge through collaborative development processes on the other. The HiAP approach can therefore be said to require both a more governed instrumental planning approach and a more communicative planning approach, which opens the door for more locally adapted solutions. These conflicting processes speak to the underlying steering mechanism of the municipality, which supported the more instrumental policy implementation (Synnevåg et al., 2018b). This reflects a conflict between the needs from a policy standpoint and a modus operandi that fits the structures within the municipality. As Synnevåg and colleagues (2018b) argue, it is particularly difficult to strike a balance between these approaches as the municipalities operate in organizations which favour instrumentally defined governmental strategies.

One way to navigate around the obstacles associated with intersectoral policies has been to make public health structures and processes into a distinct area of attention, and another is to include public health into already existing structures. The latter approach involves emphasizing that addressing the social determinants of health is something the different policy sectors do anyway and to refrain from a direct reference to health (Synnevåg et al., 2018a). However, as Holt et al. (2016) showed, this strategy may lead to policies directed at behavioural change rather than root causes and consequently fail to address the social determinants of health (Synnevåg et al., 2018a). Framing intersectoral collaboration has been a central point of debate in the public health field. Should collaborations across sectors be oriented towards health, or does that cause a lack of ownership for other policy areas? Some have warned that engaging in intersectoral collaboration with health as a starting point may be an example of health imperialism and thus lead to resistance among non-health workers (Holt, 2016;

Synnevåg et al., 2018a). Other concepts such as *social sustainability* or *living conditions* have been suggested for use as common terminology for intersectoral collaborations (Hofstad & Bergsli, 2017; Holt, 2018; Scheele et al., 2018; Synnevåg et al., 2018a). The findings from the present thesis regarding the lack of ownership for drug prevention from the policy makers suggests that even a terminology such as drug prevention, which on the surface is not directly connected to health, did not encourage policy makers from different sectors to take ownership. The findings, therefore, suggest that as long as the various policy sectors do not recognize their ownership and responsibility for the root causes of illicit drug use, those sectors will not engage in policy changes to address them. The answer to creating better intersectoral collaboration is therefore not necessarily to change the terminology but to engage in processes where using the social determinants of health can lead to a reflection of each sector's particular contribution to both the problem and the solution. In fact, this process is outlined in the Public Health Act (Ministry of Health and Care Services, 2011) but remains apparently – and stubbornly – difficult to implement.

According to Hagen (2020), the best strategy for modern public health work in municipalities is to use a *governed* and *open* HiAP strategy. This approach includes both a clear mandate for public health and freedom and autonomy to solve the tasks in a suitable fashion. Hagen's conclusion highlights the role of both the horizontal and vertical structures found in municipal administrations. Across the different policy sectors in the horizontal structure, there is a need for each sector to recognize its contribution to drug prevention and demonstrate stewardship so that the various lower-level agents in the vertical structure all contribute to the overall goal. Previous research has also demonstrated the need to break down the social determinants of health and communicate information to the operational level of the municipality (Carey & Crammond, 2015a; Synnevåg et al., 2018b). However, Synnevåg and colleagues (2018b) have pointed out that there are different understandings of public health actions at the executive and operational levels of the organization, which hinders this process. For example, the leadership in their study was thought to have a more theoretical and subordinate understanding of public health work (Synnevåg et al., 2018b). The role of leadership has proven to be important in the implementation of

public health strategies by demonstrating good communication skills, being knowledgeable and employing a democratic leadership style (Larsen et al., 2014; Weiss et al., 2016). Andréasson et al. (2007) showed that leadership commitment varied as to drug prevention in Swedish municipalities. Similarly, the experiences of the advisers in Bergen suggest a lack of commitment from the municipal leadership, since they experience the absence of a mandate to collaborate across sectors for drug prevention. This suggests that local leadership and the ability to communicate the social determinants for health in a suitable way for the operational level are standing in the way of implementing drug prevention policies in particular and public health policies in general. Facilitating more cross-sectoral meeting spaces and reorienting the institutional structures to value more successful collaborations across sectors have been suggested as possible solutions (Oldeide et al., 2019; Synnevåg et al., 2018b).

Another proposed solution to increase cross-sectoral collaborations has been the emergence of coordinating, boundary-spanning roles in the municipality, such as public health coordinators and prevention coordinators. The policy makers in the present case suggested the prevention coordinators as a resource who could aid in managing the siloed structure in the municipality, but they are limited, among other reasons, by their comparatively *low* placement in the municipal hierarchy. While the importance of placing a coordinating position high in the municipal hierarchy has been argued for and discussed both in article 1 and in the literature on public health coordinators, it is important not to solely focus on the hierarchical placement of coordinators. Hagen's (2018) research on public health coordinators found no significant correlations between municipalities having employed a public health coordinator and policies addressing the social determinants of health. This suggests that simply employing a coordinator and placing them *high* in the municipal hierarchy does not in itself serve as a structural fix for the limited collaboration between policy areas. Rather, recent research has emphasized the need for coordinating roles to manage borders instead of trying to break them down (Vik & Aarseth, 2019). Hagen also notes that coordinators may risk becoming the *owners* of the public health work and contribute to policy sectors' reluctance to address the determinants of health and join in the integration of policies. This concern reinforces the point that coordinators

should not be considered an easy fix for the complex collaboration tasks that are inherent in boundary-spanning policy areas. Rather, such coordinators need to have boundary-spanning skills such as strong problem-solving abilities, network leadership, mediation skills and deep knowledge of the system (Carey & Crammond, 2015b; Hagen, 2020; Holt et al., 2018) and continually encourage each policy field to recognize its contribution to drug prevention. While the role of leadership and *governing* is important for local public health work, Hagen (2020) also notes the need for freedom and autonomy to solve the tasks in a suitable fashion. This thesis has identified the role of the vertical structure in the municipal organization as crucial to achieving that outcome.

7.3 The role of the vertical structure in drug prevention

In the present study, "vertical structure" involves the people within the municipality operating in direct contact with the service users. In the literature, they can be referred to as service providers, street-level bureaucrats, front-line workers, or professionals (Lipsky, 2010). Within the context of the municipal organization, the role of the professionals has been described as both important actors and implementers of policy and as a management problem (Ramsdal et al., 2002). Ramsdal et al. (2002) report that professionals' role in the municipality has evolved from a formerly tight-knit relationship between welfare reforms and development within the professions to being viewed as an administrative obstacle and a threat to municipal local self-government (Kleven et al., 2000; Ramsdal et al., 2002). Historically, there have been several ways to address the role of professionals in the municipal organization. In a study evaluating the different municipal organizational forms which emerged after Norway passed the Local Government Act (Ministry of Local Government and Regional Development, 1992), researchers reported that the role of collaboration between policy sectors varied with different organizational forms (Michelsen et al., 2002). The particular approach to organizing a municipality does not appear to have a significant impact on the professionals' performance; rather, it appears to promote sharper demarcations and division between the professionals within one sector and the rest of the municipality

(Michelsen et al., 2002). This finding adds to the literature suggesting that reforms seeking to break down professional boundaries often end up unwittingly promoting the opposite outcome; namely, more rigid borders between professionals (Michelsen et al., 2002). This highlights the somewhat contradictory situation of the municipality that needs intersectoral collaboration to deal with increasingly complex challenges and the inability for professionals to create such collaborations within municipal structures.

The descriptions from the youths and policy makers in this thesis suggest that the municipal organization is characterized by both a siloed organization and fragmented services that employ "sectorized" language and cause difficulties in navigating between the municipality's organizational boundaries of (Oldeide et al., 2019; Oldeide, Holsen, & Fosse, 2020). The outreach social workers, however, are described as able to cross organizational boundaries on behalf of the youths (Oldeide, Fosse, & Holsen, 2020). The outreach service thus acts as a safety net inside the municipal organization and helps compensate for the fragmentation that besets the various professions (Oldeide, Holsen, & Fosse, 2020). This thesis has highlighted structural conditions which promote this flexible role in the municipality, such as the outreach service's broad mandate and the resource-oriented perspective adopted by outreach workers. The outreach service, therefore, may be said to represent a contrast not only to the rest of Bergen's municipal organization but also to the increasingly fragmented services of public services in general (Christensen & Lægreid, 2011; Eriksson et al., 2019). The outreach service appears to be proficient in its implementation of the overall drug prevention strategy in that it understands and has internalized its ability to contribute to the drug prevention effort. The outreach service's implementation of the drug prevention strategy is characterized by deploying a resource orientation to the selected and indicated strategies aimed at the youths with whom they interact. These findings are supported by statements the youths, who describe both an organization with a resource orientation and one that is able to help them navigate the obstacles they face in obtaining the other services they need (Oldeide, Holsen, & Fosse, 2020).

The unique role of the outreach service can be viewed as a distinct system within the municipal services; it operates with a freer mandate and boasts other key

organizational qualities. The outreach service is thus separate from other municipal services such as schools or school health nurses, which are more restricted on the organizational level. This distinct role as a safety net for fragmented services may in one regard be understood as a benefit, especially for the youths who experience the outreach service as aiding them in obtaining the services they need (Oldeide, Holsen, & Fosse, 2020). However, another way of conceptualizing the role of safety net in the fact of fragmented services is that the outreach service actually perpetuates the fragmentation of the municipality. By operating as a system within the system, the outreach service may act as a quick fix instead of addressing the fundamental, intrinsic shortcomings that afflict the rest of the municipal system. As article 1 shows, the policy makers describe the municipal organization as siloed regarding collaboration for drug prevention. This finding is also supported by the youths' description of fragmented services. As discussed previously, the lack of ownership for the root causes of illicit drug use and the absence of a mandate to collaborate across structural siloes appear to hinder the drug prevention strategy's implementation in the vertical structure of the municipality. Consequently, having actors such as the outreach service "save the day" may impede each sector from taking responsibility for its contribution to the structures of drug use and drug prevention, leaving the outreach service to end up as the *owners* of drug prevention. Due to the role of the outreach service as a prevention service primarily targeting at-risk youths through selected and indicated drug prevention strategies, it cannot contribute effectively to addressing the broader social determinants of health and the universal efforts needed to reorient the municipality towards health promoting drug prevention. Instead, one consequence may be having the general problems increase and consequently impact the at-risk youths in need of the outreach service assistance. The present thesis demonstrates that the vertical structure can play a significant role in policy implementation through its ability to adapt the overall policies to municipal structures and to devise measures suitable for the needs of the target group with whom they interact. The discussion in the next section highlights the role of the youths as receivers of the drug prevention strategy.

7.4 Youth perspective on drug prevention

In the present thesis, the youths' perspective has contributed a valuable insight into how drug prevention strategies are implemented, providing detailed knowledge into the strategies which are important for and to the youths they are designed to serve. As the discussion above shows, the outreach service may be described as a successful implementer of health-promoting drug prevention in the municipality. Following the rationale of theorists such as Lipsky (2010), certain structural conditions surrounding the outreach social workers enable this role (Oldeide, Fosse, & Holsen, 2020). In this thesis, the outreach service's role has been contrasted to other services in the municipality, which the youth experience as fragmented (Oldeide, Holsen, & Fosse, 2020). The policy makers also describe a siloed municipal organization with limited integration for drug prevention (Oldeide et al., 2019). Kaehne (2017) has criticized integration initiatives for focusing more on interprofessional collaboration and consequently losing sight of what the collaboration should be focused on; namely, the people the services are intended to assist. The findings from the present study suggest that the outreach service is able to keep the collaborations they initiate oriented towards the needs of the youths. This is supported by findings from both the youths and the outreach service itself, whose employees describe their efforts to navigate the different services on behalf of the youths (Oldeide, Holsen, & Fosse, 2020). Following Kaehne (2017) in making collaboration oriented towards the target group(s), the findings suggest that the collaboration initiated by the outreach service with other service providers is experienced as meaningful. At the very least, this is demonstrated clearly from the youths' experiences, in that they obtain access to the services they require. Similarly, the outreach service's ability to initiate collaborations with other service providers may also lie in its ability to define its target group. Research has demonstrated that defining the target group is one of the most important factors in successful intersectoral collaborations (Ramsdal, 2019). This was most recently supported in another study which combined the perspectives of service users and different professionals working with mental health; the researchers found that agreement on treatment goals and the identification of each stakeholder's contribution

were the most important ingredients to a successful collaboration (Biringer et al., 2020). It is important to note that the ideal of shared goals in collaborations is not without its critics. Vangen and Huxham (2009) express concern that such an agreement could be paradoxical due to the backgrounds of the different stakeholders involved, but the authors still insist that it is necessary to continue striving to achieve a common agreement about goals (Lindeman & Lorås, 2018). The outreach service appears to be successful in its implementation of drug prevention policies at least partly because of its ability to place the needs of the youths at the centre of its services and its ability to craft collaborations. These assumptions are based on data from the outreach service and the youths. To further understand how the collaboration surrounding at-risk youths operates, it would be valuable to include other professionals to gain additional perspectives from outside the outreach service.

The findings presented in this thesis support the growing literature that supports the use of empowering practices when interacting with youths (Oldeide, Holsen, & Fosse, 2020). While the role of empowerment is undoubtedly important in the literature on at-risk youths, including this thesis, the empowerment concept appears to be oriented towards the individual empowerment of the youths. A central point of contention in health promotion is the interface between structure and agency, which follows the ideological lines of collectivism and individualism (Woodall & Freeman, 2020). Although a wide range of ideological views are represented in health promotion, individual agency has been at the centre of most strategies (Kelly & Charlton, 1995; Nettleton & Bunton, 1995). Woodall (2016) argues that health promotion is affected by a "lifestyle-drift", which is a tendency for policies to reflect the need to act on the social determinants of health but end up drifting downstream to focus on individual lifestyle factors and consequently remain difficult to solve (Popay et al., 2010; Woodall, 2016). While there is nothing inherently good or bad about the different approaches from collectivistic or individualistic positions, the problem becomes apparent when there is a fixation on one over the other (Breslow, 1999; Minkler, 1999; Woodall & Freeman, 2020). With the growing literature on individual empowering strategies to support at-risk youths, there are also reasons to be cautious about strategies that keep solely to the individualistic level and thus do not address the larger

structures. A one-sided focus on promoting individual empowerment among youths, without any attention to the surrounding structures, may lead to the frustrating situation of disempowering the youths. This thesis, therefore, urges directing attention to the broader structures surrounding the youths, which requires each policy sector to reflect on its contribution to both the problems and solutions surrounding illicit drug use among youths. For example, including families, schools and neighbourhoods in community-empowering initiatives could lead to positive outcomes.

This thesis builds on developments within health promotion and public health that orient the focus towards the structures surrounding individuals and therefore draws on theories from the field of public administration. Carey and Friel (2015) point to the common interest of public administration and public health and – although the fields remain largely separate – there is much to gain by viewing them as more closely connected. The thesis has benefitted from combining theories from different disciplines to move the focus from solely on drug prevention policies to include a considerable emphasis on the structures in which these policies are implemented. This has led to a detailed analysis demonstrating that, although Bergen's drug prevention strategies are in line with national policies and understood at the different levels of the municipal hierarchy, there are structures within that organization standing in the way of their successful implementation, such as a siloed organization and a lack of ownership for drug prevention. In addition, through a bottom-up perspective influenced by public administration theorists like Lipsky (2010), this thesis has identified structures that support the implementation of drug prevention policies. Finally, the thesis is inspired by health-promoting theories such as empowerment when describing the youths as recipients of the overall drug prevention strategy. By including the youths' perspective, the thesis provides another dimension to evaluate the implementation of the drug prevention strategy and provide insights into the important relationship between citizens and the services they require. The thesis is offered as a step in the direction of more deeply engaging user groups regarding policy implementation and thus building on the momentum behind the WHO's initiative, "Governance for Health in the 21st Century" (Kickbusch & Gleicher, 2012). That report states that "public policies can no longer just be delivered" (p. x); rather,

successful governance for health also requires the involvement of citizens as users of services. Working more with the public can increase accountability, transparency, and confidence that a policy's intended values are upheld (Kickbusch & Gleicher, 2012).

By involving the youths as a focal point, the present thesis has been enriched in several ways. Most prominently, the youths contributed insights into how the overall drug prevention strategy is implemented in the municipality. Their experiences revealed municipal services which were ultimately fragmented; the youths had to rely on the outreach service to guide them through a complex bureaucracy. The second contribution was their description of the valued resource-oriented perspective they found in the outreach service, in contrast to other services, which were associated with a deficit focus that could limit trust and agency among the youths. These contributions reveal that engagement of users can be viewed as a continuum, "from information provision to empowerment and from consultation to co-production, delegated power and ultimate control of decisions" (Kickbusch & Gleicher, 2012, p. 60). While the present study relies primarily on the youths as recipients of policy, the findings can be used to hold health structures to account and subsequently empower at-risk youths. In the same way that theories from public administration have contributed to the field of health promotion and public health with a focus on the surrounding structures, based on this thesis, I argue that both public administration and health promotion would benefit from including more of the perspectives from policy recipients.

8. Conclusion

The overall aim of the present thesis is devoted to understanding a local drug prevention strategy and how it is implemented through the eyes of policy makers, outreach social workers and at-risk youths. The findings demonstrate that the municipality's drug prevention strategies are based on broad universal efforts that seek to create supportive environments and promote protective resources, a strategy which aligns with the social determinants of health and the health-promoting ideals of The Public Health Act (Ministry of Health and Care Services, 2011). The findings suggest that the municipality has heeded Catford's (2001) advice, who advocates broader-based health promotion approaches aimed at youths to tackle the underlying social determinants of illicit drug use.

In order to have a comprehensive policy approach, there needs to be an alignment between the policies and the structures for their implementation. However, the municipality experiences difficulties in translating its policies into practice. The youths experience fragmented services, while the policy makers describe a lack of ownership for drug prevention and a siloed organization, which appear to block the integration of drug prevention efforts. These findings reveal a lack of understanding or ability to address the social determinants of health within each policy sector. Investigating service providers in the vertical structure of the municipality showed that the local outreach service plays a buffering role vis-à-vis the fragmentation, acting as a safety net for youths who need services that can be difficult to obtain from the municipality. The outreach service represents a unique organization within the municipal administration, with a broad mandate and workers who adopt a resource-oriented perspective. In addition, the outreach service has a clearly defined understanding of the target group, which enables them to keep the collaborations they initiate oriented towards the needs of the youths. The thesis reaffirms the need for each policy area to engage in processes where using the social determinants of health can lead to reflections of its specific contribution to both the problem and solution of illicit drug use. Without a reorientation of policies which includes other policy areas, there is a concern that the outreach service will be left with the responsibility of *owning drug*

prevention and that the strategies will continue to remain at selected and indicated measures, targeting at-risk youths, and not moving upstream to promote health.

The thesis demonstrates the value of investigating the inner structures of a municipality to identify what limits and promotes local policy implementation. In that way, it is a continuation of bottom-up implementation research that explores the views of service providers as policy implementers. In addition, the thesis includes the perspectives of youths as recipients of the overall policy, which demonstrated the need to elevate the role of empowerment of at-risk youths beyond a solely individualistic focus. A further step in empowering the youths could be increasing the role of participation among youths in both implementation research and in policy making.

More than 40 years ago, Worden (1979) argued that drug prevention had to refrain from focusing solely on what he described as *popular prevention* focused on individuals and focus instead on *unpopular prevention* such as policy-oriented initiatives aimed at social, economic, and political structures. While the drug prevention field has evolved to include more environmental structures in understanding illicit drug use, the thesis has highlighted that there is still a long way to go to adequately address those structures in a local context, especially with regard to the interplay of the vertical and horizontal structures in a municipality. This is also visible in the recently proposed Drug Reform, which is scheduled to be considered by the Norwegian Parliament by summer 2021. The reform recommends decriminalization of drugs and possession of criminal substances for one's own use. The reform represents a paradigm shift from the previous punishment-dominated phase of drug policy to drugs being dealt with as a health issue (NOU, 2019). This development suggests that the drug policy field is moving towards a more holistic approach to the problems associated with illicit drug use. While there has been some progress in appreciating the complexities of health behaviours, there are considerable questions left unanswered by this policy shift. While the reform presents ambitious solutions for decriminalization based on the problematic treatment of drug users, during the open hearings some have criticized the reform for not focusing enough on how to prevent youths from developing drug problems in the first place and how to

implement policy changes into the existing structures. The thesis sheds light on the importance of these unanswered questions. By analysing the local drug prevention strategy through a health promotion perspective, it highlights the need for an upstream approach to illicit drug use and to pay particular attention to the local implementation of drug prevention policies. Inspired by the words of Worden (1979), let us not fall for the temptation to rely solely on popular prevention approaches aimed at individuals; rather, we need to keep strengthening the unpopular prevention strategies *and* understand the structures needed to translate them from policy into practice.

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RESEARCH ARTICLE

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Collaboration for drug prevention: Is it possible in a "siloed" governmental structure?

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Summary

Purpose: Norwegian municipalities report that drug misuse is the most important public health challenge. The municipalities play a unique role in drug prevention aimed at youth, since young people rely on several services in their daily lives that are organized by different municipal departments. However, the municipal structure is described as siloed, and the policy areas as differentiated. This situation has led to a need for integration between different policy sectors to prevent drug use and promote health. The following study explores how policymakers describe the structures for integration within local government in practice with regard to drug prevention aimed at youth, contributing to the ongoing debate on collaboration and integration in response to public health challenges.

Methods: A single case study design was used to investigate the accounts of policymakers from different municipal departments in a Norwegian municipality following Axelsson and Axelsson's conceptual scheme of integration.

Findings: Collaboration between departments was viewed as important to successfully address drug prevention; however, the policymakers recognized problems with integration. The participants described confusion regarding ownership between the departments and a perceived lack of a mandate for collaboration.

Conclusions: The findings and discussion illustrate that integration of drug prevention in a siloed structure relies on

departments appreciating their respective roles in drug prevention and advisers experiencing a mandate to manage the siloes that exist in the organization. By gaining a better understanding of the siloed structures, we can provide valuable information needed to navigate them.

KEYWORDS
case study, collaboration, integration, local government, prevention

1 | INTRODUCTION

In recent years, drug prevention directed at youth has increasingly included a health-promoting approach. The goal is not only to prevent and avoid problem behaviours but also to strengthen health and well-being and address the root causes of harmful behaviours. This development has paralleled the recognition of the social determinants of health. For the last 40 years, social factors, such as housing, employment, education, and the urban environment, have evolved into the strongest influences on population health.[1] This evolution coincides with what Carey et al.[2] describe as a new paradigm within public health, characterized by moving away from policies aimed at the individual and towards shaping governmental structures. The recognition of the social determinants of health has led to government policies with the goal of working together across relevant policy sectors to promote health and prevent illness.[2] One of the challenges is that governmental institutions continue to adopt a so-called siloed bureaucratic government structure, where each department is responsible for the policies within its own field, for instance health and education.[3] To effect changes in social factors, governmental strategies, such as the Health in All Policies (HiAP) approach, have been proposed to bridge structural siloes.[2] HiAP is an approach that aims to increase the responsibility of public health at all levels of the policy process and requires high degrees of collaboration within the government, which in turn must be supported by the leadership.[4,5] Norway has been described as a leader in developing health-promoting public policy due to similarities between traditional Nordic concepts of the welfare state and key principles of health promotion.[6] The HiAP approach is one of the founding principles of the Norwegian Public Health Act of 2012, which emphasizes municipalities' role in addressing the broader determinants of health through intersectoral collaboration.[7-9] Norwegian municipalities report that drug misuse is the most important public health challenge.[10] To address complex governance challenges, such as drug prevention aimed at youth, more or better collaboration and coordination between different actors, organizations, and levels is often seen as a key precondition for governments and hence as a way forward.[11] In Norway, the municipalities are responsible for many of the services on which children and youth rely in their daily lives, such as kindergarten, health care, school, school nurses, child welfare, sports, and cultural activities. The municipalities therefore have the opportunity to develop policies that affect primary, secondary, and tertiary prevention efforts directed at youth. In addition, the broad spectrum of services the municipality organizes also provide the opportunity to devise policies that move upstream towards the root causes of problem behaviours. In recent years, there has been increased differentiation among the different policy areas, which has generated a corresponding need for integration.[12] It is seen as necessary for officials in different policy areas to collaborate closely to create good living conditions. In a siloed governmental structure, it may be difficult to develop comprehensive and coordinated policies across the different policy areas addressing drug prevention aimed at youth. The present study was developed based on a case study research project investigating drug prevention policies and initiatives at the local level in Norway. The case selected was the municipality of Bergen, which is the second largest city in Norway. Bergen was known for having one of the largest open drug scenes in Northern Europe, but in 2014,

the municipality initiated a large-scale action plan to address this issue. In the wake of the action plan, the research team wanted to examine how officials in different policy areas within the municipality were preventing young people from becoming future drug users. Regarding drug prevention aimed at youth, there are three main departments that organize these services: the Department of Education and Sports; the Department of Social Services, Housing and Inclusion; and the Department of Health and Care. As outlined in the Norwegian Public Health Act, the municipalities rely on collaboration between different sectors to bridge the siloed bureaucratic government structure. In a siloed structure, it can be difficult for each department to identify how it can impact the root causes of complex health challenges, such as youth drug use. Without a comprehensive understanding of complex health challenges and a collaborative effort to address them, it is likely that the problems will continue to exist. A lack of collaboration may also generate fragmented services for youth. Hendriks and colleagues[13] point out that there are limited studies on how intersectoral collaboration is perceived by those responsible for policy development, namely, the policymakers from different policy sectors within local government.

Within the literature, concepts such as "coordination," "cooperation," and "collaboration" are used interchangeably to describe the need for members from different sectors to work together.[14] Axelsson and Axelsson[15] developed a conceptual scheme of integration to capture the different collaborative forms within organizations working with public health. The scheme was developed in the Nordic context, where public health is organized as part of the government in a hierarchical structure, with decisions flowingly implemented at the lower levels. The term integration refers to "the quality of the state of collaboration that exists among departments that are required to achieve unity of effort by the demands of the environment."[16] The conceptual scheme of integration consists of two main dimensions: vertical and horizontal integration.[15] Vertical integration refers to the different levels within a hierarchical structure, while horizontal integration refers to the structures on the same level within the structure. The scheme has previously demonstrated its relevance in several studies[17-19] and will serve as an analytical tool for the present study to highlight the structures of integration within a siloed structure for drug prevention aimed at youth (Figure 1).

Utilizing the conceptual scheme of different forms of integration, as proposed by Axelsson and Axelsson,[15] this study aims to provide insights about the structures for integration within local government by exploring the following research question: How do policymakers in a Norwegian municipality describe horizontal and vertical integration with regard to drug prevention aimed at youth? By exploring both the vertical and the horizontal structures, we can provide more comprehensive analysis of the structures of integration in a siloed governmental structure. Integration and collaboration are central to addressing public health challenges. The present study aims to contribute to this field by presenting the perceptions of the people at the centre of the policy development for drug prevention aimed at youth.

2 | METHODS

2.1 | Design

Within the literature on drug policy, case studies have previously demonstrated its value as an approach to examine policy processes.[20] Inspired by Yin,[21] a single case study design was used to investigate the accounts of policymakers in one municipality, with the data consisting of interviews. Based on Yin's[21] criteria for case selection, the municipality of Bergen was selected due to some unique traits, which can serve to illustrate particular aspects that are seen as

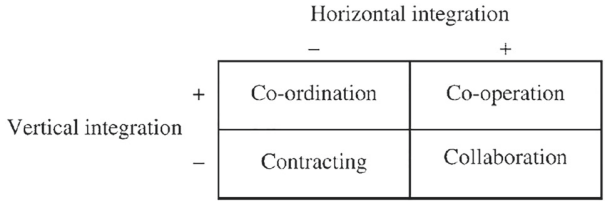

FIGURE 1 Conceptual scheme of different forms of integration[15]

relevant for the analysis. Bergen is one of two municipalities in Norway with a parliamentary governing model. In this model, the city council elects the city government, an executive body, which answers to the city council, just as a national government answers to a national parliament. This model is characterized by majority rule overseen by the top political leadership, and, consequently, the political leadership becomes more visible.[22] This organization can serve to highlight structural siloes, given that there is a political leader at the top of every department, as opposed to the aldermen model, where there is one political leader.[22] In addition, the municipality adheres to a drug and crime prevention coordination model, employing a prevention coordinator who is responsible for coordinating prevention initiatives. Both the parliamentary model and an awareness of drug prevention were unique traits of Bergen municipality, which made it a suitable case for this study.

A contact person within the organization assisted in recruiting the participants. The participants were selected for the study through collaboration between the research team and the contact person in line with a purposeful sampling strategy, with participants selected for their ability to provide information-rich data.[23] The participants were policymakers recruited from different key positions: commissioner (the political leader of a department), chief executive officer (the administrative leader of a department), and adviser (an executive officer who develops policy documents). The participants were recruited from three relevant departments of the municipal organization: the Department of Education and Sports; the Department of Social Services, Housing and Inclusion; and the Department of Health and Care. All 11 invited policymakers participated in one face-to-face interview in 2016. The participants signed informed consent forms prior to the interviews, stating that they were willing to have the interview audio recorded and that every attempt would be made to preserve confidentiality. Ethical approval for the study was given by the Norwegian Centre for Research Data. The interview guide covered topics such as drug prevention initiatives and collaboration within the municipal organization.

After 11 interviews, data saturation was reached. Audio recordings from the interviews were transcribed verbatim and then analysed following a thematic framework analysis.[24] A framework analysis follows these steps: becoming familiar with the data, identifying a thematic framework, indexing, charting, mapping, and interpreting. As a tool, this analytical approach has no allegiance to either inductive or deductive thematic analysis but can help make the analysis more transparent.[24] Each participant was marked with key attributes, such as their role in government and departmental connections. The transcripts were entered into the software QSR International NVivo 11 for organization and analysis.[25] This step enabled the researchers to compare the codes with the different departments and roles for an additional level of analysis[26] (Figure 2).

The data were organized into categories, such as "ownership of drug prevention," and presented following the vertical and horizontal structures of integration inspired by the conceptual scheme proposed by Axelsson and Axelsson. To preserve the confidentiality of the participants, the roles of the participants have not been connected to the quotes where there is a possibility of identifying them.

3 | FINDINGS

3.1 | Drug prevention requires collaboration

All the participants explained that several of the municipality's policy areas are seen as important for drug prevention aimed at youth. The following quotes emphasize that creating good living conditions is equated with drug prevention aimed at youth:

> *"It is not merely drug prevention, but health promotion in the prevention plans. We need to add the knowledge we have that a good childhood lasts for a lifetime, and if the child gets a safe attachment the first years it increases the chances for a good life … which again prevents not only drug use but all sorts of misery."—Adviser*

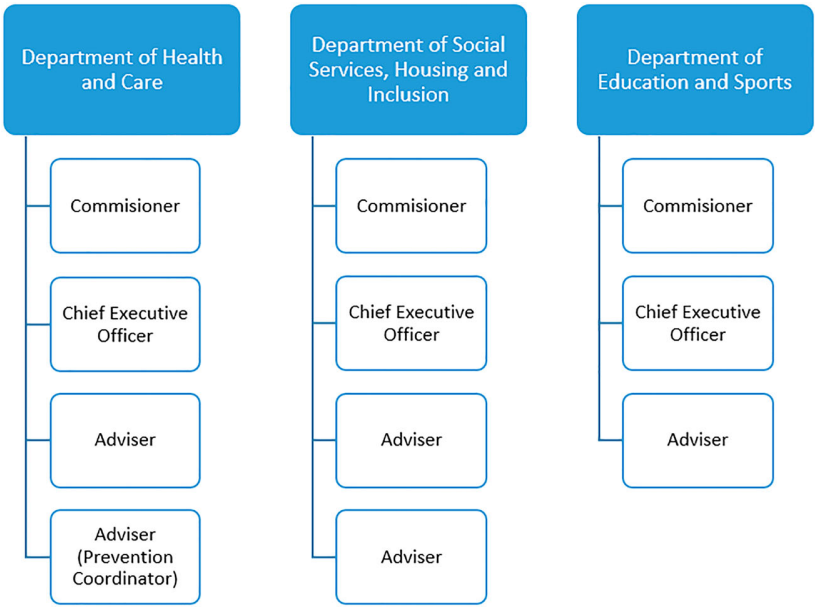

FIGURE 2 Overview of the participants divided by departments and roles

> *"We need a common understanding that a lot of this is about creating good living conditions, and then we are talking about prevention in a health promoting perspective, which has to do with a lot more than drugs. It is an ambition that we are clear on this and don't get overshadowed by the efforts directly connected to drug problems, but to the understanding of how important the general prevention is."—Director General*

Collaboration among the three relevant departments was described as paramount in drug use prevention efforts aimed at youth. The following are excerpts describing the role of collaboration:

> *"Prevention and early intervention are where I need close collaboration with the other departments."—Adviser*

> *"We need to be able to do our core tasks and, in addition, we need to recognize that I can't do this alone. I need to collaborate (…) with the Department of Education or someone to achieve the overarching goals. (…) these are important prerequisites for drug prevention."—Adviser*

3.2 | Challenges in the horizontal structure: Confusion regarding ownership of drug prevention among departments

Although the three departments (Department of Health and Care; Department of Social Services, Housing and Inclusion; and Department of Education and Sports) were described as the most important in drug prevention policies, the analysis showed that not all of these departments take ownership of such policies. Participants from the Department of Social Services specified that they work with people who have already developed drug dependency rather than working on prevention. The lack of ownership can be understood by an example from the drug policy plan development. While the Department of Social Services has had the main responsibility for developing drug policy

plans, where prevention is a key theme, it was mentioned that the sections concerning prevention had been sent to the Department of Health and Care to be written.

> *"We do not work that much with drug prevention, but rather with persons who have developed an addiction."—Participant from the Department of Social Services*

Participants from the Department of Education and Sports pointed to the importance of school settings in drug prevention; however, overall, participants from this department explained that the Department of Health and Care is mainly responsible for drug prevention. One of the reasons for this is that the prevention coordinator is employed by the Department of Health and Care.

> *"The Prevention Coordinator and the Health and Care Department have the main mandate, but we help. It is a Health and Care case as soon as it is connected to drugs (…) before, the Prevention Coordinator was placed closer to the Education Department but was moved to health, so previously, we had a clearer mandate."—Participant from the Department of Education and Sports*

The findings suggest that there is a discrepancy between the idea that drug prevention requires combined efforts from the three departments and the more passive attitude that drug prevention is the responsibility of the Department of Health and Care. This perspective is reflected in the following statement:

> *"It is the people in Health and Care who have the main directives in relation to drug prevention and these things. I don't experience that we have very strong guidelines in the work. It is primarily in the Health and Care Department, and they contact us when they need our help on things. So, they are kind of in the driving seat when it comes to the subject."—Participant from the Department of Education and Sports*

While collaboration among the departments was described as vital for drug prevention, the participants noted that, currently, the collaboration is not fulfilling its potential. Several participants referred to the organizational structure as "siloed," explaining that there are limited opportunities to work outside of one's own department. The participants referred to this situation in the following way:

> *"We are quick to think in silos, where everyone is preoccupied with their own. We have gotten better at participating with each other in collaborations, but sometimes there are situations where we think we can't prioritize it and then you get a challenge."—Adviser*

> *"We have a challenge in the way we are organized. It doesn't mean we can't fix it. I definitely don't believe that, but we have a potential for improvement when it comes to collaboration."––Chief Executive Officer*

> *"We see that the organization is too sectorized or siloed, but that is maybe a bit of an extreme word, but it is way too little coordinated throughout the organization."—Chief Executive Officer*

> *"I think it is about getting a collaboration across these silos because there are many departments who work within their field. But the silos are necessary because they show where the authority is, that being said, it may also lead to us to not being able to work together because there is no direct line to the department next to us or to the floor below. You are kind of just in your profession. So there probably are some barriers in the system."—Commissioner*

3.3 | Challenges in the vertical structure: Diverging perceptions of collaboration between the leaders and the advisers

The participants noted that there are also challenges within the departments.

> *"It is not that it is painless inside the vertical structure. Also, within the "silo" it can be challenging."—Adviser*

The participants highlighted that collaboration among the departments was hindered by time and resource factors, but they also pointed to the lack of a top-down mandate or strategy for integration within the municipality. The lack of a clear mandate for departments to work across policy sectors was particularly emphasized by participants in adviser positions across the different departments, while at the chief executive officer and commissioner level, this issue was not as prominent, revealing a discrepancy between leaders and advisers within the municipality. The advisers perceived that there was a lack of a mandate for collaboration, and some participants highlighted that this situation contrasts with the directives issued at a national level, which strongly advocate for collaboration.

> *"These silo-walls can sometimes be hard to break through or navigate over. If you invite people from other departments to contribute to the planning process, and no one has the time because they focus on their core tasks, you have a problem. There is a need for anchoring from the top on a shared vision (…). We need a top-down mandate, which goes through all the municipality plans."—Adviser*

> *"The anchoring of the drug prevention work in the Bergen municipality has been extremely demanding (…) if the Prevention Coordinator is placed on a service provider level, there is not the same opportunity to collaborate further. It has to be better anchored at the top of the municipality."—Adviser*

> *"One of the most important things the municipality has to do is more prevention. There are many municipalities that have it almost like an umbrella to a larger degree than Bergen municipality. Here, the focus has been on closing the open drug scene and so on, but you need to anchor it and keep a focus on it. As long as Bergen municipality has it as a point way down on the list, it will not be good enough."—Adviser*

3.4 | Prevention coordinator as a potential bridge builder

Collaboration for drug prevention was also described as being hindered by limited political attention. This can be exemplified by the statement from a participant describing the lack of attention by politicians to the prevention coordinator:

> *"It's been a long time since I heard a local politician use the words Prevention Coordinator. (...) When a city council member is unaware of the coordinator, it creates silence around the work. Where there is political pressure, there is also action, and, where there is silence, less is done."—Commissioner*

The prevention coordinator has an important role in prevention work within the municipality. While the purpose of the prevention coordinator is to work across sectors, some participants argued that the role today is organized within a service area of a department and not on a higher level within the municipal hierarchy. The participants noted that this situation contradicts the national model for prevention coordinators. Furthermore, they explained the difficulty of following the national model due to the parliamentary governing system within the municipality. The

parliamentary model was also suggested as an explanation for limited collaboration on prevention within the municipality; one participant expressed this as follows:

> *"We are in the same municipality but, at the same time, we have a parliamentary governing model, which means that we are more separated. We have a Chief Executive Officer who is responsible for the administration within the department and reports to the department's politician. So, there is no overall Municipal Chief Executive Officer as in the aldermen governing model. So, it becomes maybe more demanding in terms of the issues that require collaboration between departments in a parliamentary municipality."—Chief Executive Officer*

3.5 | Summary of findings

To prevent youth from starting and continuing to use drugs, the policy makers emphasize that creating good living conditions is important and highlight the role of several municipal policy areas, such as education, social services, and health. While these services that are important to youth are organized in different policy areas, the policy makers reveal that collaboration among them is limited. The participants describe divergent perceptions regarding ownership of drug prevention among departments and siloed organization, characterized by limited horizontal collaboration. The participants also describe that vertical integration issues, mainly a perceived lack of a mandate, felt especially by the advisers in the different departments. Several of the participants point to the prevention coordinator as a possible bridge builder but note that it is problematic that the coordinator is placed within a service area and not higher up in the municipal organization.

4 | DISCUSSION

The local policymakers all noted that drug prevention requires collaboration among the relevant departments. In a recent scoping review regarding the implementation of health-promoting policies at the local level, collaboration was highlighted as the most common factor in achieving goals across settings.[27] The study made clear that collaboration should be both vertically and horizontally integrated into all stages of planning, implementing, and evaluating health-promoting policies at a local level. While collaboration is described as necessary in local drug prevention work, the findings from this study show that the municipality is experiencing challenges. The lack of experienced collaboration may indicate a lack of coordinated drug prevention aimed at youth. Following the conceptual scheme of different forms of integration proposed by Axelsson and Axelsson,[15] we have highlighted some of the challenges to integration in both the horizontal and vertical structures of the municipal government.

Participants from the three main departments described divergent perceptions about the different departments' responsibilities regarding drug prevention that potentially hinder integration. These types of horizontal integration issues were also studied by Hendriks and colleagues,[13] who investigated collaboration between health and nonhealth officials. They found that divergent perceptions of collaboration hindered collaboration between different policy sectors. Diverging perceptions, especially connected to ownership, were also noted as a problem in a recent study focusing on collaboration between health care and social care for elderly populations.[28] They identified different perceptions of ownership as one of the barriers hindering collaboration; these differences were particularly linked to the different values and understandings of the different professions in the different sectors. The different professions within the different sectors may also be governed by different goals, which may cause a perceived lack of horizontal collaboration. In a study describing the collaboration of stakeholders across policy sectors involved in drug prevention and education, it was found that the collaboration was characterized by a lack of ownership and lack of a shared vision among the stakeholders.[29] The stakeholders experienced tension between target setting governing from the

leadership on one hand and collaborating as a means of achieving "joined-up" policy on the other. On one hand, the participants are measured on the goals the individual department achieves, and on the other hand, they are encouraged to collaborate seemingly without this collaboration being valued. The value of collaboration has been stressed in guiding policy documents such as the Health in All Policy approach. While the goal in these approaches is for the different policy areas to collaborate towards better health, there is a risk of ending up framing health as a means to achieve the objectives of nonhealth sectors.[30] A recent study shows that in some policy processes, health is framed as a means and as something distinct from other social issues to ensure legitimacy. The authors claim that this approach actually narrows the scope of potential policies and interventions. Instead, the authors argue for targeting the causes of causes and the distribution of societal problems.[30] The confusion surrounding the ownership of the drug prevention field is somewhat similar to the ongoing discussion of the framing of health in policy discussions. It is possible that the participants' confusion regarding the ownership of drug prevention is a result of viewing drug prevention as distant to their core tasks. The participants may experience that drug prevention does not fall into their domain and therefore not consider the causes of drug use and how each department can work together to address these root causes. The consequences of not addressing the causes may lead to an unwillingness to take responsibility for how each department plays a role in drug prevention. In addition, the municipality may experience challenges in providing comprehensive services to youth. A siloed organization may lead to difficulties in collaboration between the different services with which the youth come into contact, which are organized in different departments. Without a comprehensive and integrated municipality, it may be difficult to ensure safe transitions for youth between the different services.

Axelsson and Axelsson note that within the field of public health, integration usually takes the form of either cooperation or collaboration, characterized by a high degree of horizontal integration. The degree of vertical integration depends on the degree of governmental involvement.[15] For example, if the municipality is strongly involved, there is typically a clear sense of governing towards integration experienced throughout the municipality, from the top to the bottom of the municipal hierarchy. The participants reported that in the vertical structures, there seemed to be challenges between the leaders and advisers within each of the departments. This notion was expressed through the divergent perceptions of collaboration between the leadership and advisers within the departments. Namely, the leaders described places where the different departments met; the advisers referred to such meeting places to a lesser extent. Notably, the advisers also expressed that there was a lack of any top-down mandate to collaborate with other departments in the municipality. Following Axelsson and Axelsson's[15] conceptual scheme of vertical and horizontal integration, in this study, while the municipal leadership referred to a form of horizontal integration, the advisers, who are lower down in the municipal hierarchy, did not describe the same. The advisers described a lack of a mandate for collaboration from the municipal leadership. Similar to the findings of the present study, Pavis and colleagues[31] studied collaboration between different agencies regarding drug prevention. Pavis and colleagues[31] found that the different aims and objectives expressed by the leaders exposed the frontline project staff to unacceptable competing demands. In the present study, the lack of mandate perceived by the advisers may, in turn, indicate a lack of hierarchical management, which, according to Axelsson and Axelsson, is needed to structure the collaboration.

The horizontal dimension of integration concerns the extent to which the efforts of actors at the same level are compatible. Disproportionately, more research has been carried out on aspects of vertical integration than on aspects of horizontal integration, and there are reasons to believe that horizontal integration represents a greater challenge since there is no formal authority between the units on the same level.[32] In a bureaucratic structure like a municipality, it may be easier to oversee the integration within a unit; however, this is not necessarily the case when the personnel belong to different units.[32] The three departments in the present study are under the municipality's control. Therefore, it is within the mandate of the local government to strengthen vertical integration and for the leaders to support the advisers in their task to work across policy sectors to prevent drug use. However, will that be enough to strengthen the horizontal integration?

Hvinden[32] classified three main ways higher level actors may attempt to influence the level of horizontal integration accomplished by lower level actors to support real integration between different units. The first is increasing the mutual awareness between the lower level actors, for example, through joint meetings. A second way is for higher level actors to emphasize that lower level actors are supposed to contribute to the same goal by, for example, clarifying a mandate for the lower level actors. A third way is for higher level actors to seek to modify the patterns of interdependence between lower level actors through administrative budgets and other main channels. However, these measures are not necessarily sufficient to strengthen horizontal integration. How the actors perceive the availability of resources they require in their work is also likely to play a prominent role. Hvinden[32] cautioned that one may get an impression that higher level actors have greater power and more absolute control over processes taking place at a lower level than intended. The adjustments and strategies of lower level actors also influence the blend of functional autonomy and interdependence in a governmental structure. Factors such as multiple goals and functions, the professional discretion of the lower level actors, and internal specialization are likely to lead to disintegrative process with limited coordination and cooperation.[32] The advisers in the different departments all represent different professions with different ways of understanding the problem and different ways of navigating the system. These different factors within the governmental structure show that collaboration is not easily mandated but rather requires an understanding of the complex mechanisms at play. While it may be tempting to rearrange the organizational boundaries within the municipality to boost intersectoral collaboration, it may prove inexpedient. In a recent study, Holt[33] and colleagues argued that it is time to dismiss the idea that intersectoral action for health can be achieved by means of a structural fix. Rather than rearranging organizational boundaries, it may be more useful to seek to manage the siloes that exist in any organization, eg, by promoting awareness of their implications for public health action and by enhancing the boundary-spanning skills of public health officials.

The participants in the study expressed that they considered the departments to be siloed structures with limited room for collaboration. The role of the prevention coordinator was described as a resource that can aid in reducing these barriers and manage the siloes. However, the placement of the prevention coordinator in a service area at a low level in the municipal hierarchy is problematic according to several participants. The placement of the prevention coordinator suggests a limited mandate associated with the role, which appears to be limiting the capacity for collaboration. Researching a coordinator role similar to that of the prevention coordinator, Hagen and colleagues[34] found that a public health coordinator positioned close to the municipal executive correlated with greater intersectoral collaboration on public health in Norwegian municipalities. To achieve more effective drug prevention, the municipality will need to address the structural siloes within the municipal organization and the divergent perceptions of collaboration. It may seem tempting to organize drug prevention in a project organization within the governmental structure. However, previous research has warned that organizing interorganizational collaborations as projects tends to be counterproductive as it can create barriers between the temporary organization and other public authorities.[35,36] Permanently repositioning the prevention coordinator may enhance the role of prevention and make it easier to manage the structural siloes. While the role of the prevention coordinator is limited, its placement demonstrates the need for an awareness of the structural siloes in the municipal organization. With a revised mandate and position in the municipal organization, it may aid in providing a macroperspective for the departments where they are made aware of how they contribute to drug prevention and creating good living conditions. However, these efforts may prove futile if the departments do not take an active role in recognizing how each department plays a role in addressing the root causes of drug use and the advisers continue to experience a limited mandate to collaborate across the siloes.

The study has some limitations worth noting. The case study design is inherently limited in scope, which may limit transferability. This study provides insights into how one municipality works with drug prevention and collaboration, and given the unique characteristics of the case, readers can evaluate their own opportunities to transfer the results to other similar contexts. These findings provide insight into collaboration for complex health challenges within a siloed governmental structure and therefore are especially relevant for policymakers. While the interviews show how policymakers describe integration regarding drug prevention, the data do not constitute empirical

evidence for what they in fact do; rather, they only provide valuable information on how policymakers experience and perceive collaboration.

5 | CONCLUSION

Following the development of the social determinants of health, the interplay and collaboration between policy sectors are important to address complex health problems, such as drug prevention aimed at youth. In Norway, young people rely on several services in their daily lives that are organized by different municipal departments. The municipalities have been characterized by increasing differentiation among the relevant policy areas and with a siloed organizational form. In a siloed structure, it can be difficult to perceive the implications each department has for the public health, and services can be experienced as fragmented by youth. A siloed governmental structure may therefore limit the coordinated drug prevention aimed at youth. This risk has generated a need for more integration to offer comprehensive services. Utilizing the conceptual scheme of different forms of integration, as developed by Axelsson and Axelsson,[14] we found that the policymakers experience challenges in the horizontal and vertical structures of the municipality, which may limit the integration necessary to provide drug prevention. Following the horizontal structure, the policymakers from the different departments experience diverging perceptions of ownership of drug prevention. The diverging perceptions of ownership were discussed in relation to viewing drug prevention as distant from their core tasks and not considering how each department can contribute to the causes of drug use among youth. To effectively address drug prevention in a municipality, it is important to have a common awareness of the root causes of drug use and for each department to take responsibility for their contribution. Following the vertical structure, the leaders and advisers within the departments experience diverging perceptions of a mandate to collaborate across the sectors for drug prevention. The lack of interorganizational integration can be explained by a lack of hierarchical management, which is needed to structure cooperation.[15] We discuss ways higher level actors may attempt to promote horizontal integration between lower level actors and how lower level actors also influence interdependence in a welfare bureaucracy, revealing some of the complex mechanisms at play. As Holt[33] argues, there is a need to understand these complex structures to be able to successfully navigate and promote health. We point to the prevention coordinator as a resource to navigate the structural siloes within the governmental structure. Following the findings of the present study, integration of drug prevention in a siloed structure relies on departments appreciating their respective roles in drug prevention and advisers experiencing a mandate to manage the siloes that exist in the organization. The present study focuses on the conditions for drug prevention directed at youth in a local government at the policy level. While the local policymakers experience challenges in collaboration for drug prevention, more research is needed to understand how these challenges impact the services offered to prevent young people from engaging in drug use in practice.

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CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest.

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ORIGINAL ARTICLE

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Local drug prevention strategies through the eyes of policy makers and outreach social workers in Norway

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Abstract

More than half of the municipalities in Norway report drug misuse as the most important public health challenge. Following a whole-of-government tradition, the ambition is to achieve horizontal and vertical coordination between different policy areas to address complex problems, such as youth drug use, and avoid fragmented services. This study aims to offer new perspectives on how governmental structures shape local drug prevention. By including the perspective of both local policy makers and outreach social workers, we can come closer to understanding how local drug prevention transforms policy into practice. The study will thus explore how policy makers and outreach social workers describe the local drug prevention strategy and how the outreach social workers implement it in practice. An instrumental case study of one Norwegian municipality was used to investigate the structures for drug prevention in detail. Data were gathered through 14 interviews with public officials from the relevant policy areas and outreach social workers from a drug prevention outreach service. The data were analysed using a thematic framework analysis. This study demonstrated that the policy makers' and outreach social workers' descriptions of drug prevention highlighted the creation of good living conditions and promotion of protective factors surrounding at-risk youths. This perspective may offer a broader approach to drug policy, which includes many policy areas. While collaboration was regarded as paramount, the policy makers described a "siloed" organisation that made it difficult to collaborate. The outreach social workers, however, indicated that they were able to navigate the "siloed" structures. We discuss the structural conditions surrounding outreach social workers that shape the implementation of policies, such as the resource perspective. The discussion shows that outreach social workers may act as a safety net for a potentially fragmented municipal structure for drug prevention.

KEYWORDS

Public Health, Social Work, Public Health Policy, Qualitative Research, Health Promotion, Integrated Services

1 | INTRODUCTION

Preventing drug misuse among youths is a major concern in Europe today. In Norway, 57% of municipalities report that drug misuse is the most important public health challenge (Helgesen et al., 2014). There are different prevention strategies that address drug problems. Gordon (1983) developed a prevention classification typology that is widely adopted within the prevention field (Foxcroft, 2014). According to Gordon (1983), there are three classes of preventive measures. The first class is composed of universal measures, which are measures targeted at a general population. The second strategy is selective measures; these are aimed at members of a subgroup in which the risks are higher. The third preventive strategy is indicated measures, which are targeted towards individuals who are found to manifest a risk factor (Gordon, 1983). Municipalities will typically have services and interventions that target all of these groups, since the municipalities are responsible for many of the services on which children and youth rely in their daily lives. For example, services such as kindergarten, healthcare, school, school nurses, child welfare, sports and cultural activities are arenas that can target all youths, but they can also present themselves as a place of opportunities to provide targeted measures towards selective and indicated groups. In addition, the broad spectrum of services that the municipality organises also provide the opportunity to devise policies that move upstream towards the root causes of the problem, in this case drug use among youths.

In the last decade, the Norwegian national government adopted public health policies that include health promoting strategies, such as the Public Health Act of 2012. The policies address the broader determinants of health and include a resource perspective on health. The focus is therefore not only on preventing illness but also on promoting well-being (Public Health Act of 2012). The Public Health Act emphasises the municipalities' role and especially highlights the need for intersectoral collaboration to achieve the equal distribution of the positive factors that influence health (Fosse, 2011; Fosse & Helgesen, 2017; Hagen, Helgesen, Torp, & Fosse, 2015). National-level drug prevention policies have received more attention than local-level policies, although local governments play a significant role in developing policies suited for local needs (MacGregor, Singleton, & Trautmann, 2014; Mota & Ronzani, 2016; Tieberghien, 2016). The local governmental level also plays a significant role as public health is a municipal responsibility in many countries. Therefore, there is a need to understand drug prevention policies in local government, and how these policies are implemented in a municipal organisation (EMCDDA, 2019; Fosse & Helgesen, 2019; Sellers & Lidstrøm, 2004).

Implementation of governance research includes explicit attention to the layered characteristic of the political administrative system. Instead of focusing on a classical top/bottom dichotomy, varieties of institutional relations are addressed. These include both attention to the vertical line of governance (from policy makers to practitioners), as well as the horizontal line (the collaboration between the different policy areas) (Hill & Hupe, 2014). Thus, following this governance tradition, the structures for local drug prevention in a municipality can be described as consisting of both horizontal and vertical structures within government. The horizontal structure consists of policy makers across different policy areas who draft policy plans and documents outlining the municipality's strategies. The vertical structure consists of service providers such as teachers, police officers and social workers who follow the overall strategies proposed by the policy makers. A precursor of the governance perspective was the contribution by Lipsky (1980). Lipsky (1980) described the importance of the service providers, which he called street-level bureaucrats, as the front line staff in policy delivery. Lipsky (1980) argued that it is the street-level bureaucrats' translation of public policies that the target group receives and perceives as public policy. The street-level bureaucrats' perception of policies is therefore essential to understanding how policies are implemented. Previous studies have highlighted the need for more research on both the structural conditions and the individual conditions shaping street-level bureaucrat behaviour (Baviskar & Winter, 2017). Within the governance perspective, the whole-of-government concept plays an overlapping role (Røiseland & Vabo, 2012). The ambition of the whole-of-government approach is to achieve horizontal and vertical coordination and to avoid situations in which the different policy areas undermine each other. The goal is to create synergies and bridge different interests to offer citizens seamless, rather than fragmented services (Christensen & Lægreid, 2007; Pollitt, 2003; Røiseland & Vabo, 2012). Recent research suggests that there is a need for awareness concerning those factors that influence cross-sectoral collaboration in prevention (Willis, Corrigan, Stockton, Greene, & Riley, 2017).

What is known about this topic:

- Addressing illicit drug use among youths requires an integrated system of services with action at multiple levels of government.
- National-level drug prevention policies have received more attention than local-level policies.
- Including the perceptions of service providers can aid in understanding how policies are implemented in practice.

What this paper adds:

- Policy makers' and outreach social workers' descriptions of drug prevention policies include redirecting attention to the broader determinants of health.
- The drug prevention strategy requires a strong degree of collaboration which the policy makers struggle to sustain due to the siloed organisational structure.
- The outreach social workers are able to navigate the structural silospotentially due to a resource perspective and a flexible role within the municipality.

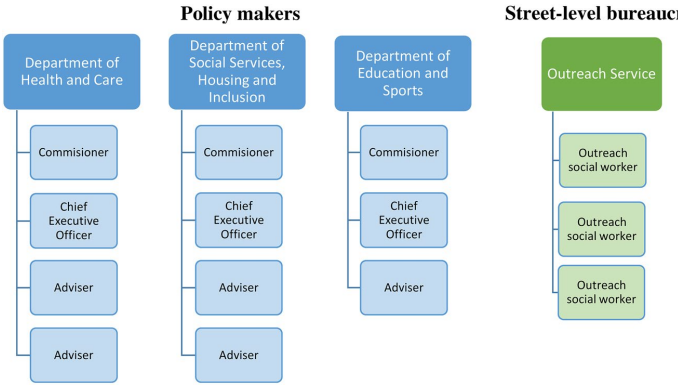

FIGURE 1 Overview of the participants divided by departments and roles

The present study aims to provide insight into both the horizontal and vertical structures for drug prevention by including the perspectives of policy makers and street-level bureaucrats, as well as an account of how the street-level bureaucrats describe the implementation. By including both perspectives, we can come closer to understanding how public organisations collaborate about complex social problems, such as drug prevention, and bring attention to the role of service providers as policy implementers. In order to demonstrate the perspectives of the policy implementation within a municipality, we developed a case study. The case studied is a Norwegian municipality that includes two units of analysis: (a) Policy makers across different policy areas representing the horizontal structure and (b) outreach social workers from an outreach service directed at drug prevention for at-risk youths representing the street-level bureaucrats in the vertical structure. The present study was developed based on a larger research project investigating drug prevention policies and initiatives at the local level in Norway. While the case concerns a Norwegian municipality, the goal is to highlight through the case study the broader theme of drug prevention policy implementation from the perspective of policy makers and outreach social workers. The present study will answer the following research questions: How do policy makers and outreach social workers describe drug prevention strategies? How are outreach social workers able to turn policies into action?

2 | METHODS

Case studies have previously demonstrated their value as an approach to examining policy processes (Lancaster & Ritter, 2014). An instrumental case study can be used to understand a phenomenon the case represents. Rather than focussing on the methods of enquiry, the focus is on seeking out the multiple perspectives of those involved in the case (Stake, 1995). Inspired by Stake (1995), an instrumental case study design was used in the present study to investigate the accounts of political and administrative leadership and street-level bureaucrats in local government. The data consisted of interviews with policy makers and outreach social workers. A contact person within the organisation assisted in recruitment and placed the first author in direct contact with the participants. The selection of the participants for the study was made in collaboration with the research team (authors) and the contact person in line with a purposeful sampling strategy (Patton, 1990). In line with Patton (1990) all the participants were selected for their ability to provide information-rich data about the drug prevention aimed at youths in a municipal organisation. The main inclusion criterion was that the participants had a position within the municipal organisation with responsibility relevant for the topic. In policy making the role of the political leader, the administrative leader and the advisors play a key role when developing and implementing policy. We therefore included participants in these three different roles:

-Commissioner: Political leader of a department
-Director General: Administrative leader of a department.
-Advisers: Executive officers who develop policy documents.

The policy makers were recruited from three main departments of the municipal organisation which are the most relevant to drug prevention, as described by the contact person within the municipality and the participants. This was the Department of Education, the Department of Social Services, Housing and Inclusion and the Department of Health and Care. All the participants had been employed in their position for years and had experience with the topic, except for one policy maker who was new in his job. In total, the first author carried out 14 interviews with 11 policy makers and 3 outreach social workers. To understand the role of the outreach service as policy implementers, we included participants which were all senior social workers with considerable experience in outreach services. The aim of the outreach service office is to prevent maladjustment in at-risk youths through various measures, such as employment training courses and traditional outreach work in urban areas and schools. In addition, we asked the participants to suggest potential other participants, in line with a snowball recruitment strategy, but the suggested participants were already included in the

study. In Figure 1, we present an overview of the different participants by department and role:

All 14 invited individuals participated in face-to-face, semi-structured interviews in the spring and autumn of 2017. The participants signed informed consent forms prior to the interviews stating that they were willing to have the interview audio recorded and that they understood that every attempt would be made to preserve confidentiality. The first author and research assistants transcribed the interviews verbatim, and the research team read the transcripts. The length of the interviews varied from 45 to 120 min. The participants answered questions such as: How are you involved in drug prevention work? Which departments are important for drug prevention work? Ethical approval for the study was given by the Norwegian Centre for Research Data.

2.1 | Data analysis

Data from the interviews were analysed following a thematic framework analysis (Ritchie & Lewis, 2003). The framework analysis follows these steps: becoming familiar with the data, identifying the thematic framework, indexing, charting, mapping and interpreting. In addition, the framework underwent continuous revisions throughout the analysis to reflect the emerging themes. For example: The prevention strategies of universal, selective and indicated measures include themes developed from the original framework, but the theme of health promotion perspective in prevention was developed in the analysis. Each participant was marked with key attributes, such as their position and departmental connection. The transcripts were entered into the software program QSR International NVivo 11 for organisation and analysis (QSR International Pty Ltd, 2016). This approach enabled the research team to compare the codes with the roles of policy makers and outreach social workers for an additional level of analysis (Bazeley, 2009). To preserve the confidentiality of the participants, the roles of the different participants are connected to quotes but not which departments the participants were affiliated with. The following are detailed quotes from the participants that enable the reader to make decisions about the applicability of the findings (Creswell & Miller, 2000).

3 | FINDINGS

The findings are organised into two main themes. The first theme concerns how the participants describe the drug prevention strategies. The analysis follows the traditional prevention framework of universal, selective and indicated measures. In addition, we identify the health promoting perspective as an emerging theme with both policy makers and outreach social workers. The second theme is about how these strategies are implemented into action, revealing a disparity between the description given by the policy makers and outreach social workers.

3.1 | Describing drug prevention strategies

To understand the structures for drug prevention within the local government, we need to investigate how drug prevention is understood by both the policy makers and outreach social workers. The policy makers across different municipal departments emphasised universal prevention by stressing the importance of improving living conditions for all through policy action across different municipal departments:

> It is not merely drug prevention but also health promotion in the prevention plans. A good childhood lasts for a lifetime. Safe kindergartens will foster good development. A good school with good teachers, social relations, social inclusion and participation in school (…) again prevents not only drug use but all kinds of misery. (Adviser)

> We need a common understanding that a lot of this [drug prevention] is about creating good living conditions, and then, we are talking about prevention from a health promoting perspective, which has to do with a lot more than drugs, and we need to not get overshadowed by the efforts directly connected to drug problems. (Director General)

The outreach social workers describe themselves as targeting mostly at-risk youths; therefore, their measures are mainly aimed at a selective group of youths. Although targeting at-risk youths, the outreach social workers, similar to the policy makers, describe a focus on a positive dimension of prevention. The positive dimension includes a focus on the protective factors surrounding the youths, which we label a resource perspective:

> School health nurses are important, but not everyone is lining up to see these nurses. Many fall outside and for different reasons don't want to wait in line (…). These are the ones we meet (…) our task is to work with those who have an increased chance of developing problems. (Outreach social worker)

> Youths have risk factors and protective factors, and we need to protect before we know if it is drugs we are preventing, or something else, such as mental illness or loneliness. (Outreach social worker)

The outreach social workers emphasise providing youths with resources, such as employment training courses, and recreational activities, such as going to the cinema, bowling or eating at restaurants. In addition, the outreach service is mindful that the youths are often met with a problem focus, and therefore they focus on the resources the youths have within them:

> Sometimes, it is necessary to focus on the challenges. It can be serious mental health problems, but it may be more effective to look at their resources. To help and aid youths in becoming aware of their strengths so that they can utilise their potential. (Outreach social worker)

> There is a strong problem-focus on youths today; all you see is the bad, and no one sees what the youths actually can do. (…) So what we have been trying now is to have a positive entry point. (…) So, the resource perspective is really important. (Outreach social worker)

When describing the drug prevention strategies, both the policy makers and outreach social workers describe a positive dimension of prevention, which we identify as an emerging theme of a health promoting perspective. The health promoting perspective is visible in the policy maker's description of creating good living conditions on a universal level and the resource perspective the outreach social workers describe when interacting with selective groups of youths.

3.2 | Implementing drug prevention policies

The policy makers express that the goal of creating good living conditions was a central aspect of the universal prevention strategy. The participants mention, among others, schools, parks, healthcare, sports and the municipality's outreach programme as important structures for creating good living conditions. Collaboration between these departments is described as paramount for the creation of good living conditions and, subsequently, preventing drug use. One participant describes the need for collaboration through a metaphor in which people using drugs are described as sick trees:

> A forest botanist comes across a corner of a forest that is covered by sick trees. The forest botanist would not start to fix one tree at a time. He would think, "What is wrong with this corner of the forest" and put into place a strategy, but in the health sector, we tend to see one tree at a time. So, there is too little focus on universal health promotion. We need all arenas and to make sure that the knowledge flows and the activity is targeted towards the forest and not just a single tree. (Adviser)

All of the participants express that collaboration across the relevant policy sectors was needed with regard to drug prevention:

> We need to be able to do our core tasks, and in addition, we need to recognise that I can't do this alone. I need to collaborate (…) with the Department of Education or someone to achieve the overarching goals. (…) these are important prerequisites for drug prevention. (Adviser)

Nevertheless, the policy makers describe difficulties in the collaborations between the different policy sectors at the top level of the municipality:

> We are quick to think in silos, where everyone is preoccupied with their own issues. (Adviser)

> I think it is about getting a collaboration across these silos because there are many departments who work within their field. (…) there is no direct line to the department next to us or to the floor below. You are kind of just in your profession. So there probably are some barriers in the system. - Commissioner

The outreach social workers describe the relationship with the policy makers as challenging with regard to implementing drug prevention policy:

> Sometimes it can be challenging when we have to follow the municipal system and the organisational lines. We hear about plans that are sent from the departments to the service providers, but we lose track of it. (Outreach social worker)

> The drug policy plan is going through the system for a hearing (…) and when it comes down to our service area, what you can change is limited (Outreach social worker)

The description of the top level of the municipality as a bureaucratic and siloed structure was in contrast with the outreach social workers' description of their service as a more flexible part of the municipal organisation:

> We are a youth prevention service, so our mandate is prevention and to do outreach work, and then, many other projects pop up along the way (laughter). We have an opportunity to develop and start new projects and initiatives. (Outreach social worker)

> Our mandate is broad, and that is how we want it to be because it gives us more room. We are the eyes and ears of the municipality on the streets. And sometimes, we can extend our mandate to youths in schools too. We should be there for the youths who fall between the cracks. (Outreach social worker)

In the process of implementing prevention policies aimed at the protective factors surrounding youths, the outreach social workers indicate that they require close collaboration with other services. For example, the outreach social workers feel that the at-risk youths had difficulties accessing healthcare services. Therefore, the outreach social workers organise a youth healthcare centre in their offices twice a year to provide youths with direct access to health services. Another

example is the close collaboration the outreach service initiated with schools to support the youths. The outreach social workers point to the outreach methodology and their closeness with the youths; they experience the broad needs the youths have up close, a possible explanation for their ability to create collaborations with other services:

> Because of the outreach method, we turn into an organisation that says yes maybe more than we should. Since we see the needs and think, someone should do something. We are a service that primarily works with establishing contact and building alliances for the services that are a part of the treatment chain. We are not just coordinating with others who do the job; many facilitate and coordinate, and maybe, there is a lack of those who work closely with the actual clients. (Outreach social worker)

4 | DISCUSSION

To understand the underlying principles of local drug prevention and how they are translated and implemented in practice, we gathered data from both policy makers, who represent the horizontal structure, and outreach social workers, who represent the vertical structure in a municipality. The policy makers describe universal measures in which the goal is to create good living conditions for all citizens. The outreach social workers describe selective measures with a similar resource perspective focussing on supporting protective factors surrounding youths. Both these descriptions follow an emerging health promoting theme that describes a positive dimension of prevention. Because of this expressed policy, both the policy makers and outreach social workers describe a heavy reliance on collaboration across different policy sectors to be able to have a successful drug prevention strategy. However, the policy makers describe the departments at the top level of the municipality as siloed, finding it difficult to collaborate for universal prevention. The outreach social workers, however, describe an ability to navigate the silos and collaborate with other services on selective measures to provide needed services to at-risk youths. These findings can serve to highlight the important role of the street-level bureaucrats and the role of collaboration in public service organisations. In the following section, we will discuss the similarities between the drug prevention strategies and the differences in the participants' ability to turn the policies into action, with a particular focus on the outreach social workers.

4.1 | Health promoting dimension of drug prevention policies

The policy makers' and the outreach social workers' descriptions of the goal of creating good living conditions and promoting protective factors can be understood as being in juxtaposition to traditional prevention concepts with a narrow focus on risk factors. Biglan promotes the idea that "*rather than focusing on features of interventions, it may be more useful to focus on the functional features of environments that affect well-being*" (Biglan, 2014, p. 2). Creating good living conditions seems to correspond with a shift in public policy from disease and risk prevention towards a focus on the determinants of health and the social factors surrounding individuals (Carey, Crammond, & Keast, 2014; Marmot, 2005). This shift in public policies has also been demonstrated as occurring in local governments. In a review, Weiss, Lillefjell, and Magnus (2016) identified a total of 53 studies of health promoting policies and interventions on a local governmental level. Within the field of drug policy, there is limited research on how drug prevention policies are described, but some research describes a comprehensive approach to prevention that bears similarities to the perspectives we have identified in the present study (Ferri, Ballotta, Carra, & Dias, 2015). This finding suggests that drug prevention strategies at the municipal level include a health promoting dimension. This health promotion dimension reflects an approach to local drug prevention policies, which may serve as a useful contribution to the ongoing debate on the public health approach in international drug policy. Authors such as Rogeberg (2015) have criticised the dominant public health perspective for having a narrow focus on approaches that judge drug policies exclusively based on their effects on population health and longevity, stating that other concerns and outcomes should affect policy design. A health promoting dimension may, in this regard, offer a broader approach to drug policy. By not only focussing on health as a means to ensure longevity but also understanding health as a broader concept, which encompasses the social determinants of health, it can aid in redirecting attention towards positive factors that can improve living conditions.

4.2 | Need for collaboration in drug prevention

To effectively address the broader determinants of health within the field of drug prevention, many of the municipality's policy areas, for instance, education, healthcare and social services, must be included. These policy areas are organised within different municipal departments. The participants thus expressed a need for collaboration between the departments with regard to drug prevention. In the review from Weiss et al. (2016) about the implementation of health promoting policies on a local level, collaboration was highlighted as the most common factor necessary to achieve goals across different settings. The study made clear that collaboration should be both vertically and horizontally integrated into all stages of the planning, implementation and evaluation of health promoting policies on a local level (Weiss et al., 2016). The need to seek collaboration has increased as a response that addresses the complexities of today's society and counters the silo approaches to public services, which can result in fragmented services (Christensen & Lægreid, 2011; Eriksson, 2019). There is a need for an awareness of the factors that influence cross-sectoral collaboration (Willis et al., 2017). While the findings from the

present study show that collaboration is described as necessary in local drug prevention work, the policy makers and the outreach social workers give diverging accounts as to their ability to collaborate with other stakeholders. The policy makers describe collaboration with other municipal departments in the municipality as siloed and fragmented, making it difficult to coordinate and thereby achieve universal prevention. The outreach social workers, however, describe an ability to navigate these silos and coordinate with other services on selective measures in order to provide the needed services to at-risk youths. The perceived lack of collaboration concerning drug prevention as conveyed by the policy makers is itself in contrast to the expressed goal to collaborate across policy areas to create good living conditions. This perceived lack of collaboration may potentially lead to fragmented services as a result of an unclear mandate for collaboration throughout the municipal organisation. Previous research has highlighted the importance of advisers receiving a clear mandate to collaborate in order to effectively address drug prevention in a siloed governmental structure (Oldeide, Fosse, & Holsen, 2019).

4.3 | Outreach social workers' ability to collaborate in a siloed organisation

Outreach social workers often work with youths who have complex needs and may rely on many different services within the welfare state, such as child welfare services, social services and healthcare (Almqvist & Lassinantti, 2018a). These youths are consequently particularly vulnerable to fragmented services, and therefore the need to seek collaboration is especially important. Although the policy makers describe difficulties in collaboration, the outreach social workers whose task is to implement drug prevention policies give a diverging account. The findings from this study demonstrate that the outreach social workers describe an ability to manage the siloes and create collaborations with relevant stakeholders for at-risk youth. The outreach social workers' perceived ability to seek collaboration in a siloed organisation suggests an idiosyncrasy that highlights the role of bottom-up processes in a governance perspective. In line with this perspective, we find that although both policy makers and outreach social workers operate in a governmental organisation characterised by silos, the outreach service seems also able to foster collaboration with relevant services.

Previous studies have researched factors that stimulate interdisciplinary collaboration among youth social workers (Buljac-Samardzic, Van Wijngaarden, Van Wijk, & Van Exel, 2011; Rumping, Boendermaker, & De Ruyter, 2019). In the present study, we aim to contribute to this knowledge base with a focus on the unique role that outreach social workers have as policy implementers. The present study demonstrates that in addition to the resource perspective, which motivates outreach social workers to collaborate with other stakeholders, the outreach social workers' ability to collaborate may lie in the role they play as implementers of policy. When Lipsky (1980) first introduced the important role of the street-level bureaucrats and the discretion they use when implementing policies, the focus was not on individual agency but rather on the structural determinants surrounding the street-level bureaucrats. We argue that the characteristics within the outreach service itself act as an important structural factor for outreach social workers and may reinforce the flexible role that outreach social workers play as implementers of policy. For example, in a study by Kloppenburg and Hendriks (2013) comparing outreach services in different countries, all workers expressed that outreach social work was not well defined and that "*Outreach approaches seem to demand a kind of unconventional maybe even rebellious attitude of the worker, a willingness to step outside the paved paths*" (Kloppenburg & Hendriks, 2013, p. 617). Similarly, the present study's findings indicate that the outreach service has taken on a flexible role when navigating the siloed structures within the municipality and is described as having a wide mandate to do so. For example, the outreach social workers describe an ability to act on the needs of the youths and innovate new projects crossing organisational silos. The flexible role the outreach service has developed is also highlighted by Szeintuch (2015) as an important strategy for services aimed at addressing people with complex problems. While flexibility in collaborative networks is described as the main success factor to solve complex problems, this flexibility is under constant pressure from bureaucratic structures (Willem & Lucidarme, 2014). This flexible role may also come with a cost. While other municipal services are strongly regulated by law, outreach services are not mandated, and the municipality can discontinue the service. The outreach service has therefore a vulnerable role, thus it is important to be aware of the unique role the outreach service plays in the municipality. An outreach social worker in the present study describes that he or she works with youths who have fallen through the cracks of the system. The outreach service may be characterised as a safety net for a potentially fragmented system of drug prevention and thus as having a compensating role within the municipality. The present study has provided some insight into the unique role that outreach social workers have as policy implementers, but more research is needed to understand how these policies are received by youths themselves.

4.4 | Limitations

While the interviews show how the policy makers and outreach social workers describe the local drug prevention system, it is not empirical evidence of what they in fact do. However, the study provides valuable insight into the priorities and viewpoints that guide the policy process and practical drug prevention work.

5 | CONCLUSION

By exploring the descriptions given by local policy makers and outreach social workers, this study demonstrates that the participants'

descriptions of drug prevention policies focuses on creating good living conditions when addressing universal measures and promoting protective factors surrounding vulnerable youths. This health promotion dimension of drug prevention may offer a broader approach to drug policy, changing the focus from health as a means to ensure longevity to understanding health by directing attention to the social determinants of health, which include different policy areas. In line with this perspective, the findings suggest that drug prevention requires collaboration across the relevant policy sectors to promote health and prevent drug use. The policy makers describe municipal organisation as siloed, making it difficult to collaborate on drug prevention. However, outreach social workers indicate that they are able to navigate the siloed structural landscape and collaborate with stakeholders to support at-risk youths. We discuss possible explanations for the role assumed by the outreach service in order to ensure integrated services for at-risk youths. Following the rationale proposed by Lipsky (1980), we highlight the structural conditions surrounding the outreach social workers, such as having a broad mandate and resource perspective, which creates a flexible role in the municipality. The discussion highlights the unique role the outreach service plays in the municipality, acting as a safety net for a potentially fragmented municipal structure for drug prevention.

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CONFLICT OF INTEREST

The authors declare that there are no conflicts of interest.

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III

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Youth perspective on outreach service: A safety net for at-risk youth in a municipality

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ABSTRACT

At-risk youth often rely on different municipal services, such as child welfare services, social services and medical services. All of these services play an important role in preventing drug use and promoting well-being, following the health promoting principles in the Norwegian Public Health Act of 2012. While the goal is for these services to coordinate their actions, many youths fall through the cracks of the system. Some municipalities have developed outreach services aimed at helping these at-risk youth. This study gives insight into the relationship between the outreach service and the youths, and how the youths experience the outreach service as compared to other municipal services through individual interviews and focus groups. The findings demonstrate that the outreach service has legitimacy as a trustworthy service, emphasizing the importance of at-risk youth having trusting relationships with professionals. The outreach service also promotes the youth's empowerment, which was contrasted to the deficit-focus the youths experienced with other services. The outreach service's resource-orientation endorses the need for empowering-oriented approaches aimed at at-risk youths. The findings also show that the outreach service is able to aid the youths in navigating with the other services. We discuss the outreach service role as a "safety net" between disintegrated services in the municipal organization, enabled by their legitimacy as a trustworthy service and the empowering approach. The study illustrates the valuable role a service such as the outreach service can play, both for the individual at-risk youth and also on a structural level within a municipal organization.

1. Introduction

At-risk youth refers to young persons who are surrounded by an increased level of risk factors, such as dropping out of school and using drugs (Etzion & Romi, 2015; Resnick & Burt, 1996). At-risk youth often rely on different municipal services, such as child welfare services, social services and medical services, and are therefore particularly vulnerable to any fragmentation regarding how these are offered. Within health services, there has been an increased differentiation of roles and responsibilities (Ahgren & Axelsson, 2011). This illustrates a key challenge within the field of public health, manifested as a siloed approach to complex societal problems (Carey, Crammond, & Keast, 2014). This development has accelerated the need for a whole-of-government approach to address the complex needs of at-risk youth and the social determinants of health (Carey et al., 2014). In 2012, Norway adopted a public health act that emphasises the municipalities' role in addressing the broader determinants of health and the equal distribution of factors that influence health through a whole-of-government approach (Fosse, Sherriff, & Helgesen, 2019; Ministry of Health and Care Services, 2011). In addition, the Norwegian Public Health Act also emphasises health promoting strategies, where the goal is not only "repairing" disorders but also reducing negative factors or increasing positive protective factors that promote health (Ministry of Health and Care Services, 2011). Accordingly, health promoting concepts such as agency and empowerment, defined as "*the individual's ability to make decisions and have control over his or her own personal life in health promotion*" (World Health Organization, 1998, p. 354), have demonstrated the value of such promotion, especially among at-risk youth (Ungar & Teram, 2000). Municipalities have a central role in health promotion and drug prevention work, as they are responsible for many of the services youth rely on in their daily lives such as, for example, health care, education, school nurses, child welfare, sports, and cultural activities. To ensure that at-risk youth receive the services they require and to promote good health and prevent drug use, there needs to be a high degree of integration between the services (Resnick & Burt, 1996).

At-risk youth are in a period of life where young people generally experiment with new roles and lifestyles and express opposition to parents, teachers and other authority figures (Klepp & Aarø, 2017).

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However, these youth may experience elevated risk factors and face complex challenges. The term at-risk youth does not have an accepted and comprehensive definition (Etzion & Romi, 2015). In the present study, we use the concept of at-risk youth, which overlaps with the concept of "youth with complex needs", as meaning youth who require services from many professionals from different organisations within the welfare system (Almqvist & Lassinantti, 2018b). It should be noted that the term at-risk youth comes with certain normative assumptions, and the divergence of at-risk youth merely represents a lifestyle that is different from the dominant middle class culture (Henningsen, Backe, Berg, Egge, & Eidsvåg, 2009). The concept has received criticism from both researchers and such youth themselves, who have argued for a more positive concept such as "promising youth" or "youth in flight" (Follesø, 2015). Although the concept of at-risk youth focuses on risk factors, the present study – and the outreach service and youth at the centre of the study – focus on the protective factors.

Municipalities in urban areas and some rural districts have developed outreach services to meet the needs of youth who fall outside work and school (Henningsen et al., 2009). Outreach services often address selected and previously indicated groups of youth among whom there are elevated risk or present risk factors (Gordon, 1983). The main working method of outreach services is outreach work characterised by a presence in arenas where youth already are, such as hangout areas and schools (Klepp & Aarø, 2017). Through their outreach approach, outreach services have demonstrated a unique power to reach populations who would otherwise not receive essential services (Szeintuch, 2015).

Previous literature on outreach services focuses mainly on describing the different methods that outreach services use by highlighting the characteristics of outreach programmes (Andersson, 2013; Chan & Holosko, 2017; Connolly & Joly, 2012; Grymonprez, Roose, & Roets, 2017; Hart, 2017; Kloppenburg & Hendriks, 2013; Maeseele, Bouverne-De Bie, & Roose, 2013; Mounteney & Berg, 2008; Szeintuch, 2015). When describing the target groups of outreach services, the literature is somewhat sparse. Some previous research addresses how outreach social workers view at-risk youth (Chui & Chan, 2012; Tam, 2012), or how youth describe the reasons behind problem behaviour in an outreach programme context (Tam, 2011). In an article from 2016, the youth involved describe their ability to adapt and maintain boundaries with youth workers (Hart, 2016). Although the youth perspective regarding outreach services is present in the literature, it is infrequent and does not focus on how youth experience outreach services in relation to other services. In a recent study regarding professionals working with youth with complex needs, the authors call for studies that illuminate young people's opinions and experiences about the support they receive and the organisations they interact with (Almqvist & Lassinantti, 2018b). Thus this study aims to contribute with the youth perspective concerning how they experience the integration of municipal services.

Szeintuch (2015) suggests that outreach services are able to develop a unique role in municipal organisations due to their limited result-orientation. Previous research also describes outreach services as usually having a freer mandate and less target-result management style when compared to similar services. As Stenersen (2016) puts it, "*Few services have the opportunity to put other tasks on hold, to be present over time without producing immediate results*" (p. 88). Szeintuch (2015) warns that outreach services need to avoid becoming result-oriented services, where resources are negated by following a target-measured neo-liberal policy—a policy that may favour working with those who are more likely to succeed while abandoning those who are in most need and require more tailored services. Previous research has shown that the municipal structure can be characterised as siloed and bureaucratic (Oldeide, Fosse, & Holsen, 2019). The siloed organisation may be limiting the integration of services, and as a potential consequence, youths who rely on different services may find themselves "falling between the cracks" of the public organisations. Stenersen (2016) argues in a report that the outreach service is not the answer to public health challenges but may act as an important piece of the puzzle that can fill in the holes when the local public health service does not work as planned (Stenersen, 2016).

The present study combines the perspectives of both outreach social workers and at-risk youths in answering the following research question: What characterises the relationship between at-risk youths and the outreach service? How do at-risk youths experience the role of the outreach service in comparison with other municipal services?

2. Methods

The present article is based on an instrumental case study of local drug prevention for young people in a Norwegian municipality. Instrumental case studies are often used as a way of examining and understanding a phenomenon, where the case acts as a facilitator for the phenomenon. The focus is therefore on what the case represents rather than the aspects of the particular case, which enables the reader to see the transferability of the case findings (Stake, 1995). At the centre of the present case study is the role, from a mainly youth perspective, an outreach service can play in a municipal organisation with regard to the integration of services. The present case includes data from three focus group interviews with at-risk youth, which helps us explore their experiences with municipal services aimed at drug prevention. In addition, we interviewed employees from the municipal outreach service. The outreach service is organised as a part of the Department of Health and Care and receives its mandate and budget from the municipality. It is located in the metropolitan area with a citywide mandate that aims to prevent at-risk youth from developing problems and improve their circumstances. The interviews were organised in the fall of 2017. The data from the focus groups were triangulated with the individual interviews to enrich the findings and thus create a deeper understanding by expanding the youths' experiences and including voices from the outreach service (Denzin, 1978).

At any given time, the outreach service is in contact with approximately 100 youths from 13 to 25 years old. We organised three focus group interviews with six to eight participants in each group. In total, there were 21 participants aged between 16 and 24 years. Six were young men, and 15 were young women. The main inclusion criteria for participants were that they were 16 or above and had experience with the studied outreach service. The majority of participants were in their mid-teens, from the metropolitan area and born in Norway. However, there were some individual differences: several were immigrants, a few lived in smaller neighbouring villages, and some were older. Multiple participants had been familiar with the outreach service for several years, while others had only come into contact a couple of months prior to the interview. The participants were recruited to the study by social workers in the outreach service, who invited them to participate in an afternoon focus group on designated days at the outreach service's venue, which was a familiar setting for the youths. The participants were told that their participation would not have any direct influence on their relationship with the outreach service. The outreach service's role in recruitment may be a concern with regard to the validity of the study and will be further discussed. Each participant received 200 NOK (approximately 20 euros) in compensation to cover transportation. The first author acted as a moderator together with a co-moderator by structuring and including all the participants in the discussion. Each focus group interview lasted approximately three hours. After completing the third focus group, the first author and co-moderators assessed that enough data had been generated to answer the questions. The composition of each group was such that some knew each other from before while others did not. Below is a figure visualisation of the focus groups' composition (see Fig. 1).

The themes discussed in the focus groups were experiences with the outreach service, experiences of other services in the municipality and drug prevention in general. We recruited three senior staff members for

Fig. 1. Overview of the participants in the three focus groups.

Table 1
Summary of key findings showing global, organising, and basic themes.

Global themes	Organising themes	Basic themes
The outreach service has legitimacy as a trustworthy service	Acceptance and acknowledgment	No judgment
		Experience with drugs and mental health issues
		Available
	Care	Friendly
		Supportive
	Trustworthiness	Follows strict confidentiality
		Asks before involving others
		Volunteer principle
The outreach service promotes empowerment	Agency	In charge of your own destiny
		More than passive receivers of help
	Resource-orientation	Mapping resources of each youth
		Too much problem focus
		Other services have a deficit-focus
		More opportunities with the outreach service
		"In charge of the positive"
The outreach service aids in navigating with the other services	Practical support	Driving to appointments
		Translating bureaucratic language
		Acting as custodian
		Helping youth find a part-time job
		Wake-up calls
	Motivational support	Believes in you
		Provides options and alternatives
	Barriers to navigating with other services	Difficult to understand the "system"

individual interviews from among the outreach social workers, all of whom had considerable experience in the outreach service. All of the participants signed informed consent forms and were given pseudonyms in the analysis. Ethical approval for the study was given by the Norwegian Centre for Research Data. Data from the interviews were analysed following a thematic network analysis, where the analysis gradually develops from basic themes to more abstract organising themes. The organising themes are then clustered into global themes representing the highest degree of the analysis (Attride-Stirling, 2001). The first author thoroughly read the transcripts and coded the data. We then grouped the codes together and labelled them as basic themes. The basic themes were arranged together with other similar basic themes about the same topics, which informed the development of the organising themes. The global themes emerged by grouping the organising themes together into a higher abstraction. To demonstrate the different levels of analysis and key findings explored in the present paper, we have included the table below (see Table 1).

3. Findings

3.1. The outreach service has legitimacy as a trustworthy service

At the start of each focus group, the moderator asked general questions about youth culture and drug use. In one of the focus groups, the conversation drifted into how youths cope when having trouble. Cassandra, who had not said much until then, mentioned the importance of support from others when coping with difficult times. In response to Cassandra, many of the other youths in the group agreed that social support was important when dealing with difficult times. Cassandra then than raised the role of the outreach service, stating; "*that is what the outreach service does*" to the nodding of others (FG 1).

The notion that the outreach service can help youths cope was analysed as being part of a larger global theme regarding the legitimacy of the outreach service as trustworthy. In the following sections, we will illustrate how the youths describe the outreach service's approach. A typical way for the youths across all three focus groups to describe the outreach service's approach was that they felt acknowledged and accepted by the outreach service social workers. Tammy points to this by differentiating what she experiences as the harsh nature of the drug scene:

> Tammy: Sometimes, you're so tired and broken down than you can't bear it anymore. Everyone needs positive things, love, and those things don't exist in the drug scene. But you are met by someone who sees you as you are, in spite of everything you have done, or your looks or stuff like that, then you kind of feel like there is good the world.
> Naomi: To feel welcome and not get judged in any way. (FG 1)

Some participants felt accepted due to outreach service's long experience with issues such as drugs and mental health problems.

> Tammy: You don't feel that you are stupid for asking for help, because they have probably heard it all before. It's not like they look funny at you if you are embarrassed.
> Naomi: They are very open.
> Luke: You're welcomed with open arms
> Naomi: Taken seriously (FG 1)
> Carol: They don't judge you for anything because they have heard it all before. If you do drugs you can say it, you can say what you struggle with, and they won't look down on you. They are positive, regardless. (FG 2)

The sense of acceptance the youths described is related to the description of the outreach services as a service that cares for them. This was expressed across all the focus groups, and exemplified by Nate who points to the availability of the outreach service:

> Nate: They really care, more than my doctor or sometimes my mom. You can always contact them when you have problems. Even in the middle of the night if you feel bad. They are there. One of the best things since living in Norway is being with the outreach service. (FG 3)

The youths across all the focus groups devoted considerable attention to the theme of the outreach service's trustworthiness. Some of the youths were naturally concerned about the possibly of professionals tattling on them to their parents or police. One participant described previous negative experiences with service providers not respecting her privacy. All of the youths agreed that the outreach service was to be trusted.

> Paul: The confidentiality they follow is beautiful.
> Marcus: That's true.
> Paul: If it hadn't been for that it would be so much harder to talk with them. It's great for kids who are having a tough time.
> Sophie: It's so much easier talking to them rather than those at school. If you tell anyone at school that something very bad has happened to you they will tell your parents. But, with the outreach service you can tell. They say something when they have to contact the police.
> Carol: Yes, and it takes a lot for them to have to bring it forward, again they don't judge you for anything because they have already heard everything,
> Lisa: They are in the outreach service because they want to help. (FG 2)

In the interviews, the outreach service social workers also described the importance of trust, and they spent considerable time encouraging the youths to seek and accept help from relevant services such as police and medical professions.

> We work based on the volunteer principle. That's the most important. We are on their [the youths'] side and we are staying there. We are very clear that we are here, and we are here when you need us. If you are not ready now, then we are there for you later. (…) Our main activity is outreach work so we totally depend on being allowed to talk with the, and being allowed to help. We aren't always able to do it. Have you been let down by too many adults then it's really difficult. It is our main mission to get into position to help and if we are so worried that we have an obligation to notify [health care professionals or the police] we of course do that, but usually with some cleverness and dedication we get there together. (OSW 2)

3.2. The outreach service promotes empowerment

When the youths described the help provided by the outreach service, they spent some time highlighting their role as agents in their own lives and that they needed a push in the right direction. This is illustrated by discussions in the following focus group:

> Patrick: These days kids are just seen as a bunch of hell raisers, but it's the complete opposite. It's people who want to move on in their lives, and no matter how bad it is, we want to be able to get away somewhere. So even if kids say that they want to end up on the streets and smoke weed the rest of their lives, they don't mean it. Nobody can mean that.
> Nate: No we all want [stops]…
> Patrick: Everyone can create their own future, and everyone wants to create their own future. It's just, sometimes, you need a little push in the right direction. That's what is so great about the outreach service, what they do is that they give us that little push. (FG 3)

Viewing youths as agents in their own lives can be understood as part of a larger empowering resource perspective guiding the outreach service. The youths are more than passive receivers of help, which is reflected in both the philosophy and the practice of the outreach service. The following are quotes from interviews with the outreach social service staff describing how they steer towards resources when working with youth:

> Outreach work requires a resource perspective. We focus on both prevention and health promotion, and the resources are health promoting. So, we work systematically by following up and mapping both resources and challenges (…) Sometimes it is necessary to have a focus on the challenges. It can be mental health, but it may be more effective to look at their resources. To help and aid youths in becoming aware of their strengths so that they can utilise their potential. Mainly, we do both because the resources are so important. (OSW 3)
> There is a strong problem-focus on youths today. You see everything that is wrong, and nobody knows what this kids actual competence is, nobody knows! That's the worst part of it all. You know this kid who has been in the system for so long, and what can this youth do? We don't know since the problems take up so much space. (…) So, we focus on the resources. (OSW 2)

The outreach service as resource-oriented became especially clear to the youths when describing their contact with other public organisations and services. Most youths participating in the focus groups demonstrated experience with many different services, among others, psychiatric services, school nurses, teachers, social services, etc. They thus compared the outreach service with these other services, highlighting that their contact with the outreach service was associated with more opportunities.

> Carol: You feel there are more choices [out of a problem] when you talk to them, because as I said they don't get shocked no matter what you say to them. You see that they are neutral, no, not that neutral, but they don't react as strongly as other do. So it's easier to talk to them. They are always positive. (FG 2)

Furthermore, the youths highlighted that when visiting a psychologist, they experienced a deficit-focus, which stands in contrast to the resource-orientation of the outreach service:

> Lisa: Psychologists today are doctors, while the real psychologists are the outreach social workers.
> Marcus: They don't push you in the way that a real psychologist does.
> Sophie: They are here to help you, while psychologists are there to give you an illness. (FG 2)
> Lisa: The thing about the outreach service is they know many different… Like they have more experience. They see to that they don't treat you the same way as everybody else. Like, they try to figure out how they can help you because you are a different person [than a diagnosis].

> Carol: Yeah, psychologists think more on a group level. They think you belong to that group, but the outreach service they talk to you and think that you are an individual, not a group of people. You are unique, not like everyone else. (FG 2)

Later in the same focus group, one participant opposed this description of psychologists and expressed having a positive relationship with a psychologist. This may serve to highlight the different roles of public services, where some agencies and professionals focus on the problematic areas while others, such as the outreach service, have a strong resource perspective. The outreach service has therefore taken the role of "being in charge of the positive". One outreach social worker explained this role when working with girls who were in contact with many service providers such as child welfare, social services, psychiatric teams, drug counsellors and schools:

> Lately there have been several cases where we have been in charge of the positive in young people's lives. Everything that is hard and difficult is channelled to the professionals in charge of treatment, and our job has been to find something they master. (OSW 2)

3.3. The outreach service aids in navigating with the other services

Many of the youth across the three focus groups described that they regularly contact different municipal services such as social services, child welfare services, and psychologists. In two of the focus groups, the youths spent some time discussing how the outreach service played an important role in helping them navigate these different services, both by motivating them and providing aid when interacting with the other services. They underlined practical issues such as being able to drive them to the social services offices, helping them translate the bureaucratic language and acting as a custodian when it was needed. One participant described the struggle of finding sufficient motivation to finish upper secondary school. He was called everyday by an outreach social worker to make sure he was up and ready for school in the morning. In the third focus group, Jane and Nate had a discussion that captures the role of the outreach service in relation to the other service providers:

> Jane: Some years ago, I went to school and had a lot of problems. I didn't live at home and had nowhere to go (…) I needed help, and the outreach service helped me. They helped me sort out stuff with social services, they helped me find a home, they helped me find a job and they helped me get away from all the bullshit and just continue to push through. Today, I have my driver's license, a job, I finished school. I have to say that it is a big thanks to the outreach service. If they hadn't been there for me things could have gotten a lot worse.
> Nate: Amen, totally agree. (…) I went to the social services and tried to get a job. First my psychologists said yes and my doctor said no, then the doctor said yes and the psychologists said no and social services said no. When I found a job myself, then again they said no, "health comes first", but then the outreach service said "he doesn't need medication, he needs to be active, he goes to the gym twice in a day and has a lot of energy". So bit by bit I built myself up, now I work in a charity thanks to the outreach service to show I can work and I am responsible. (FG 3)

This discussion points to the difficult situation some youths are facing when navigating the different service providers. This was supported by an outreach social worker in the following way:

> When we think it's hard to help a youth through the system, just imagine how hard it is for the youth. When we as educated social workers are struggling to get it right, there has to be many youths out there in the system who are struggling with the same. – OSW 2

Jane and Nate's discussion also addresses the outreach services' ability to aid the youths in navigating these bureaucratic obstacles, both by providing motivational support and practical support.

The findings in the present study demonstrate that the relationship between the outreach service and the youths is characterised by the outreach service having legitimacy as a trustworthy service. The youths described that they felt acknowledged, trusted, and cared for. The outreach services also promote empowerment through a resource-oriented approach. The youths described a sense of agency and opportunity when interacting with the outreach service, which was different from the deficit-focus experience associated with other services. The outreach service themselves described a resource-oriented approach both in theory and practice. Youths who are experiencing difficulties in navigating other services acknowledge the motivational and practical support provided by the outreach service.

4. Discussion

We proposed research questions above about what characterises the relationship between outreach social workers and at-risk youths and how these youths experience the outreach service in comparison with other municipal services. The findings reveal a relationship characterised by the youths viewing the outreach service as a legitimate and trustworthy service provider. The youths also experience the outreach service as having a resource-orientation approach, which is in contrast to how they perceive the other service providers. In addition, we found that the outreach service aids the youths in navigating other services. In the following discussion, we postulate that these themes may partly explain why the youths experience the outreach service as capable of navigating the other service providers and consequently able to act as a safety net for at-risk youths.

The relationship between the outreach service and the youths is characterised by trust, which gives the outreach service legitimacy as a service provider. A recent study based on focus groups identifies success factors in higher education for youths with experiences in child welfare organisations (Pinkney & Walker, 2020). The study recognised, among others, the role of ongoing relational support from supportive adults, characterised by "*genuine concern, human warmth and knowledge of the young person*" (Pinkney & Walker, 2020, p. 8.). The study goes on to emphasise that the supportive adult needs to be non-judgemental and available to provide both practical help and emotional encouragement. The findings from this and the present study, which are centred on the youth's perspective, support the importance of the youths experiencing a trusting relationship with the professionals surrounding them.

A key characteristic of how the youth experience the outreach service, as opposed to the other services, was identified as promoting empowerment. The youths described a degree of agency and opportunities, which differed from the interaction with other services. The resource-orientation was also expressed from the viewpoint of the outreach social workers in the individual interviews. The outreach social workers described how viewing the youth from a resource perspective is a guiding principle in their work. The resource-orientation of the outreach service can be understood as a health promoting approach that accentuates youths' individual empowerment and ability to take control over their own lives (World Health Organization, 1998). A central part of empowerment is the youths' experience of agency, which refers to a person's degree of involvement in a course of action (Drydyk, 2013). In a recent study of adolescent girls with multiple and complex needs, a key finding was that the adolescents expressed a need for agency when interacting with health and social care (Van Den Steene, Van West, & Glazemakers, 2018). Van Den Steene et al. (2018) point to the different benefits of increased participation and agency in youth care, showing that agency provides youth with the ability to make decisions and affirms their capacity for self-sufficiency (Metselaar, Van Yperen, Van Den Bergh, & Knorth, 2015; Scannapieco, Connell-Carrick, & Painter, 2007; Vis, Strandbu, Holtan, & Thomas, 2011). Several researchers point to the strong link between the youths' perceived agency

and their relationship to the service providers who facilitate youth empowerment (Van Bijleveld, Dedding, & Bunders-Aelen, 2015; Van Den Steene, Van West, & Glazemakers, 2018; Vis et al., 2011). Consistent with the present findings, Almqvist and Lassinantti (2018a) (in a review of social work practices directed at youth with complex needs) identify collaboration-, relationship- and empowerment-oriented practices as the three main themes across the studies.

The way the youth in the present study describe the empowerment-oriented practices of the outreach service is in opposition to how they describe their interaction with the other services. When in contact with other services, such as child welfare services, social services or psychologists, the youth experienced more problem-oriented dialogues. While acknowledging that the outreach service is in a different position than, for example, doctors and psychologists, the above findings demonstrate the need for more health promoting practices aimed at at-risk youth. One study demonstrates that when vulnerable youth experience respectful and empowering practices from two services concurrently, it appears to have a sustained impact on their wellbeing and resilience (Sanders & Munford, 2014). The present study therefore adds to the literature by encouraging empowering practices when interacting with youth (Almqvist & Lassinantti, 2018a; Haight, Bidwell, Marshall, & Khatiwoda, 2014; Lerner et al., xxxx; Sanders & Munford, 2014).

At-risk youth often require coordinated action from several services. Some youth struggle in school; some would benefit from being active in a sport; others are in the custody of child welfare services, and some need help from a doctor, psychologist, school nurse or social services. In the present case, three different municipal departments organise these services. In the focus groups, the youths described some of the bureaucratic barriers they face when in need of multiple services. Previous research demonstrates that the municipal structure can be characterised as siloed and bureaucratic (Oldeide, Fosse, & Holsen, 2019). The youth describe how the outreach service has a facilitating role in helping them navigate the municipal structures through motivational- and practical support. Previous research highlights the outreach service as employing a unique role as service providers, characterised by a freer-organisation and less target-result management. Based on the findings from the present study, we argue that the legitimacy as a trustworthy service, and the empowering approach, enable the outreach service to position itself in aid of youths who struggle with disintegrated services. The outreach service may, thus, play a valuable role by supporting individual youths and aiding them on a structural level as a "safety net" when other services fail. The disintegration of services that the youths' experience is in contradiction to the goal of the public health act, which outlines a whole-of-government approach where integration between services is essential. The role taken by the outreach service may, from a youth perspective, curtail the experience of disintegrated services in a municipal structure. We see the need to further evaluate the services for at-risk youth in a municipal organisation where the needs of youth are placed in the centre.

It is possible that youths who are outspokenly negative about the outreach service were excluded from the study. However, all the youths included in the study described the outreach programme in desirable terms, and the analysis follows their experiences. Youths who have negative encounters with the outreach service would arguably not experience, for example, the outreach service as having legitimacy as a trustworthy service in the same way. Therefore, it is important to note that the analysis builds on the experiences of those who benefit from the outreach service. Investigating the perceptions of those who have had a negative experience would be very interesting but was not within the scope of this project.

5. Conclusion

At-risk youth rely on services provided by many different professionals across different organisations within a municipality. While the goal is for these services to coordinate their actions, many youth fall through the cracks of the system. We combined the perspective of outreach social workers and the youths themselves to shed light on the relationship between the youths and outreach service as well as how the youths experience the outreach service in comparison with other municipal services. The analysis reveals that the relationship was characterised by the outreach service as having legitimacy as a trustworthy service. The youths described an outreach service that is focused on empowering practices, which is a contrast to the more deficit-oriented focus of other services. These findings were discussed in relation to the growing literature on empowerment-oriented approaches directed towards at-risk youth. Consequently, based on the youths' experiences and the growing literature, other services would benefit from developing a stronger resource focus when interacting with at-risk youth. The findings also show that the outreach service plays an important role in aiding the youths in navigating with other services. We discuss the legitimacy and empowering approach the outreach service has as a trustworthy service provider and what potentially enables the outreach service to acquire this unique position. By aiding the youths who are struggling with disintegrated services, the outreach service can therefore be described as acting as a safety net for at-risk youths in a municipality. This may be the reason why a youth from one of the focus groups described the outreach service in the following way: "*They are youth superheroes, because they help out with serious problems and actually guide us to a solution*".

CRediT authorship contribution statement

Olin Oldeide: Conceptualization, Methodology, Investigation, Data curation, Writing - original draft, Writing - review & editing. **Ingrid Holsen:** Conceptualization, Writing - review & editing. **Elisabeth Fosse:** Conceptualization, Writing - review & editing.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

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Appendix

Appendix A: Norwegian Centre for Research Data approval letter

Norsk samfunnsvitenskapelig datatjeneste AS
NORWEGIAN SOCIAL SCIENCE DATA SERVICES

Harald Hårfagres gate 29
N-5007 Bergen
Norway
Tel: +47-55 58 21 17
Fax: +47-55 58 96 50
nsd@nsd.uib.no
www.nsd.uib.no
Org.nr. 985 321 884

Olin Blaalid Oldeide
HEMIL-senteret Universitetet i Bergen
Christiesgt. 13
5015 BERGEN

Vår dato: 03.03.2016 Vår ref: 47342 / 3 / AGL Deres dato: Deres ref:

TILBAKEMELDING PÅ MELDING OM BEHANDLING AV PERSONOPPLYSNINGER

Vi viser til melding om behandling av personopplysninger, mottatt 12.02.2016. All nødvendig informasjon om prosjektet forelå i sin helhet 02.03.2016. Meldingen gjelder prosjektet:

47342	*Rusførebyggande arbeid retta mot unge i Bergen kommune*
Behandlingsansvarlig	*Universitetet i Bergen, ved institusjonens øverste leder*
Daglig ansvarlig	*Olin Blaalid Oldeide*

Personvernombudet har vurdert prosjektet, og finner at behandlingen av personopplysninger vil være regulert av § 7-27 i personopplysningsforskriften. Personvernombudet tilrår at prosjektet gjennomføres.

Personvernombudets tilråding forutsetter at prosjektet gjennomføres i tråd med opplysningene gitt i meldeskjemaet, korrespondanse med ombudet, ombudets kommentarer samt personopplysningsloven og helseregisterloven med forskrifter. Behandlingen av personopplysninger kan settes i gang.

Det gjøres oppmerksom på at det skal gis ny melding dersom behandlingen endres i forhold til de opplysninger som ligger til grunn for personvernombudets vurdering. Endringsmeldinger gis via et eget skjema, http://www.nsd.uib.no/personvern/meldeplikt/skjema.html. Det skal også gis melding etter tre år dersom prosjektet fortsatt pågår. Meldinger skal skje skriftlig til ombudet.

Personvernombudet har lagt ut opplysninger om prosjektet i en offentlig database, http://pvo.nsd.no/prosjekt.

Personvernombudet vil ved prosjektets avslutning, 12.04.2019, rette en henvendelse angående status for behandlingen av personopplysninger.

Vennlig hilsen

Katrine Utaaker Segadal

Audun Løvlie

Kontaktperson: Audun Løvlie tlf: 55 58 23 07
Vedlegg: Prosjektvurdering

Dokumentet er elektronisk produsert og godkjent ved NSDs rutiner for elektronisk godkjenning.

Personvernombudet for forskning

Prosjektvurdering - Kommentar

Prosjektnr: 47342

Formålet er å undersøke det rusførebyggande arbeidet i Bergen kommune i eit helsefremmande perspektiv.

Prosjektet består av to deler: 1) intervju med Utekontakten, administrativt og politisk ansatte i kommunen; 2) intervju med ungdom som deltar på tiltak arrangert av Utekontakten.

Utvalget informeres skriftlig om prosjektet og samtykker til deltakelse. Informasjonsskrivene er godt utformet, men vi ber om korrigering i informasjonsskrivet til ungdomsdelen, setningen: "og der vil vere 5-8 personar i alderen 15 og oppover" må endres til "der vil vere 5-8 personar i alderen 16 og oppover", da ungdommer under 16 ikke selv kan samtykke til deltakelse når det samles sensitive opplysninger, jf telefonsamtale 02.03.2016.

Ombudet mener at det må tas høyde for at det vil bli behandlet sensitive personopplysninger om helseforhold.

Hovedregelen når det registreres sensitive opplysninger til forskningsformål om ungdom under 18 år, er at det må innhentes samtykke fra foreldrene. I dette prosjektet vurderer personvernombudet det imidlertid slik at ungdommer over 16 år kan samtykke til deltakelse på selvstendig grunnlag. Dette ut fra en helhetsvurdering av opplysningenes art og omfang. Det vises til at ungdom i denne alderen har selvbestemmelse på en rekke områder de kan bl.a. selv velge utdanning, samtykke til helsehjelp, de er over den seksuelle lavalder, og melde seg inn/ut av foreninger. Det er personvernombudets vurdering at ungdommene på 16 år og eldre i dette prosjektet har forutsetninger for å forstå hva deltagelse innebærer.

Data innhentes ved personlig intervju. Vi minner om at det av hensyn til ansattes taushetsplikt ikke kan fremkomme identifiserbare opplysninger om enkeltbrukere/ungdommer. Vi anbefaler at forsker minner informanten om dette ifm. intervjuet.

Personvernombudet legger til grunn at du etterfølger Universitetet i Bergen sine interne rutiner for datasikkerhet.

Det oppgis at personopplysninger skal publiseres. Personvernombudet legger til grunn at det foreligger eksplisitt samtykke fra den enkelte til dette. Vi anbefaler at deltakerne gis anledning til å lese igjennom egne opplysninger og godkjenne disse før publisering.

Forventet prosjektslutt er 12.04.2019. Ifølge prosjektmeldingen skal innsamlede opplysninger da anonymiseres. Anonymisering innebærer å bearbeide datamaterialet slik at ingen enkeltpersoner kan gjenkjennes. Det gjøres ved å:
- slette direkte personopplysninger (som navn/koblingsnøkkel)
- slette/omskrive indirekte personopplysninger (identifiserende sammenstilling av bakgrunnsopplysninger som f.eks. bosted/arbeidssted, alder og kjønn)

- slette digitale lyd-/bilde- og videoopptak

Endringsskjema

for endringer i forsknings- og studentprosjekt som medfører meldeplikt eller konsesjonsplikt
(jf. personopplysningsloven og helseregisterloven med forskrifter)

Endringsskjema sendes per e-post til: personvernombudet@nsd.no

1. PROSJEKT

Navn på daglig ansvarlig:	Prosjektnummer:
Olin Blaalid Oldeide	47342
Evt. navn på student:	

2. BESKRIV ENDRING(ENE)

Endring av daglig ansvarlig/veileder:	*Ved bytte av daglig ansvarlig må bekreftelse fra tidligere og ny daglig ansvarlig vedlegges. Dersom vedkommende har sluttet ved institusjonen, må bekreftelse fra representant på minimum instituttnivå vedlegges.*
Endring av dato for anonymisering av datamaterialet: 12.04.2020	*Ved forlengelse på mer enn ett år utover det deltakerne er informert om, skal det fortrinnsvis gis ny informasjon til deltakerne.*
Gis det ny informasjon til utvalget? Ja: ____ Nei: ___x_ Hvis nei, begrunn: Utvalget består av tre ulike grupper. Denne forlenga anonymiseringa vil berre råke 2 grupper som er informert om denne nye datoen. Det første utvalget vil bli anonymisert innen original oppgjett frist.	
Endring av metode(r):	*Angi hvilke nye metoder som skal benyttes, f.eks. intervju, spørreskjema, observasjon, registerdata, osv.*
Endring av utvalg:	*Dersom det er snakk om små endringer i antall deltakere er endringsmelding som regel ikke nødvendig. Ta kontakt på telefon før du sender inn skjema dersom du er i tvil.*
Annet: Mari Jacoby Steina Lilleng og Katrine Ask er masterstudentar ved studieprogrammet Master i Helsefremmende arbeid og helsepsykologi ved UiB og vil skrive masteroppgåva si som ein del av prosjektet. Dei blir veileda av dagleg ansvarleg PhD kandidat Olin Blaalid Oldeide og Professor Elisabeth Fosse som biveileder. Studentane vil delta i samband med dagleg ansvarleg i datainnsamlinga med fokusgruppediskusjonen og transkribere dette materialet. Studentane vil nytte delar av denne innsamla dataen frå prosjektet som omhandlar ungdom som er organisert i utekontakten. Studentane vil skrive masteroppgåva innanfor det eksisterande prosjektet med eit utvida fokus på eit resursperspektiv på ungdom. Vi har også inkludere at deltakarane sine utgifter for transport og anna vil bli dekket av prosjektet.	

3. TILLEGGSOPPLYSNINGER

4. ANTALL VEDLEGG

Revidert informasjonsskriv til ungdom.	*Legg ved eventuelle nye vedlegg (informasjonsskriv, intervjuguide, spørreskjema, tillatelser, og liknende.)*

Avsender: Sentralarkivet i Bergen kommune
Postboks 7700
5020 Bergen

Olin Blaalid Oldeide
Postboks 7807
5020 BERGEN

Vedr. prosjektet rusforebygging i Bergen kommune

Dokumentet følger vedlagt. Du kan nå lese de fleste brev fra Bergen kommune i din digitale postkasse !

•Brev til deg selv
For å lese brev til deg selv må du opprette en digital postkasse. Det er enkelt og gratis på denne siden: https://www.norge.no/nb/velg-digital-postkasse

•Brev til bedrift/organisasjon
Du kan lese brev til bedriften/organisasjonen i meldingsboksen i Altinn: https://www.altinn.no Under «Profil, roller og rettigheter» kan du se om kontaktinformasjonen er riktig, eventuelt legge til kontaktinformasjon. Her kan du også delegere rollen «Post/arkiv» dersom du ønsker at en annen person skal lese post på vegne av bedriften/organisasjonen.

BERGEN
KOMMUNE

BYRÅDSAVDELING FOR HELSE OG OMSORG
Bergen Rådhus
Postboks 7700, 5020 Bergen
Sentralbord 05556
Telefaks 55 56 74 99
postmottak.helse.sosial@bergen.kommune.no
www.bergen.kommune.no

Olin Blaalid Oldeide
Postboks 7807
5020 BERGEN

Deres ref.	Deres brev av:	Vår ref.	Emnekode	Dato
		201700048-15 MSSO	ESARK-40	01. august 2017

Vedr. prosjektet rusforebygging i Bergen kommune

Det vises til forespørsel om deltakelse i doktorgradsprosjekt om rusforebygging rettet mot unge i Bergen kommune.

Vi har mottatt dokumentasjon på at Personvernombudet for forskning, NSD AS, har godkjent prosjektet. Vi har registrert at innsamlede data anonymiseres ved prosjektslutt 12.4.2019.

Byrådsavdeling for helse og omsorg godkjenner med dette at prosjektet gjennomføres i samsvar med det som er beskrevet i søknaden og fremlagt dokumentasjon dersom etaten og resultatenhetene finner at de har ressurser til gjennomføring. Vi forutsetter at utleverte data ikke anvendes for andre formål enn det som er her er søkt om.

Kontaktpersoner i det videre arbeidet er leder ved Utekontakten i Bergen, Joachim Bjerkvik.

Bergen kommune ser frem til å motta et eksemplar av ph.d.-avhandlingen når denne foreligger.

Vi ønsker deg lykke til med arbeidet.

Med hilsen

BYRÅDSAVDELING FOR HELSE OG OMSORG

Marianne Nikolaisen Solbakk - saksbehandler
Benedicte Løseth - seksjonssjef

Dette dokumentet er godkjent elektronisk.

UNIVERSITETET I BERGEN

Førespurnad om deltaking i forskingsprosjektet «Rusførebygging i Bergen kommune»

Bakgrunn og formål

Formålet med dette forskingsprosjektet er å få kunnskap om korleis rusførebyggande politikk vert utarbeida og implementert på ulike nivå i den kommunale organisasjonen. Vi ynskjer difor å gjere personlege intervju med tilsette i den kommunale leiinga og tilsette i dei relevante tenesteområda. I tillegg vil ein ha fokusgrupper med ungdomar som deltek i ulike rusførebyggande tiltak. Vi vil også gjere dokumentanalyser av kommunale plan- og styringsdokument med relevans for rusførebyggande arbeid. Dette forskingsprosjektet er ein doktorgradsstudie ved Universitet i Bergen.

Kva inneberer det å delta i studien?

For at vi skal forstå korleis ein arbeider rusførebyggande i Bergen kommune trur vi at du kan gje oss viktig informasjon og vi vil setje stor pris på om du kan delta på eit intervju. Intervjuet vil vare i ca. ein time og omhandlar dine erfaringar og tankar kring tema som: rusførebyggande tiltak og samarbeid i arbeidet med rusførebygging. Det vil verte nytta lydopptak under intervjua for å betre hugse kva som vart sagt.

Kva skjer med informasjonen om deg?

Prosjektet skal vere avslutta 12.04.2020 og då vil datamaterialet vere anonymisert og alle lydopptak vil vere sletta. Fram til då er det berre underteikna som har tilgang til materialet. Prosjektet er meldt inn til Personvernombudet for forsking, Norsk samfunnsvitskapleg datatjeneste AS. Stillingskildring og kommunenamn vil kunne nyttast i publikasjonar. Vi vil så langt det er mogleg unngå gjenkjenning i publikasjonar, men det vil moglegvis vere indirekte gjenkjennbar data som bakgrunn og erfaring. Difor vil vi gjerne gje deg anledning til å godkjenne bruk av sitat der det er mogleg å gjennkjenne deg.

Frivillig deltaking

Deltaking i prosjektet er frivillig og du kan velje å trekke deg så lenge studien pågår. I slike tilfeller så vil alle opplysingar verte sletta med det same.

APPENDIX C: Example of an informed consent form for individual interviews

UNIVERSITETET I BERGEN

Dersom du har spørsmål, ta kontakt med Ph.d. stipendiat Olin Blaalid Oldeide

Olin Blaalid Oldeide, Ph.d. Stipendiat ved Universitet i Bergen (UiB)
e-post: Olin.Oldeide@uib.no
Telefon: 924 62 636
Adresse: Christies gate 13, 5020 Bergen

Hovudrettleiar: Elisabeth Fosse, Professor ved Universitet i Bergen
e-post: Elisabeth.Fosse@uib.no
Telefon: 555 82 758

Samtykke til deltaking i studien

Eg har motteke informasjon om studien, og er villig til å delta

---

(Signert av prosjektdeltakar, dato)

APPENDIX D: Example of interview guide for policy makers:

Intervjuguide til politisk- og administrativt tilsette i Bergen kommune

Innleiing:

Opplysningar om deltakaren

- Kor lenge har du arbeida i denne jobben og eventuelt i andre liknande stillingar?
- Kva fagleg bakgrunn har du?

Korleis er du involvert i rusførebyggande arbeid i kommunen?

Utviklingsprosessen av rusførebyggande politikk

- Kva aktørar deltek når ein utviklar rusførebyggande politikk?
- Er målgruppa involvert?
- Kven utfører strategien? Utekontakten? Andre?
- Legitimitet:
    - I kva grad er det rusførebyggande arbeide prioritert?
    - Er det skilnad mellom avdelingane og einingane?
    - Kven er viktige pådrivarar?
    - Kva rolle har politikarane?
    - Er det skilnad mellom dei ulike partia?

Rusførebyggande strategi og tiltak

- Kva er bakgrunnen for å lage ein ruspolitisk handlingsplan?
- Kva er de viktigaste prinsippa for arbeidet
- Kva kjenneteiknar måten ein arbeider i Bergen med rusførebygging?
- Utfordringar og suksessar innan rusførebyggingsarbeidet?
- Kva er målet med strategien?
- Kva rusførebyggande tiltak eksisterer?
- Kva karakteriserer tiltak utvikla i Bergen?
- Kva ressursar vert via til abeidet?
- På kva nivå vert det forankra?

Implementeringsprosessen

- Kan du ta meg gjennom korleis ein den overordna rusførebyggande strategien vert implementert utover i organisasjonen steg for steg?

Samspelet

- Kva skal til for å lage gode mål for det rusførebyggande arbeidet?
- Kven er involvert?

- Kven har eigarforhold til denne typen arbeid?
- Kva kjenneteiknar samarbeidet mellom einingane på bystyrenivå?
- Kva kjenneteiknar samarbeidet med Utekontakten? Utførarar?
- Korleis vert målgruppa for arbeidet involvert?
- På kva nivå driv ein med samarbeidet?
- Kor formalisert er dette? Fast møteplass? Kven deltek?

Rekruttering til russcener

- Kva gjer ein i Bergen kommune for å hindre rekruttering til russcener i Bergen?
- Kva tenker du er viktig å gjere framover for å hindre rekruttering til opne russcener?

Har du noko du vil legge til?

APPENDIX E: Example of interview guide with outreach social worker:

Intervjuguide til tilsette ved Utekontakten

Opplysningar om deltakaren

- Kor lenge har du arbeida i denne jobben og eventuelt i andre liknande stillingar?
- Kva fagleg bakgrunn har du?

Korleis er du involvert i rusførebyggande arbeid i kommunen?

Utekontaken generelt

- Korleis arbeider Utekontaken rusførebyggande?
- Kva er mandatet til utekontakten?
- Kven påverka korleis dykk arbeider? (vert ein styrt av politiske føringar? Handlingsplanar? Feltet? Eigne interesser?)
- Påverker dykk i utekontakten Bergen kommune sin politikk? (korleis?)
    - Deltek det i planarbeid? (f.eks: ruspolitisk handlingsplan)
- Korleis vert målgruppa for arbeidet involvert?
- Beskriv korleis dette tiltaket arbeider rusførebyggande?

Rusførebyggande strategi og tiltak

- Kva er de viktigaste prinsippa for arbeidet
    - I kva grad er det rusførebyggande arbeide prioritert?
    - Er det skilnad mellom einingane?
    - Kven er viktige pådrivarar?
- Kva kjenneteiknar måten ein arbeider i Bergen med rusførebygging?
- Utfordringar innan rusførebyggingsarbeidet?
- Suksessar innan rusførebyggingsarbeidet?
-

Samarbeid

- Kor viktig er samarbeid i det rusførebyggande arbeidet utekontakten driv?
- Kven er det de i Utekontakten samarbeider med?
- Korleis er samspelet mellom utekontakten og byrådsavdeling for helse og omsorg?
- Korleis er samspelet mellom utekontakten og andre byrådsavdelingar?
- Kva kjenneteiknar samarbeidet mellom Utekontakten og etat for barn og familie?
- Samarbeid med SLT-koordinatorar?
- Barrierar i samarbeidet?

Rekruttering til russcener

- Kva gjer ein i Bergen kommune for å hindre rekruttering til russcener i Bergen?

- Kva tenker du er viktig å gjere framover for å hindre rekruttering til opne russcener?

Har du noko du vil legge til?

APPENDIX: F Example of thematic guide for focus groups

Temaguide:

Velkommen
Introduksjon av oss (fasilitator og med-fasilitator). Formålet med denne fokusgruppen er at vi ønsker å lære mer om hva dere tenker om rusforebygging og utekontakten.

Informasjon om fokusgruppen:

- Rollen til fasilitator. Stille spørsmål og oppmuntre til diskusjon. Forklare om noe er uklart. Medfasilitator vil ta notater (for å huske hvem som sier hva).
- Målet er at dere diskuterer dere imellom. Vi ønsker at alle snakker. Om du ikke har sagt noe på en stund så kan du bli spurt direkte
- Tid satt av til fokusgruppen (1,5 til 2 timer)
- Du trenger ikke å dele personlige erfaringer, men kan gjerne snakke generelt om temaet
- Det er ikke noe rett eller feil svar på spørsmål. Alle sine erfaringer er viktige og om du er uenig eller enig med noe så si i fra. Vi ønsker å høre mange forskjellige meininger.

Informert samtykke:
Bruk et kvarter til å skrive under informert samtykke skjema.

- Det er bare vi som har tilgang til det dere sier og vi vil ikke bruke navnene deres når vi skriver om dette så dere vil være anonyme.
- Vi bruker en båndopptaker for å bedre huske hva som blir sagt og tar notater
- Alle som deltar her har taushetsplikt for det som blir sagt
- Du kan gi deg når som helst uten at du trenger å forklare hvorfor
- Vi jobber ikke i utekontakten, det dere sier vil ikke ha påvirkning på ditt forhold til utekontakten. Ingen i utekontakten vil vite om du trekker deg.
- For å dekke reiseutgifter får dere 200,- etter fokusgruppen.

Innledede spørsmål

- Hva er det som kjennetegner det å være ung i dag? (Forskjell på ungdom og foreldre?)
- Hva tenker dere det er som gjør at ungdommer bruker alkohol og andre rusmidler?
- Hvor mye tenker dere alkohol og andre rusmidler påvirker ungdommer sitt hverdagsliv?

Utekontakten og rusforebygging

- Hvem er i kontakt med utekontakten? Hva kjennetegner dem?
- Hva er det med Utekontakten som gjør at ungdom ønsker å ha kontakt med dem?
- Forebygger utekontakten rusbruk blant unge? Hvordan?
- Hva tilbyr utekontakten til ungdom som andre tiltak ikke får til?
- Føler dere dere forstått og hørt av de som jobber i utekontakten? Hvordan?
- Om du bestemte over kommunen, hva ville dere gjort for å hindre at ungdom utviklet dårlige rusvaner?

Utekontakten og ressurser

- Hva tenker dere når vi snakker om ressurser? Hvilke ressurser tror dere er viktige for ungdom?

- Er det noe som skiller ressursene til ungdom i utekontakten fra ressursene til ungdom ellers?
- Mange ungdom opplever vanskelige situasjoner i hverdagen. Hva tror dere gjør at de likevel klarer seg?
- Opplever dere at utekontakten klarer å fange opp ressursene til ungdommen som er i kontakt med dem?
    - Hvis ja: Hva gjør de for å få det til?/Hva er det de gjør som fungerer?
    - Hvis nei: Hva skulle vært gjort annerledes for å få det til?

Avsluttende spørsmål:

- Har dere noe å tilføye?

UNIVERSITETET I BERGEN

Vil du delta i forskningsprosjektet «Rusforebygging i Bergen kommune»?

Hvorfor gjør vi denne studien?

Vi ønsker å få om hvordan rusforebyggende politikk blir laga og gjennomført på ulike nivå i Bergen kommune. For å få en best mulig forståelse av dette så vil vi blant anna gjennomføre en fokusgruppediskusjon med en gruppe ungdom som har kjennskap til Utekontakten sine tjenester. Forskingsprosjektet inngår som en del av en doktorgradsstudie ved Universitet i Bergen.

Hva innebærer det å delta i studien?

Vi vil gjerne at du skal delta i en gruppediskusjon der vi vil spør om hva tanker dere som ungdommer har om rusforebygging. Der vil vi stille spørsmål som handler om rusforebygging og Utekontakten sitt arbeid.

Som deltaker trenger du ikke å dele personlige erfaringer, men vi vil gjerne at du forteller generelt om tanker du har om disse temaene. Vi vil bruke en bandopptaker under diskusjonen for å hjelpe oss å huske hva som bli sagt.

Alle som deltar har taushetsplikt for alt som blir diskutert i løpet av gruppediskusjonen. Om du velger å delta i studien vil det ikke ho noen konsekvenser for ditt forhold med Utekontakten.

Vi trur at du kan gi oss viktig informasjon og vi vil sette stor pris på om du kan delta. Fokusgruppa vil vare i ca. 2 timer og der vil være 5-8 personer i alderen 16 og oppover. Utgifter til transport og lignende vil bli dekket.

Hva skjer med informasjonen om deg?

Datamaterialet vil lagres konfidensielt og det er bare forskerne i prosjektgruppen som har tilgang. Prosjektet skal være avsluttet 12.04.2020 og da vil datamaterialet være anonymisert og alle lydopptak er slettet. Prosjektet er meldt inn til Personvernombudet for forsking, Norsk samfunnsvitenskapelig datatjeneste AS som et ledd for å sikre personvernet ditt. Du vil ikke kunne gjenkjennes i publikasjoner i forbindelse med forskingsprosjektet.

Frivillig deltaking

UNIVERSITETET I BERGEN

Deltaking i prosjektet er frivillig og du kan velge å trekke deg så lenge studien pågår. I slike tilfeller så vil alle opplysninger bli slettet med en gang.

Dersom du har spørsmål, ta kontakt med Ph.d. stipendiat Olin Blaalid Oldeide

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Biveileder: Ingrid Holsen, Professor ved Universitet i Bergen
Epost: Ingrdi.Holsen@uib.no
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Masterstudent: Mari Jacoby Steina Lilleng
Epost: Mari.lilleng@student.uib.no

Masterstudent: Katrine Ask
Epost: Katrine.Ask@student.uib.no

Samtykke til deltaking i studien

Jeg har mottatt informasjon om studien, og er villig til å delta

APPENDIX G: Example of an informed consent form for focus groups

UNIVERSITETET I BERGEN

(Signert av prosjektdeltaker, dato)

Doctoral Theses at The Faculty of Psychology, University of Bergen

1980	Allen, Hugh M., Dr. philos.	Parent-offspring interactions in willow grouse (Lagopus L. Lagopus).
1981	Myhrer, Trond, Dr. philos.	Behavioral Studies after selective disruption of hippocampal inputs in albino rats.
1982	Svebak, Sven, Dr. philos.	The significance of motivation for task-induced tonic physiological changes.
1983	Myhre, Grete, Dr. philos.	The Biopsychology of behavior in captive Willow ptarmigan.
	Eide, Rolf, Dr. philos.	PSYCHOSOCIAL FACTORS AND INDICES OF HEALTH RISKS. The relationship of psychosocial conditions to subjective complaints, arterial blood pressure, serum cholesterol, serum triglycerides and urinary catecholamines in middle aged populations in Western Norway.
	Værnes, Ragnar J., Dr. philos.	Neuropsychological effects of diving.
1984	Kolstad, Arnulf, Dr. philos.	Til diskusjonen om sammenhengen mellom sosiale forhold og psykiske strukturer. En epidemiologisk undersøkelse blant barn og unge.
	Løberg, Tor, Dr. philos.	Neuropsychological assessment in alcohol dependence.
1985	Hellesnes, Tore, Dr. philos.	Læring og problemløsning. En studie av den perseptuelle analysens betydning for verbal læring.
	Håland, Wenche, Dr. philos.	Psykoterapi: relasjon, utviklingsprosess og effekt.
1986	Hagtvet, Knut A., Dr. philos.	The construct of test anxiety: Conceptual and methodological issues.
	Jellestad, Finn K., Dr. philos.	Effects of neuron specific amygdala lesions on fear-motivated behavior in rats.
1987	Aarø, Leif E., Dr. philos.	Health behaviour and sosioeconomic Status. A survey among the adult population in Norway.
	Underlid, Kjell, Dr. philos.	Arbeidsløyse i psykososialt perspektiv.
	Laberg, Jon C., Dr. philos.	Expectancy and classical conditioning in alcoholics' craving.
	Vollmer, Fred, Dr. philos.	Essays on explanation in psychology.
	Ellertsen, Bjørn, Dr. philos.	Migraine and tension headache: Psychophysiology, personality and therapy.
1988	Kaufmann, Astrid, Dr. philos.	Antisosial atferd hos ungdom. En studie av psykologiske determinanter.

	Mykletun, Reidar J., Dr. philos.	Teacher stress: personality, work-load and health.
	Havik, Odd E., Dr. philos.	After the myocardial infarction: A medical and psychological study with special emphasis on perceived illness.
1989	Bråten, Stein, Dr. philos.	Menneskedyaden. En teoretisk tese om sinnets dialogiske natur med informasjons- og utviklingspsykologiske implikasjoner sammenholdt med utvalgte spedbarnsstudier.
	Wold, Bente, Dr. psychol.	Lifestyles and physical activity. A theoretical and empirical analysis of socialization among children and adolescents.
1990	Flaten, Magne A., Dr. psychol.	The role of habituation and learning in reflex modification.
1991	Alsaker, Françoise D., Dr. philos.	Global negative self-evaluations in early adolescence.
	Kraft, Pål, Dr. philos.	AIDS prevention in Norway. Empirical studies on diffusion of knowledge, public opinion, and sexual behaviour.
	Endresen, Inger M., Dr. philos.	Psychoimmuniological stress markers in working life.
	Faleide, Asbjørn O., Dr. philos.	Asthma and allergy in childhood. Psychosocial and psychotherapeutic problems.
1992	Dalen, Knut, Dr. philos.	Hemispheric asymmetry and the Dual-Task Paradigm: An experimental approach.
	Bø, Inge B., Dr. philos.	Ungdoms sosiale økologi. En undersøkelse av 14-16 åringers sosiale nettverk.
	Nivison, Mary E., Dr. philos.	The relationship between noise as an experimental and environmental stressor, physiological changes and psychological factors.
	Torgersen, Anne M., Dr. philos.	Genetic and environmental influence on temperamental behaviour. A longitudinal study of twins from infancy to adolescence.
1993	Larsen, Svein, Dr. philos.	Cultural background and problem drinking.
	Nordhus, Inger Hilde, Dr. philos.	Family caregiving. A community psychological study with special emphasis on clinical interventions.
	Thuen, Frode, Dr. psychol.	Accident-related behaviour among children and young adolescents: Prediction and prevention.
	Solheim, Ragnar, Dr. philos.	Spesifikke lærevansker. Diskrepanskriteriet anvendt i seleksjonsmetodikk.
	Johnsen, Bjørn Helge, Dr. psychol.	Brain assymetry and facial emotional expressions: Conditioning experiments.
1994	Tønnessen, Finn E., Dr. philos.	The etiology of Dyslexia.
	Kvale, Gerd, Dr. psychol.	Psychological factors in anticipatory nausea and vomiting in cancer chemotherapy.

	Asbjørnsen, Arve E., Dr. psychol.	Structural and dynamic factors in dichotic listening: An interactional model.
	Bru, Edvin, Dr. philos.	The role of psychological factors in neck, shoulder and low back pain among female hospitale staff.
	Braathen, Eli T., Dr. psychol.	Prediction of exellence and discontinuation in different types of sport: The significance of motivation and EMG.
	Johannessen, Birte F., Dr. philos.	Det flytende kjønnet. Om lederskap, politikk og identitet.
1995	Sam, David L., Dr. psychol.	Acculturation of young immigrants in Norway: A psychological and socio-cultural adaptation.
	Bjaalid, Inger-Kristin, Dr. philos.	Component processes in word recognition.
	Martinsen, Øyvind, Dr. philos.	Cognitive style and insight.
	Nordby, Helge, Dr. philos.	Processing of auditory deviant events: Mismatch negativity of event-related brain potentials.
	Raaheim, Arild, Dr. philos.	Health perception and health behaviour, theoretical considerations, empirical studies, and practical implications.
	Seltzer, Wencke J., Dr. philos.	Studies of Psychocultural Approach to Families in Therapy.
	Brun, Wibecke, Dr. philos.	Subjective conceptions of uncertainty and risk.
	Aas, Henrik N., Dr. psychol.	Alcohol expectancies and socialization: Adolescents learning to drink.
	Bjørkly, Stål, Dr. psychol.	Diagnosis and prediction of intra-institutional aggressive behaviour in psychotic patients
1996	Anderssen, Norman, Dr. psychol.	Physical activity of young people in a health perspective: Stability, change and social influences.
	Sandal, Gro Mjeldheim, Dr. psychol.	Coping in extreme environments: The role of personality.
	Strumse, Einar, Dr. philos.	The psychology of aesthetics: explaining visual preferences for agrarian landscapes in Western Norway.
	Hestad, Knut, Dr. philos.	Neuropsychological deficits in HIV-1 infection.
	Lugoe, L.Wycliffe, Dr. philos.	Prediction of Tanzanian students' HIV risk and preventive behaviours
	Sandvik, B. Gunnhild, Dr. philos.	Fra distriktsjordmor til institusjonsjordmor. Fremveksten av en profesjon og en profesjonsutdanning
	Lie, Gro Therese, Dr. psychol.	The disease that dares not speak its name: Studies on factors of importance for coping with HIV/AIDS in Northern Tanzania
	Øygard, Lisbet, Dr. philos.	Health behaviors among young adults. A psychological and sociological approach
	Stormark, Kjell Morten, Dr. psychol.	Emotional modulation of selective attention: Experimental and clinical evidence.

	Einarsen, Ståle, Dr. psychol.	Bullying and harassment at work: epidemiological and psychosocial aspects.
1997	Knivsberg, Ann-Mari, Dr. philos.	Behavioural abnormalities and childhood psychopathology: Urinary peptide patterns as a potential tool in diagnosis and remediation.
	Eide, Arne H., Dr. philos.	Adolescent drug use in Zimbabwe. Cultural orientation in a global-local perspective and use of psychoactive substances among secondary school students.
	Sørensen, Marit, Dr. philos.	The psychology of initiating and maintaining exercise and diet behaviour.
	Skjæveland, Oddvar, Dr. psychol.	Relationships between spatial-physical neighborhood attributes and social relations among neighbors.
	Zewdie, Teka, Dr. philos.	Mother-child relational patterns in Ethiopia. Issues of developmental theories and intervention programs.
	Wilhelmsen, Britt Unni, Dr. philos.	Development and evaluation of two educational programmes designed to prevent alcohol use among adolescents.
	Manger, Terje, Dr. philos.	Gender differences in mathematical achievement among Norwegian elementary school students.
1998 **V**	Lindstrøm, Torill Christine, Dr. philos.	«Good Grief»: Adapting to Bereavement.
	Skogstad, Anders, Dr. philos.	Effects of leadership behaviour on job satisfaction, health and efficiency.
	Haldorsen, Ellen M. Håland, Dr. psychol.	Return to work in low back pain patients.
	Besemer, Susan P., Dr. philos.	Creative Product Analysis: The Search for a Valid Model for Understanding Creativity in Products.
H	Winje, Dagfinn, Dr. psychol.	Psychological adjustment after severe trauma. A longitudinal study of adults' and children's posttraumatic reactions and coping after the bus accident in Måbødalen, Norway 1988.
	Vosburg, Suzanne K., Dr. philos.	The effects of mood on creative problem solving.
	Eriksen, Hege R., Dr. philos.	Stress and coping: Does it really matter for subjective health complaints?
	Jakobsen, Reidar, Dr. psychol.	Empiriske studier av kunnskap og holdninger om hiv/aids og den normative seksuelle utvikling i ungdomsårene.
1999 **V**	Mikkelsen, Aslaug, Dr. philos.	Effects of learning opportunities and learning climate on occupational health.
	Samdal, Oddrun, Dr. philos.	The school environment as a risk or resource for students' health-related behaviours and subjective well-being.
	Friestad, Christine, Dr. philos.	Social psychological approaches to smoking.
	Ekeland, Tor-Johan, Dr. philos.	Meining som medisin. Ein analyse av placebofenomenet og implikasjoner for terapi og terapeutiske teoriar.

H	Saban, Sara, Dr. psychol.	Brain Asymmetry and Attention: Classical Conditioning Experiments.
	Carlsten, Carl Thomas, Dr. philos.	God lesing – God læring. En aksjonsrettet studie av undervisning i fagtekstlesing.
	Dundas, Ingrid, Dr. psychol.	Functional and dysfunctional closeness. Family interaction and children's adjustment.
	Engen, Liv, Dr. philos.	Kartlegging av leseferdighet på småskoletrinnet og vurdering av faktorer som kan være av betydning for optimal leseutvikling.
2000 V	Hovland, Ole Johan, Dr. philos.	Transforming a self-preserving "alarm" reaction into a self-defeating emotional response: Toward an integrative approach to anxiety as a human phenomenon.
	Lillejord, Sølvi, Dr. philos.	Handlingsrasjonalitet og spesialundervisning. En analyse av aktørperspektiver.
	Sandell, Ove, Dr. philos.	Den varme kunnskapen.
	Oftedal, Marit Petersen, Dr. philos.	Diagnostisering av ordavkodingsvansker: En prosessanalytisk tilnærmingsmåte.
H	Sandbak, Tone, Dr. psychol.	Alcohol consumption and preference in the rat: The significance of individual differences and relationships to stress pathology
	Eid, Jarle, Dr. psychol.	Early predictors of PTSD symptom reporting; The significance of contextual and individual factors.
2001 V	Skinstad, Anne Helene, Dr. philos.	Substance dependence and borderline personality disorders.
	Binder, Per-Einar, Dr. psychol.	Individet og den meningsbærende andre. En teoretisk undersøkelse av de mellommenneskelige forutsetningene for psykisk liv og utvikling med utgangspunkt i Donald Winnicotts teori.
	Roald, Ingvild K., Dr. philos.	Building of concepts. A study of Physics concepts of Norwegian deaf students.
H	Fekadu, Zelalem W., Dr. philos.	Predicting contraceptive use and intention among a sample of adolescent girls. An application of the theory of planned behaviour in Ethiopian context.
	Melesse, Fantu, Dr. philos.	The more intelligent and sensitive child (MISC) mediational intervention in an Ethiopian context: An evaluation study.
	Råheim, Målfrid, Dr. philos.	Kvinners kroppserfaring og livssammenheng. En fenomenologisk – hermeneutisk studie av friske kvinner og kvinner med kroniske muskelsmerter.
	Engelsen, Birthe Kari, Dr. psychol.	Measurement of the eating problem construct.
	Lau, Bjørn, Dr. philos.	Weight and eating concerns in adolescence.
2002 V	Ihlebæk, Camilla, Dr. philos.	Epidemiological studies of subjective health complaints.

	Rosén, Gunnar O. R., Dr. philos.	The phantom limb experience. Models for understanding and treatment of pain with hypnosis.
	Høines, Marit Johnsen, Dr. philos.	Fleksible språkrom. Matematikklæring som tekstutvikling.
	Anthun, Roald Andor, Dr. philos.	School psychology service quality. Consumer appraisal, quality dimensions, and collaborative improvement potential
	Pallesen, Ståle, Dr. psychol.	Insomnia in the elderly. Epidemiology, psychological characteristics and treatment.
	Midthassel, Unni Vere, Dr. philos.	Teacher involvement in school development activity. A study of teachers in Norwegian compulsory schools
	Kallestad, Jan Helge, Dr. philos.	Teachers, schools and implementation of the Olweus Bullying Prevention Program.
H	Ofte, Sonja Helgesen, Dr. psychol.	Right-left discrimination in adults and children.
	Netland, Marit, Dr. psychol.	Exposure to political violence. The need to estimate our estimations.
	Diseth, Åge, Dr. psychol.	Approaches to learning: Validity and prediction of academic performance.
	Bjuland, Raymond, Dr. philos.	Problem solving in geometry. Reasoning processes of student teachers working in small groups: A dialogical approach.
2003 V	Arefjord, Kjersti, Dr. psychol.	After the myocardial infarction – the wives' view. Short- and long-term adjustment in wives of myocardial infarction patients.
	Ingjaldsson, Jón Þorvaldur, Dr. psychol.	Unconscious Processes and Vagal Activity in Alcohol Dependency.
	Holden, Børge, Dr. philos.	Følger av atferdsanalytiske forklaringer for atferdsanalysens tilnærming til utforming av behandling.
	Holsen, Ingrid, Dr. philos.	Depressed mood from adolescence to 'emerging adulthood'. Course and longitudinal influences of body image and parent-adolescent relationship.
	Hammar, Åsa Karin, Dr. psychol.	Major depression and cognitive dysfunction- An experimental study of the cognitive effort hypothesis.
	Sprugevica, Ieva, Dr. philos.	The impact of enabling skills on early reading acquisition.
	Gabrielsen, Egil, Dr. philos.	LESE FOR LIVET. Lesekompetansen i den norske voksenbefolkningen sett i lys av visjonen om en enhetsskole.
H	Hansen, Anita Lill, Dr. psychol.	The influence of heart rate variability in the regulation of attentional and memory processes.
	Dyregrov, Kari, Dr. philos.	The loss of child by suicide, SIDS, and accidents: Consequences, needs and provisions of help.
2004 V	Torsheim, Torbjørn, Dr. psychol.	Student role strain and subjective health complaints: Individual, contextual, and longitudinal perspectives.

	Haugland, Bente Storm Mowatt Dr. psychol.	Parental alcohol abuse. Family functioning and child adjustment.
	Milde, Anne Marita, Dr. psychol.	Ulcerative colitis and the role of stress. Animal studies of psychobiological factors in relationship to experimentally induced colitis.
	Stornes, Tor, Dr. philos.	Socio-moral behaviour in sport. An investigation of perceptions of sportspersonship in handball related to important factors of socio-moral influence.
	Mæhle, Magne, Dr. philos.	Re-inventing the child in family therapy: An investigation of the relevance and applicability of theory and research in child development for family therapy involving children.
	Kobbeltvedt, Therese, Dr. psychol.	Risk and feelings: A field approach.
2004 H	Thomsen, Tormod, Dr. psychol.	Localization of attention in the brain.
	Løberg, Else-Marie, Dr. psychol.	Functional laterality and attention modulation in schizophrenia: Effects of clinical variables.
	Kyrkjebø, Jane Mikkelsen, Dr. philos.	Learning to improve: Integrating continuous quality improvement learning into nursing education.
	Laumann, Karin, Dr. psychol.	Restorative and stress-reducing effects of natural environments: Experiencal, behavioural and cardiovascular indices.
	Holgersen, Helge, PhD	Mellom oss - Essay i relasjonell psykoanalyse.
2005 V	Hetland, Hilde, Dr. psychol.	Leading to the extraordinary? Antecedents and outcomes of transformational leadership.
	Iversen, Anette Christine, Dr. philos.	Social differences in health behaviour: the motivational role of perceived control and coping.
2005 H	Mathisen, Gro Ellen, PhD	Climates for creativity and innovation: Definitions, measurement, predictors and consequences.
	Sævi, Tone, Dr. philos.	Seeing disability pedagogically – The lived experience of disability in the pedagogical encounter.
	Wiium, Nora, PhD	Intrapersonal factors, family and school norms: combined and interactive influence on adolescent smoking behaviour.
	Kanagaratnam, Pushpa, PhD	Subjective and objective correlates of Posttraumatic Stress in immigrants/refugees exposed to political violence.
	Larsen, Torill M. B. , PhD	Evaluating principals` and teachers` implementation of Second Step. A case study of four Norwegian primary schools.
	Bancila, Delia, PhD	Psychosocial stress and distress among Romanian adolescents and adults.
2006 V	Hillestad, Torgeir Martin, Dr. philos.	Normalitet og avvik. Forutsetninger for et objektivt psykopatologisk avviksbegrep. En psykologisk, sosial, erkjennelsesteoretisk og teorihistorisk framstilling.

	Nordanger, Dag Øystein, Dr. psychol.	Psychosocial discourses and responses to political violence in post-war Tigray, Ethiopia.
	Rimol, Lars Morten, PhD	Behavioral and fMRI studies of auditory laterality and speech sound processing.
	Krumsvik, Rune Johan, Dr. philos.	ICT in the school. ICT-initiated school development in lower secondary school.
	Norman, Elisabeth, Dr. psychol.	Gut feelings and unconscious thought: An exploration of fringe consiousness in implicit cognition.
	Israel, K Pravin, Dr. psychol.	Parent involvement in the mental health care of children and adolescents. Emperical studies from clinical care setting.
	Glasø, Lars, PhD	Affects and emotional regulation in leader-subordinate relationships.
	Knutsen, Ketil, Dr. philos.	HISTORIER UNGDOM LEVER – En studie av hvordan ungdommer bruker historie for å gjøre livet meningsfullt.
	Matthiesen, Stig Berge, PhD	Bullying at work. Antecedents and outcomes.
2006 H	Gramstad, Arne, PhD	Neuropsychological assessment of cognitive and emotional functioning in patients with epilepsy.
	Bendixen, Mons, PhD	Antisocial behaviour in early adolescence: Methodological and substantive issues.
	Mrumbi, Khalifa Maulid, PhD	Parental illness and loss to HIV/AIDS as experienced by AIDS orphans aged between 12-17 years from Temeke District, Dar es Salaam, Tanzania: A study of the children's psychosocial health and coping responses.
	Hetland, Jørn, Dr. psychol.	The nature of subjective health complaints in adolescence: Dimensionality, stability, and psychosocial predictors
	Kakoko, Deodatus Conatus Vitalis, PhD	Voluntary HIV counselling and testing service uptake among primary school teachers in Mwanza, Tanzania: assessment of socio-demographic, psychosocial and socio-cognitive aspects
	Mykletun, Arnstein, Dr. psychol.	Mortality and work-related disability as long-term consequences of anxiety and depression: Historical cohort designs based on the HUNT-2 study
	Sivertsen, Børge, PhD	Insomnia in older adults. Consequences, assessment and treatment.
2007 V	Singhammer, John, Dr. philos.	Social conditions from before birth to early adulthood – the influence on health and health behaviour
	Janvin, Carmen Ani Cristea, PhD	Cognitive impairment in patients with Parkinson's disease: profiles and implications for prognosis
	Braarud, Hanne Cecilie, Dr.psychol.	Infant regulation of distress: A longitudinal study of transactions between mothers and infants
	Tveito, Torill Helene, PhD	Sick Leave and Subjective Health Complaints

	Magnussen, Liv Heide, PhD	Returning disability pensioners with back pain to work
	Thuen, Elin Marie, Dr.philos.	Learning environment, students' coping styles and emotional and behavioural problems. A study of Norwegian secondary school students.
	Solberg, Ole Asbjørn, PhD	Peacekeeping warriors – A longitudinal study of Norwegian peacekeepers in Kosovo
2007 H	Søreide, Gunn Elisabeth, Dr.philos.	Narrative construction of teacher identity
	Svensen, Erling, PhD	WORK & HEALTH. Cognitive Activation Theory of Stress applied in an organisational setting.
	Øverland, Simon Nygaard, PhD	Mental health and impairment in disability benefits. Studies applying linkages between health surveys and administrative registries.
	Eichele, Tom, PhD	Electrophysiological and Hemodynamic Correlates of Expectancy in Target Processing
	Børhaug, Kjetil, Dr.philos.	Oppseding til demokrati. Ein studie av politisk oppseding i norsk skule.
	Eikeland, Thorleif, Dr.philos.	Om å vokse opp på barnehjem og på sykehus. En undersøkelse av barnehjemsbarns opplevelser på barnehjem sammenholdt med sanatoriebarns beskrivelse av langvarige sykehusopphold – og et forsøk på forklaring.
	Wadel, Carl Cato, Dr.philos.	Medarbeidersamhandling og medarbeiderledelse i en lagbasert organisasjon
	Vinje, Hege Forbech, PhD	Thriving despite adversity: Job engagement and self-care among community nurses
	Noort, Maurits van den, PhD	Working memory capacity and foreign language acquisition
2008 V	Breivik, Kyrre, Dr.psychol.	The Adjustment of Children and Adolescents in Different Post-Divorce Family Structures. A Norwegian Study of Risks and Mechanisms.
	Johnsen, Grethe E., PhD	Memory impairment in patients with posttraumatic stress disorder
	Sætrevik, Bjørn, PhD	Cognitive Control in Auditory Processing
	Carvalhosa, Susana Fonseca, PhD	Prevention of bullying in schools: an ecological model
2008 H	Brønnick, Kolbjørn Selvåg	Attentional dysfunction in dementia associated with Parkinson's disease.
	Posserud, Maj-Britt Rocio	Epidemiology of autism spectrum disorders
	Haug, Ellen	Multilevel correlates of physical activity in the school setting
	Skjerve, Arvid	Assessing mild dementia – a study of brief cognitive tests.

	Kjønniksen, Lise	The association between adolescent experiences in physical activity and leisure time physical activity in adulthood: a ten year longitudinal study
	Gundersen, Hilde	The effects of alcohol and expectancy on brain function
	Omvik, Siri	Insomnia – a night and day problem
2009 V	Molde, Helge	Pathological gambling: prevalence, mechanisms and treatment outcome.
	Foss, Else	Den omsorgsfulle væremåte. En studie av voksnes væremåte i forhold til barn i barnehagen.
	Westrheim, Kariane	Education in a Political Context: A study of Konwledge Processes and Learning Sites in the PKK.
	Wehling, Eike	Cognitive and olfactory changes in aging
	Wangberg, Silje C.	Internet based interventions to support health behaviours: The role of self-efficacy.
	Nielsen, Morten B.	Methodological issues in research on workplace bullying. Operationalisations, measurements and samples.
	Sandu, Anca Larisa	MRI measures of brain volume and cortical complexity in clinical groups and during development.
	Guribye, Eugene	Refugees and mental health interventions
	Sørensen, Lin	Emotional problems in inattentive children – effects on cognitive control functions.
	Tjomsland, Hege E.	Health promotion with teachers. Evaluation of the Norwegian Network of Health Promoting Schools: Quantitative and qualitative analyses of predisposing, reinforcing and enabling conditions related to teacher participation and program sustainability.
	Helleve, Ingrid	Productive interactions in ICT supported communities of learners
2009 H	Skorpen, Aina Øye, Christine	Dagliglivet i en psykiatrisk institusjon: En analyse av miljøterapeutiske praksiser
	Andreassen, Cecilie Schou	WORKAHOLISM – Antecedents and Outcomes
	Stang, Ingun	Being in the same boat: An empowerment intervention in breast cancer self-help groups
	Sequeira, Sarah Dorothee Dos Santos	The effects of background noise on asymmetrical speech perception
	Kleiven, Jo, dr.philos.	The Lillehammer scales: Measuring common motives for vacation and leisure behavior
	Jónsdóttir, Guðrún	Dubito ergo sum? Ni jenter møter naturfaglig kunnskap.
	Hove, Oddbjørn	Mental health disorders in adults with intellectual disabilities - Methods of assessment and prevalence of mental health disorders and problem behaviour
	Wageningen, Heidi Karin van	The role of glutamate on brain function

	Bjørkvik, Jofrid	God nok? Selvaktelse og interpersonlig fungering hos pasienter innen psykisk helsevern: Forholdet til diagnoser, symptomer og behandlingsutbytte
	Andersson, Martin	A study of attention control in children and elderly using a forced-attention dichotic listening paradigm
	Almås, Aslaug Grov	Teachers in the Digital Network Society: Visions and Realities. A study of teachers' experiences with the use of ICT in teaching and learning.
	Ulvik, Marit	Lærerutdanning som danning? Tre stemmer i diskusjonen
2010 V	Skår, Randi	Læringsprosesser i sykepleieres profesjonsutøvelse. En studie av sykepleieres læringserfaringer.
	Roald, Knut	Kvalitetsvurdering som organisasjonslæring mellom skole og skoleeigar
	Lunde, Linn-Heidi	Chronic pain in older adults. Consequences, assessment and treatment.
	Danielsen, Anne Grete	Perceived psychosocial support, students' self-reported academic initiative and perceived life satisfaction
	Hysing, Mari	Mental health in children with chronic illness
	Olsen, Olav Kjellevold	Are good leaders moral leaders? The relationship between effective military operational leadership and morals
	Riese, Hanne	Friendship and learning. Entrepreneurship education through mini-enterprises.
	Holthe, Asle	Evaluating the implementation of the Norwegian guidelines for healthy school meals: A case study involving three secondary schools
H	Hauge, Lars Johan	Environmental antecedents of workplace bullying: A multi-design approach
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