EUROMEDITERRANEAN MANUAL
ON YOUTH DRUG ADDICTION TREATMENT AND SOCIAL REINTEGRATION THROUGH EDUCATION AND JOB SEARCHING

The Mediterranean today occupies **a central place in contemporary debates on migration**, **social exclusion** and **problematic substance use**. Beyond its geographical dimension, it has progressively become one of the real borders of Europe: **a territory shaped by global inequalities**, restrictive migration policies, violent transit routes and processes of exclusion that **directly impact the lives and health** of thousands of young people. Since the late twentieth century, the Mediterranean has come to function not only as a geographical border, but also as a social, political and humanitarian frontier.

In this context, Spain, Italy and Greece occupy a particularly significant position. Spain and Greece represent the western and eastern extremes of Europe's southern border, while Italy occupies a central position within Mediterranean migration routes. Although the three countries differ institutionally and culturally, they share very similar social dynamics: the **arrival of young migrants in vulnerable situations**, housing exclusion, administrative precarity, racism, informal economies and **difficulties accessing healthcare, education and employment systems**.

In many cases, problematic substance use cannot be understood as an isolated or exclusively individual phenomenon. Substances frequently **fulfil functions** linked to **emotional regulation, everyday survival, socialisation or the management of psychological suffering** in contexts marked by trauma, uncertainty, displacement and precarity. For many young migrants, substance use is **connected to experiences** of homelessness, violence, exploitation, isolation and the absence of safe spaces of care and belonging. Understanding this function of substance use is essential in order to **avoid simplistic or exclusively punitive responses** that ultimately increase exclusion and distance people from systems of care.

Another key element is the existence of significant linguistic and cultural barriers in accessing health and social care services. Communication difficulties, unfamiliarity with institutional codes and previous experiences of discrimination frequently generate distrust towards institutions. For this reason, incorporating **transcultural perspectives** is **essential**

when working with young migrant populations. This involves adapting languages, methodologies and forms of support, while recognising **different cultural understandings of care, autonomy, suffering** and **mental health**.

From a perspective close to the anthropology of health, it is also important to understand that substance use, suffering, care and recovery are deeply shaped by the social, cultural and political contexts in which people live. The ways in which distress is expressed, the body is understood, help is sought or trust is built are not universal, but depend on cultural trajectories, migration experiences and material living conditions. Working with young migrant populations therefore requires **moving beyond rigid or exclusively biomedical models** in order to incorporate approaches capable of understanding substance use not only as an individual behaviour, but also as a **socially situated practice shaped by power relations, exclusion, identity and everyday survival**.

At the same time, **Mediterranean culture** itself offers particularly valuable elements for this work. Historically, Mediterranean territories have been spaces of **exchange, coexistence and cultural mixing**. Compared to other more homogeneous or institutionally rigid European regions, many Mediterranean contexts maintain more flexible forms of social relations, a strong presence of community life and a greater centrality of public space. These elements can **facilitate relationship-building, outreach work** and **the development of more accessible and relational models of care**.

For this reason, strengthening cooperation between Mediterranean countries is especially important. Although responses are often developed separately within each territory, the social realities affecting Spain, Italy and Greece are deeply interconnected. Identifying and sharing good practices in harm reduction, treatment and social inclusion allows for the development of **shared learning processes**, strengthens more effective intervention models and helps **avoid fragmented responses** to clearly transnational challenges.

Harm reduction approaches have demonstrated a strong capacity to build trust and create accessible spaces from which processes of care, support and stabilisation can begin. Beyond reducing the physical risks associated with substance use, harm reduction constitutes **an ethical, political and relational framework grounded in dignity, human rights, public health and social justice**. At the same time, experiences developed across different Mediterranean territories show that harm reduction and treatment alone are **insufficient if they are not accompanied by** real opportunities for social inclusion, **housing, education, employment** and **community participation**.

This manual emerges precisely from this shared need: to contribute to the development of **more humane, coordinated and rights-based responses** for supporting young people simultaneously affected by migration, social exclusion and problematic substance use within the Euro-Mediterranean context. It is structured around **two complementary sections** that reflect two fundamental dimensions of social inclusion: keeping people safe and connected to care, and supporting them in building meaningful futures through work and education. This guide is intended as a practical resource for professionals, practitioners and organisations looking to develop, replicate or adapt responses to similar challenges in their own contexts. Each practice has been documented following a common framework that captures its rationale, methodology, target population, gender-equality objectives, evaluation approach, key findings and conditions for transferability.

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HARM REDUCTION & OUTREACH STRATEGIES

Section 1: Harm Reduction and Outreach Strategies

This section brings together practices that prioritise the health, dignity and safety of people who use drugs and of those experiencing homelessness, often in contexts of acute vulnerability. The practices described here share a common foundation: the recognition that reducing harm is not a concession but a right, and that meeting people where they are, whether on the street, in a residential setting or any other situation or place, is a prerequisite for any meaningful engagement with care. These practices range from managed alcohol programmes and low-threshold residential services to safer-use kit distribution and outreach-based crisis intervention.

1. The Outreach and Treatment Service

Organisation: FONDAZIONE GRUPPO ABELE ETS · Turin, Italy

Type: Harm reduction / Prevention / Support service

Overview:

The Outreach and Treatment Service is one of the main access points for people facing vulnerable situations linked to substance use and behavioural addictions, and to difficulties in their relationships and family life. Operating within a social context marked by growing isolation and a shrinking supply of spaces where people can be genuinely listened to and receive qualified support, the service functions as a first point of contact, guidance and early intervention. This allows to reach people who are not yet ready, or not yet able, to engage with structured support programmes.

The service is run by a multidisciplinary team of three psychotherapists and one social educator, offering psychological, educational and psychoeducational support through individual and group formats. It works with people experiencing problematic substance use, gambling and betting, as well as with family members who are indirectly affected by these problematic dynamics. In doing so, it positions itself not just as an individual support space but as a strategic hub within the local service network, facilitating access to resources and promoting pathways towards care and inclusion.

Who is this practice for?

The service is designed for people who are experiencing addiction-related difficulties but who, for a range of reasons, are not accessing or are not yet ready to access public services or formal treatment programmes. This includes people at an

early stage of recognising a problem, people who have tried and disengaged from other services, and family members who are living with the consequences of a loved one's strugglings without having a dedicated space of their own. This is one of the service's defining features, since these situations reshape entire family systems, parents, partners and siblings are often left without any qualified support of their own. The service explicitly addresses this gap.

The main targeted profiles are:

- People who use substances
- Young people
- Women
- LGBTQI+ people
- Migrant people
- Parents and other family members

A gender-sensitive and intersectional approach informs the work across all these profiles, promoting equal access regardless of gender and attending to the overlapping vulnerabilities that shape each person's experience.

How does this practice work?

The service operates as a low-barrier entry point: it does not require a referral, a formal diagnosis or a commitment to treatment as a precondition for access. People can come or be brought by family members at whatever point they are at in their relationship with their addiction, and the service adapts to where they are rather than requiring them to fit a pre-existing pathway.

The core methodology rests on an in-depth analysis of each person's background and situation, followed by targeted interventions calibrated to individual needs. This first initial and in-depth assessment interviews create space for people to articulate their situation, often for the first time, and allow the team to understand the specific constellation of difficulties (problematic substance use or behavioural addictions, relational problems, social withdrawal, economic stress, etc.) that shape each case. This phase also includes an individual psychological and psychoeducational support for people with addiction issues, working at the person's own pace and focused on building awareness of harmful patterns and motivation for change. Alongside, support for family members is offered through their introduction to tools aimed at improving their understanding of the situation and developing more effective relational strategies without making their support conditional on the person using substances also being in contact with the service. Clients also benefit from therapeutic and psychoeducational groups as a complement to individual work, creating space for shared experience and peer support. Once somebody is ready to move into a more structured recovery programme, they are referred and accompanied to other local services or resources available and suitable for them. This accompaniment is meant to ensuring continuity rather than leaving people to navigate the system alone.

The service acknowledges that addiction rarely presents in isolation and that a purely substance-focused frame misses much of what people are actually experiencing. This is why the programme addresses a broader range of behavioural issues such as gambling, betting, social distress, relationship difficulties.

What results has it brought?

In 2025, the service reached 276 people assisted by the service and 1,858 consultations carried out. Beyond these volume figures, the service reports meaningful qualitative outcomes across three interconnected domains. First, it plays a vital role in early identification. It then offers people a space for qualified support that is often genuinely difficult to find elsewhere, and catching distress at a stage where intervention is still relatively uncomplicated.

Second, through interviews and support processes, it increases self-awareness and motivation: many people who engage with the service subsequently move into more structured treatment programmes that they would not previously have considered or been able to access. Third, it produces specific outcomes for family members:

- Improved understanding of addiction dynamics and their effects on family systems.
- More effective relational strategies for managing life alongside a family member with addiction.
- Reduced isolation for family members, who often carry the weight of these situations without any support network of their own.

What makes this practice work?

The service's effectiveness rests on a set of relational and methodological principles that are straightforward to describe but require consistent professional investment to maintain in practice.

- Active listening as a therapeutic stance: the quality of attention offered by the service is itself a significant action, which is not merely a preliminary to "real" support offered.
- Respecting the person's own timing: the service does not push people towards readiness they do not yet have. It accompanies them in becoming aware of harmful patterns at their own pace, which is precisely what makes engagement possible for people who would otherwise disengage from more directive approaches.
- Involving family members as active participants: where appropriate and where it is positive for the process, the inclusion of family members in managing addiction situations significantly extends the service's reach and improves outcomes for everyone involved.
- A multidisciplinary team with complementary expertise: the combination of psychotherapists and an educator allows the service to address the full range of difficulties people bring without fragmenting them across different services.

- Integration with the local service network: rather than trying to do everything itself, the service functions as a connector identifying needs, building motivation and then facilitating warm referrals to the right resources at the right moment.
- A safe, gender-sensitive and non-discriminatory environment: reducing stigma and institutional distrust is a precondition for reaching the people who most need support and are least likely to seek it through conventional channels.

What challenges or limitations have been identified?

The main constraint facing The Outreach and Treatment Service is structural rather than methodological: it, which work at the threshold between need and formal treatment, operates in a policy and funding environment that tends to prioritise treatment over prevention, and intervention over early support. This creates a persistent tension between the demand the service faces and the resources available to meet it.

Finally, the dependence on institutional and policy support is another challenge faced during the implementation. The service's ability to function as a connector within the local network depends on the existence and quality of the services it connects to. Where the broader system is fragmented or underfunded, the referral pathways that give this model its strategic value become much harder to sustain.

How can it be transferred to other contexts?

The Outreach and Treatment Service model is highly transferable, in part because it does not require specialist infrastructure like residential facilities, supervised consumption spaces, etc. What it does require is a well-trained,

multidisciplinary team, a commitment to low-threshold and non-judgmental practice, and a local service ecosystem into which it can plug.
Key enabling conditions for replication include:

- Well-trained staff with complementary expertise committed to low-threshold and non-judgmental practice so that the model is not undermined by implicit barriers of stigma or gatekeeping.
- Partnerships with local institutions and services that make referral pathways real. The service's value as a connector depends entirely on having somewhere meaningful to connect people to.
- A safe, gender-sensitive and violence-free framework that makes the service genuinely accessible to the people who most need it and are least likely to trust institutional settings.

More information: https://www.gruppoabele.org/it-schede-19-serve_aiuto

2. KitSafe – Safer Use and Harm Reduction Supply Programme

Organisation: ABD (Associació Benestar i Desenvolupament) · Barcelona, Spain

Type: Harm reduction / Prevention / Community health / Safer-use material distribution

Overview:

KitSafe is a safe supply and harm reduction programme that combines the provision of adapted safer-use materials with targeted awareness and risk-reduction interventions for people who use drugs. Implemented by ABD in Barcelona since 2019, the programme goes beyond material distribution by actively promoting safer consumption practices, increasing risk awareness and supporting informed decision-making across diverse and often high-risk contexts of use.

KitSafe operates as both a public health and a community intervention. Beyond the provision of materials, it facilitates engagement with services, promotes self-care practices and contributes to the prevention of infectious diseases, injuries and overdose. A gender-sensitive and intersectional perspective is integrated into the design and contents of the kits, attending to the specific needs of women and gender-diverse people and promoting autonomy and self-care across diverse identities and practices.

Who is this practice for?

The programme is specifically designed to reach people who may not access conventional health services whether due to stigma, legal precarity, housing instability or geographic barriers, and for whom having the right materials and information can make a concrete difference to their safety and health.

- People who use drugs
- People experiencing homelessness or housing instability
- Women
- LGBTQI+ people
- Migrants
- Street-based or high-risk use contexts
- Limited access to health services

The programme pays particular attention to the specific needs of women and gender-diverse people who use drugs. This is a population whose consumption contexts, practices and risks often differ from those assumed in generic harm reduction materials.

How does this practice work?

The core of KitSafe is the design and distribution of safer-use kits adapted to different substances and routes of administration. This is not a generic provision of standard materials. Each kit is developed with attention to the specific risks, practices and bodies involved, incorporating a gender-sensitive and intersectional lens into the content and design. Each kit integrates tailored awareness components, including printed and visual materials, designed to promote risk awareness, safer-use practices and informed decision-making, rather than simply providing information passively.

- Distribution reaches people where they are, through a network of channels designed to maximise accessibility.
- Harm reduction services and outreach teams that operate in street-based and community contexts, meeting people at the point of use rather than waiting for them to come to a fixed service.
- Community and low-threshold settings including shelters, drop-in centres and social services with which ABD has established partnerships.
- Local and international partner organisations that extend the reach of the programme beyond ABD's own operational footprint.

A key feature of the model is its continuous adaptation. The programme monitors the number and type of kits distributed, distribution contexts and channels, and emerging needs reported by both users and professionals. Epidemiological and field data are used to adjust kit contents and priorities as drug markets and consumption patterns shift. This requires ongoing investment but is central to the programme's relevance and effectiveness. The programme is not limited to the distribution of materials; it is designed as a combined safe supply and behavioural awareness intervention.

What results has it brought?

KitSafe's evaluation relies on a combination of ongoing monitoring data and qualitative feedback from users and professionals. While the programme does not report specific outcome statistics, the evidence gathered consistently points to meaningful changes in behaviour, self-care and engagement with services.

- Increased adoption of safer-use practices among people who received kits and accompanying information, reflecting a genuine shift in behaviour rather than just material provision
- Improved self-care and awareness of consumption-related risks, suggesting that the information component of the kits is being understood and applied

- Reduction of harms associated with unsafe equipment use such as injuries, infections and disease transmission. This is particularly relevant in contexts where access to sterile materials is otherwise limited.
- Enhanced engagement with harm reduction services, with KitSafe functioning as a point of entry for people who might not otherwise access support.
- High acceptability across diverse user profiles, including women, LGBTQI+ people, migrants, who are often harder to reach with standard harm reduction approaches.
- The observed changes are linked not only to access to safer-use materials but also to the awareness and risk-reduction components embedded in the kits and distribution processes.

What makes this practice work?

KitSafe's effectiveness rests on a set of design principles that are straightforward in concept but require consistent effort to maintain in practice. At its core, the programme works because it meets people where they are (geographically, practically and without judgement) rather than requiring them to adapt to a service logic built around compliance or eligibility.

- Low-threshold and non-judgmental access removes the principal barriers like stigma, fear of criminalisation, distrust of institutions, preventing people who use drugs from accessing harm reduction resources.
- Flexibility and rapid adaptation to new patterns of use means the programme remains relevant as drug markets evolve, new substances emerge and consumption practices change, often absent from more rigid service models.
- Clear, accessible and non-stigmatising information ensures that the materials are not just physically available but actually usable and understood by the people they are designed for.
- Integration with existing harm reduction and outreach services amplifies reach and ensures that KitSafe does not operate in isolation but as part of a broader continuum of care.
- Scalability and ease of distribution allow the programme to expand its reach without requiring proportional increases in infrastructure, making it a cost-effective public health strategy.

- Strong alignment with public health goals (infectious disease prevention, overdose reduction, health promotion, etc) gives the programme a solid evidence base and facilitates institutional support.

What challenges or limitations have been identified?

KitSafe operates within constraints that affect both its day-to-day functioning and its longer-term sustainability. These are not specific to Barcelona, but structural challenges faced by most harm reduction programmes.

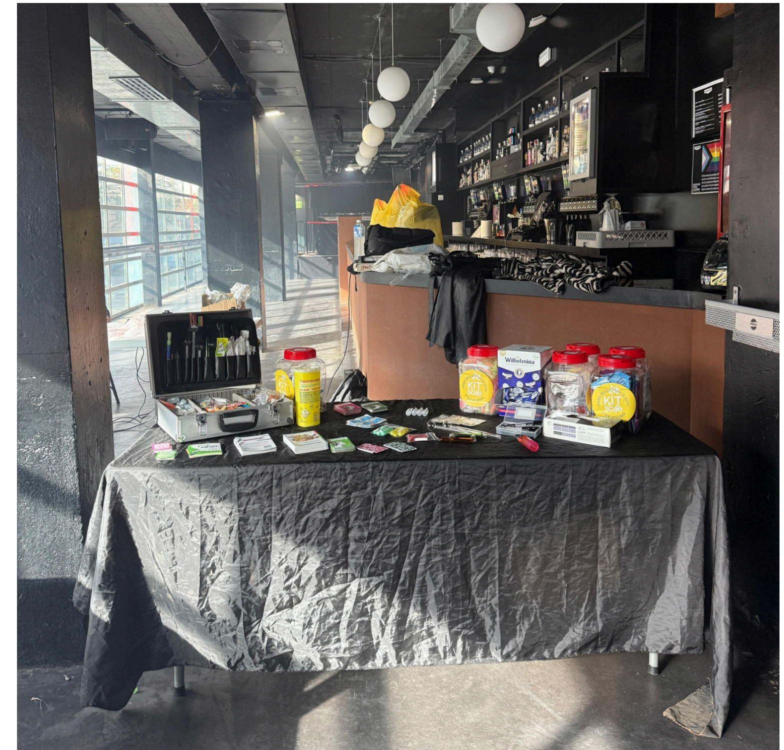
- Legal and regulatory barriers: the distribution of certain materials like syringes, pipes, safer sex supplies, etc., remains legally restricted or politically contested in many jurisdictions. These restrictions limit what can be included in kits and where and how they can be distributed, often in direct tension with public health evidence
- Dependence on funding and production capacity: the programme's ability to reach the people who need it most depends on sustained financial investment and production infrastructure. Funding gaps translate directly into reduced distribution and, ultimately, into increased harm for people who rely on the kits
- Continuous updating requirements: drug markets change rapidly, and maintaining the relevance of kit contents requires ongoing monitoring, adaptation and production capacity. This is not a one-time investment but a permanent operational demand that needs to be built into the programme's resource planning.

How can it be transferred to other contexts?

Contexts seeking to replicate the model should plan for regulatory negotiations from the outset, particularly around the materials that are most contested but also most needed. Supply chain and production limitations also require attention, since distributing at scale requires logistics capacity that may not exist in organisations implementing harm reduction for the first time. On top of that, cultural adaptation of the information materials, including language, visual representation and assumptions about gender and sexuality, is equally important and should not be treated as a secondary consideration.

These are the key conditions for successful replication:

- A harm reduction policy environment or pilot framework that allows or, at least, tolerates the distribution of safer-use materials without criminalising either providers or recipients
- Partnerships with community and outreach services that have established trust with target populations and can serve as distribution points and feedback channels
- Capacity for local adaptation of kit contents to reflect the specific substances, routes of administration and risk profiles present in each context. A generic kit is always less effective than one designed for actual local patterns of use
- Commitment to non-punitive, user-centred approaches across all involved organisations, ensuring that the low-threshold character of the programme is not undermined at the point of distribution



Reference and more information:

Associació Benestar i Desenvolupament (ABD). (2019). *KitSafe: Harm reduction supply programme.* Barcelona. Retrieved from https://abd.ong/en/programs/kitsafe/

3. DROP IN

Organisation: FONDAZIONE GRUPPO ABELE ETS · Turin, Italy

Type: Harm reduction / Community outreach /Safer-use material distribution

Overview:

This programme is designed to reduce the health and social risks associated with drug use through the distribution of safer-use kits and materials, combined with clear and accessible harm reduction information. The programme targets people who use drugs across a range of contexts, either street-based settings, unstable housing and low-threshold services. It operates on a community-based, low-threshold model that prioritises accessibility, flexibility and responsiveness to evolving patterns of consumption.

Beyond the provision of materials, Drop In functions as a broader community intervention: it supports engagement with health and social services, promotes self-care practices, and contributes to the prevention of infectious diseases, injuries and overdose. The programme also provides street outreach, legal support and accompaniment to healthcare services, extending its reach beyond material distribution into active relationship-building with people who use drugs in some of the most marginalised conditions.

Who is this practice for?

It is specifically designed for people who do not or cannot access conventional health services, whether due to stigma, legal precarity, distrust of institutions or practical barriers:

- People who use drugs, especially those in high-risk use contexts like streets or prison

- People experiencing homelessness or housing instability
- Women
- LGBTQI+ people
- Migrants
- Limited access to health services

A gender-aware and intersectional perspective informs how the programme understands and responds to the specific needs of women and gender-diverse people who use drugs. These groups' consumption practices, risk contexts and barriers to access often differ significantly from those assumed in generic harm reduction models. The programme also works with people who use drugs in prison, a population that is frequently excluded from harm reduction provision entirely.

How does this practice work?

At the core of Drop In is the design and distribution of safer-use kits adapted to different substances and routes of administration. Kits are developed with attention to diverse consumption contexts, practices and bodies, incorporating a gender-aware lens into both content and design. Distribution happens through a network of channels that takes the programme to people rather than waiting for them to come to a fixed service:

- Harm reduction services and street outreach that operate where people actually are building relationships over time as a foundation for deeper engagement.
- Low-threshold settings including drop-in spaces and community services that people can access without appointments, eligibility criteria or preconditions.

- Partnerships with local organisations that extend the programme's reach and embed it within a broader network of support.

What distinguishes Drop In from a purely logistical distribution operation is the relational dimension of its work. Street outreach is not just a delivery mechanism, but a sustained process of relationship-building that enables trust, reduces isolation and creates pathways into care. The programme provides accompaniment to healthcare services, legal support, and specific outreach to people who use drugs in prison, recognising that harm reduction cannot stop at the prison gate.

The programme monitors the number and types of kits distributed, distribution contexts and emerging needs reported by both users and professionals, using field data to continuously adjust kit contents and priorities as consumption patterns and drug markets evolve.

What results has it brought?

Drop In's evaluation relies on ongoing monitoring data and qualitative feedback from users and professionals. The evidence gathered, while not presented as formal outcome statistics, points consistently to meaningful changes in behaviour and risk awareness among people reached by the programme.

- Improved self-care and awareness of consumption-related risks among people receiving kits and accompanying information, reflecting genuine behaviour change rather than simple material receipt
- Reduction of harms associated with unsafe equipment use, including infections, injuries and disease transmission, particularly significant in contexts where access to sterile materials would otherwise be absent

What makes this practice work?

The programme works not just because it provides the right materials, but because it does so within a framework of sustained presence, trust and non-judgement.

- Low-threshold and non-judgmental access removes the stigma and institutional distrust that prevent many people who use drugs from seeking help, making engagement possible for people who would otherwise remain outside the reach of any service
- Clear, accessible and non-stigmatising information ensures that the materials distributed are genuinely usable and understood, not just physically available but practically meaningful for the people receiving them.
- Integration with existing harm reduction and outreach services means Drop In operates as part of a care continuum rather than in isolation, amplifying both its reach and its ability to connect people with further support.
- Street outreach and relationship-building are understood as therapeutic and preventive interventions in their own right, not merely as logistics. The sustained presence of outreach workers in people's environments builds the trust that makes all other elements of the programme possible.
- Accompaniment to healthcare services bridges the gap between harm reduction and formal health care and increases the support efforts towards clients when navigating systems that can feel hostile or inaccessible.
- Legal support addresses one of the most concrete barriers facing people who use drugs, particularly those who are undocumented or have a history of criminalisation, and signals that the programme understands vulnerability in its full complexity.
- Support for people who use drugs in prison extends harm reduction into a setting where it is most often absent and most urgently needed.

What challenges or limitations have been identified?

Like other harm reduction programmes operating in community and street-based contexts, Drop In faces constraints that are structural as much as operational:

- Legal and regulatory barriers: the distribution of certain materials remains restricted or politically contested in many jurisdictions. This limits what can be included in kits and how they can be distributed, as this often directly contradicts public health evidence.
- Dependence on funding and production capacity: the programme's ability to reach the people who need it is directly dependent on sustained financial investment. Funding gaps reduce distribution and translate into increased harm for people who rely on the kits as their primary access to safer-use materials.
- Continuous updating requirements: drug markets evolve rapidly, and maintaining the relevance of kit contents requires ongoing monitoring, field intelligence and production adaptation. This is a permanent operational demand, not a one-time design challenge

How can it be transferred to other contexts?

The Drop In model is replicable, but its transferability is inseparable from the question of institutional environment. The programme depends not just on having the right materials and methods, but on operating within or being able to build a network of non-stigmatising institutions willing to support harm reduction as a legitimate public health approach. Where that network does not exist, replication requires significant groundwork before the programme itself can be implemented.
Key conditions for successful adaptation include:

- Ongoing collaboration with other organisations to keep the network connected: Drop In does not function as a standalone service but as a node within a broader ecosystem of harm reduction, health and social support

- Support from European and international organisations for methodology exchange and continuous updates on changes in substance use and emerging substances: a particularly important condition given how rapidly drug markets change and how unevenly that intelligence is distributed across contexts
- Capacity for local adaptation of kit contents and outreach approaches to reflect the specific substances, consumption practices and population profiles present in each context
- A non-punitive policy environment or, at least, the willingness to advocate for one, since the low-threshold character of the model is undermined wherever drug use is treated primarily as a criminal rather than a public health issue.

More information: https://www.gruppoabele.org/it-schede-630-riapre_a_torino_il_drop_in_del_gruppo_abele_un_luogo_per_gettare_la_maschera

4. Housing Support Centre (CRI GALENA)

Organisation: ABD (Associació Benestar i Desenvolupament) · Barcelona, Spain

Type: Harm reduction / Housing support / Homelessness / Gender / Social and health care / Trauma-informed care

Overview:

CRI Galena is a low-threshold residential harm reduction service for people experiencing homelessness who use illegal substances and/or alcohol. Implemented in Barcelona in 2020 as a response to the COVID-19 pandemic and lockdown, the centre was designed to address a specific gap in the field: the absence of non-mixed, gender-sensitive residential services for highly vulnerable people in active substance use.

The centre offers 45 residential places and provides comprehensive care through a multidisciplinary team specialised in harm reduction, high-vulnerability substance use, conflict resolution, trauma-informed care and gender issues. Alongside supervised consumption rooms, psychosocial support and healthcare, the service guarantees basic needs as a non-negotiable precondition for care. The model is guided by a trauma-informed and gender-sensitive framework, prioritising dignity, safety, bonding, responsibility and self-management, and deliberately avoiding the medicalisation of traumatic experiences.

Who is this practice for?

The service explicitly targets populations facing multiple and intersecting vulnerabilities:

- People experiencing homelessness
- People who use drugs and/or alcohol
- Women
- LGBTQI+ people
- Migrant people
- People with a history of incarceration
- People in end-of-life care
- People requiring convalescence after hospitalization

A specific priority is given to women and gender-diverse people, including people engaged in sex work, for whom differentiated access conditions have been developed to facilitate adherence. The model also works with men around masculinities, making it a genuinely intersectional mixed service rather than simply a generic one.

How does this practice work?

The centre operates as a mixed residential service open to all genders, but with explicit structural provisions to ensure it is genuinely safe and accessible for women and gender-diverse people. This means combining shared spaces with non-mixed areas available specifically for women, alongside specific protocols and differentiated access conditions to facilitate adherence for women involved in sex work, in gender-based violence situations or any form of discrimination and transphobia.

The methodological backbone of CRI Galena rests on three interconnected frameworks: a harm reduction approach, a trauma-informed care model, and a gender-sensitive and intersectional perspective. These are not applied in sequence but integrated simultaneously into every aspect of the service. The care team is multidisciplinary aimed at covering health, social work and psychology. The team is supported by monthly training sessions, external gender expert supervision, and a dedicated psychologist supporting staff wellbeing.

Key service components include:

- Supervised consumption rooms that allow people in active use to consume under safe conditions, reducing risk without requiring abstinence as a condition of access.
- Psychosocial and psychological support tailored to high-vulnerability profiles and explicitly trauma-informed, avoiding the pathologisation of experiences rooted in structural violence.
- Coverage of basic needs as a precondition for any further engagement, not as a reward for compliance.
- Leisure, daily life and community activities that support reconnection with routines, identity and social bonds. This includes non-mixed spaces fostering trust and peer support among women and dedicated workshops for men residents.
- The presence of a community liaison worker who actively connects the service with the neighbourhood’s social fabric, ensuring residents’ participation in activities organised by local organisations as well as by grassroots social movements.
- Regular meetings between professionals and residents as a mechanism for continuous adaptation and participatory care.

What results has it brought?

CRI Galena does not rely on formalised quantitative indicators, a limitation discussed further below. However, the qualitative evidence gathered through professional and resident feedback, adherence tracking and observed changes points to significant and consistent improvements across multiple dimensions.

The most striking quantitative signal emerging from the service is around consumption: within the first three months of residence, the centre observed **reductions in substance use of between 50% and 70%**. This figure alone challenges assumptions about what is achievable with people in active and chaotic use within a low-threshold, non-abstinence-based setting.

Beyond consumption, the qualitative picture is equally significant:

- Reframing substance use: Substance use is frequently identified by residents as a coping mechanism linked to trauma, violence and structural vulnerability. This reframing is central to the model and shifts intervention away from control towards understanding and stabilisation.
- Changes in consumption patterns: Over time, use tends to move from compulsive or survival-driven patterns towards more regulated or recreational use, indicating processes of psychological and environmental stabilisation rather than mere behavioural compliance.
- Health and service engagement: Increased adherence to health services (CAP, CAS, hospitals) and improved treatment continuity have been observed, alongside a reduction in emergency interventions and better management of chronic conditions.

- Reduction of risk and harm: The supervised consumption spaces (inhalation and injection) and on-site care have contributed to safer use, early detection of complications and a low number of severe incidents relative to the level of vulnerability and intensity of use.
- Improved dignity and self-perception: Residents report increased sense of dignity, safety and recognition, as well as a shift towards seeing themselves as active agents in their own processes. This is an outcome rarely achieved in more restrictive or abstinence-based models.
- Gender and diversity-sensitive outcomes: Differences in symptomatology, access and engagement confirm the need for gender-sensitive and differentiated approaches. Higher adherence has been observed among women and LGTBIQ+ residents, strongly linked to the availability of non-mixed spaces and tailored protocols.
- Stabilisation beyond substance use: Improvements are also observed in areas such as daily structure, self-care, conflict reduction and social functioning, which are essential preconditions for any longer-term process.
- Community coexistence and integration: Despite the complexity of the profile, the service has maintained a relatively low number of community incidents and has generated positive feedbac

What makes this practice work?

Its effectiveness emerges from the combination of a stable residential environment, a genuinely integrated methodological approach, and a structural commitment to gender and trauma as design principles. The residential model is once again the foundation: by guaranteeing housing, food and hygiene, the service removes survival as the overriding preoccupation and creates the conditions in which care can actually happen.

- Harm reduction combined with trauma-informed care means that substance use is understood in context rather than treated as the problem to be eliminated. This reframing is essential for building trust with a population that has often been failed or pathologised by health and social services.

- Gender-sensitive design within a mixed service including non-mixed spaces, specific protocols and external gender supervision. This enables the service to reach and retain women and LGBTQI+ people who would otherwise disengage from a generic residential model.
- Strong professional supervision and staff support, including a dedicated psychologist for the team and monthly training, sustains the quality and consistency of care over time and prevents burnout in a high-intensity environment
- Non-mixed spaces fostering trust and peer support among women have been specifically identified as enabling deeper therapeutic engagement and higher adherence rates
- Work on masculinities with male residents creates a more equitable coexistence within the mixed service and addresses gender dynamics that would otherwise go unacknowledged.

What challenges or limitations have been identified?

CRI Galena's model is resource-intensive by design. This is both a strength and a constraint. The level of specialised, individualised support it provides is precisely what makes it effective for highly vulnerable populations, but it also makes it demanding to sustain and to scale.

- **Intensive professional support requirements**: the complexity of the profiles served means that some cases demand long-term and in-depth intervention, stretching team capacity and requiring sustained investment in training and supervision that not all institutions are prepared to maintain.

- **Absence of formalised quantitative indicators**: the service currently relies on qualitative assessment on adherence, observed changes, professional and resident feedback, but without standardised outcome measures. While the qualitative evidence is compelling, the lack of comparative data limits the ability to evaluate impact systematically or make the case to funders and policymakers in evidence-based terms.

- **Regulatory barriers** around supervised consumption: as with other harm reduction services, the legal framework governing supervised consumption spaces varies across contexts and can create significant obstacles to implementation, even where need is well-documented.

- **Emerging consumption patterns and increased complexity**: The rise of stimulant use (particularly methamphetamine) and practices such as chemsex introduces new clinical and psychosocial challenges, often involving acute crises, high-intensity care needs and complex coordination across services. These situations significantly increase the demand on teams and require ongoing adaptation of intervention models.

- **Absence of cost-benefit evaluation**: To date, the service has not undergone a formal cost-benefit or cost-effectiveness evaluation. While available data and qualitative evidence suggest reductions in harm, improved health engagement and decreased crisis situations, there is currently no systematic analysis comparing the cost of the intervention with potential savings in other systems (e.g. emergency healthcare, hospitalisations, policing or social services). This represents a key limitation for long-term sustainability and for positioning the model within public policy and funding frameworks.

- **Tension with the wider service network**: A significant limitation identified is the difficulty in accessing or transitioning to other housing or care resources. Despite stabilisation processes, residents are often excluded from more autonomous or abstinence-oriented services due to ongoing substance use, while at the same time being considered “already housed” within the homelessness system. This creates structural bottlenecks and limits pathways for progression.

How can it be transferred to other contexts?

CRI Galena shows high transferability potential to other urban and international contexts where homelessness, substance use and trauma intersect. The core principles of the model are not Barcelona-specific: they respond to structural conditions that exist across many cities and welfare systems. However, successful replication depends on a set of enabling conditions that need to be in place before implementation:

- Residential or shelter-based infrastructure capable of accommodating people in active substance use without imposing abstinence as a condition of access, along with a multidisciplinary, gender-trained teams with access to ongoing supervision, external expert support and regular training.
- A harm reduction policy framework that allows and, ideally, supports supervised consumption and low-threshold service models.
- Institutional commitment to trauma-informed and non-medicalising approaches, which requires not just policy alignment but genuine cultural change within organisations.
- Strong coordination with the wider service network, including health, homelessness and social services. At the same time, contexts should anticipate potential gaps or exclusions within existing systems, particularly regarding access to more autonomous housing for people who remain in active use.
- Community and territorial work as a core function, not an add-on. The experience of CRI Galena shows that sustained engagement with neighbours, local businesses and community organisations is essential to ensure coexistence, reduce conflict and enable gradual integration of residents into the social fabric.
- Institutional commitment to trauma-informed and non-medicalising approaches, which requires not only policy alignment but also deep organisational and cultural change.

Contexts seeking to adapt the model should anticipate regulatory barriers around supervised consumption spaces, which remain politically contested in many jurisdictions. The resource intensity required for staff supervision and training also needs to be factored into planning from the outset, since under-resourcing the team is the most direct route to undermining the model's effectiveness.
Where a full residential implementation is not immediately feasible, the gender-sensitive design elements and trauma-informed framework offer meaningful components that can be integrated into existing services as a starting point. Importantly, replication should avoid a purely formal or structural transfer of the model (e.g. opening a residential space) without ensuring the underlying principles and conditions are in place. Where a full residential implementation is not immediately feasible, key components such as gender-sensitive design, trauma-informed approaches and harm reduction practices can be progressively integrated into existing services.

Reference and more information:

Associació Benestar i Desenvolupament (ABD). (2020). *Integral Residential Centre La Galena.* Barcelona. Retrieved from https://abd.ong/en/programs/lotus-center/

5. CRISIS CENTRE: MOLO18

Organisation: FONDAZIONE GRUPPO ABELE ETS · Turin, Italy

Type: Harm reduction / Housing support

Overview:

Centro Crisi – Molo 18 is a unique residential crisis centre in Italy for young people aged 18 to 28 with problematic use of crack, cocaine, medicines or other substances. Reopened in January 2024 by Fondazione Gruppo Abele ETS in Turin, the centre was designed in response to a growing and underserved phenomenon: the increase in crack use among young people, a substance for which no pharmacological substitution therapies exist, and whose effects, like compulsive craving, loss of the capacity for pleasure without the drug, require a response grounded in relationships and therapeutic environment rather than medication.

The programme lasts between three and nine months and is structured in two phases (the Pause and the Restart) with a highly personalised approach that replaces substance use with body care, meaningful relationships and personal planning. The centre's model is explicitly relational and non-judgmental, focused on recognising the potential of young people rather than correcting their behaviour.

Who is this practice for?

Molo 18 is designed specifically for young people between 18 and 28 years old for whom existing services have failed them because of its design focused on older adults or requiring a level of stability that young people in crisis do not have. The

programme is developed in close collaboration with the SERD (public addiction treatment services) of Turin and Piedmont, which refer participants and maintain a therapeutic relationship throughout the process.

The programme applies an intersectional lens to its work, promoting equal access regardless of gender, supporting inclusive and non-discriminatory processes, and attending to the overlapping vulnerabilities, including gender, migration status and sexuality. Alongside participants, the centre also works with families: in its first year, 20 families received dedicated support through individual interviews and mediation sessions.

How does this practice work?

The programme is structured in two consecutive phases, each with a distinct therapeutic focus:

Phase 1: The Pause.

This phase is focused on physical and emotional stabilisation: interrupting crack use and associated risky behaviours, managing craving through physiological regulation techniques, restoring sleep–wake cycles, and reducing the irritability, anxiety and agitation that accompany withdrawal. A central element of this phase is emotional literacy which consists of helping young people identify the emotions and internal and external triggers that precede or drive substance use. The goal is to create the internal stability from which further work becomes possible.

Phase 2: The Restart.

This second phase is oriented towards the future, with pathways tailored to each young person: continuation in a therapeutic community, transition to shared apartments, or assisted family reintegration. This phase builds on the stabilisation achieved in the Pause to develop concrete emotional regulation skills, such as grounding, coping, problem-solving, DBT techniques; alongside relational skills like assertive communication, conflict management, family dynamics and boundary setting. It also involves working on motivation for change: exploring cognitive dissonance, clarifying personal values and defining life goals. Social reintegration happens gradually and with support, through engagement in education, work, sport and other structured activities.

Throughout both phases, the relational dimension is treated as the primary therapeutic tool. It has proven to generate a positive impact when there is little age difference between staff and residents. This has helped to provide clients with an environment that feel like a community rather than an institution. Daily life is structured through activities that serve multiple therapeutic functions:

- **Physical activity** and sport to reactivate dopamine pathways naturally and reconnect young people with their bodies, supported by a volunteer trainer.
- **Art therapy and creative activities** to foster emotional expression and creativity as alternatives to substance use.
- **Psychoeducational interventions and group sessions**: weekly group, a dedicated affection/relationship emotions group, and a relapse prevention group using DBT skills.
- **Individual psychological support** and, where indicated, hypnosis as a complementary tool for craving and anxiety management.
- **Cooking and daily life management:** the kitchen is run by the residents themselves, building responsibility, routine and a sense of shared ownership.

Across all these elements, there is a structured methodological commitment to building a stable daily rhythm. The programme introduces predictability, routine and frustration tolerance as responses to the chaotic lifestyle often associated with substance dependence. The therapeutic objective is to support a shift in identity, moving from “I am someone who uses” towards “I am someone who can choose”. This reconstruction of self-efficacy and the development of a non-substance-centred sense of self are understood as the foundation for lasting change.

What results has it brought?

After its first year of operation, Molo 18 reports encouraging early outcomes. The data available is still limited. Even if the centre has been recently created, the initial picture is consistent and meaningful.

- 42 young people welcomed in the first year
- 25 average age of participants
- 6 months average length of stay
- 20 families supported alongside participants

The qualitative picture shows consistent improvements:

- Reduction in problematic substance use and decreased polydrug use among participants who remain in the programme
- Improved management of withdrawal and emotional symptoms associated with substance use, particularly craving, anxiety and irritability

- Enhanced quality of life, especially in terms of safety, rest and daily functioning
- Particularly positive outcomes for young people attributed to the safe, violence-free and non-judgmental environment

What makes this practice work?

Molo 18's approach was described by its own team as starting "disarmed" in methodological terms. This has been a deliberate choice to let the stories and needs of young people shape the programme rather than imposing a fixed protocol. This flexibility, combined with a clear therapeutic framework, is one of the features that distinguishes it from more rigid residential models.

- The residential setting as a safe place: the physical environment as one that is stable, contained and predictable which provides the security that young people in active crack use typically lack, and from which all other therapeutic work becomes possible. In this case, a young, non-judgmental team that closes the age gap with residents guarantees an environment filled with trust and sense of belonging that make engagement possible
- Meeting basic needs as a non-negotiable foundation: housing, food, structure and daily routine are not rewards for compliance but the conditions that allow young people to focus on their recovery beyond immediate survival and craving
- Strong collaboration with public SERD services: the programme does not operate in isolation but in close partnership with the public addiction treatment network, which provides referrals, clinical support and continuity of care before and after the residential period
- Psychoeducation and emotional literacy: teaching young people to recognise triggers, manage emotional states and develop concrete coping skills gives them tools that outlast their time at the centre

- Physical activity, arts and structured daily life: these are not recreational add-ons but neurobiological and psychological interventions. These activities open dopamine pathways, build frustration tolerance and restores a sense of agency and identity in residents.
- Gender-sensitive and inclusive design: equal access regardless of gender, respect for diversity, and attention to intersectional vulnerabilities ensure the programme reaches and retains young people whose needs a more generic model would overlook.

What challenges or limitations have been identified?

The main challenge identified so far is the need for ongoing institutional and policy support. The programme depends on sustained backing from public health institutions and on funding that allows it to maintain its model without being pushed towards more standardised, less relational approaches. This support cannot be taken for granted.

How can it be transferred to other contexts?

The Molo 18 model has confirmed the validity of a relational, age-specific approach to residential crisis intervention. This validation is itself a transferable finding. The focus on a specific age group (18–28) allows for more targeted and effective care, better addressing the developmental, relational and identity needs of young adults with substance use disorders in ways that generic adult services cannot.

Some of the most important enabling conditions for replication include:

- Residential treatment centres or supportive housing capable of offering a safe, stable and contained environment for young people in active use without requiring abstinence as a precondition for access

- Multidisciplinary teams specialised in working with young people, with capacity for sustained relational engagement and comfort with a model that is deliberately flexible and co-constructed with residents
- Close integration with public addiction treatment services (or equivalent referral networks) that can provide clinical support, continuity of care and legitimacy within the broader health system
- A safe, gender-sensitive and violence-free framework that makes the centre accessible and genuinely safe for young people across genders and identities

The principal **constraint** on transferability is the absence of integrated health and social care networks in many contexts. The SERD collaboration that underpins Molo 18 is structural. Organisations seeking to replicate the model in settings where public addiction services are fragmented or underfunded will need to invest significant effort in building equivalent partnership structures before the residential programme itself can function effectively.

More information:

https://www.gruppoabele.org/it-schede-1867-un_anno_di_molo_18
https://lavialibera.it/it-schede-1894-dipendeze_viaggio_centro_crisi_droghe

6. Alcohol Maintenance Programme in a Residential Setting

Organisation: ABD (Associació Benestar i Desenvolupament) · Barcelona, Spain

Type: Harm reduction / Residential intervention

Overview:

The Programme was launched in Barcelona in April 2020 as an emergency response to COVID-19 lockdown measures, which dramatically restricted access to alcohol and placed people with severe alcohol use disorder (AUD) experiencing homelessness at acute risk of withdrawal and death. What began as a crisis intervention has since evolved into a sustained residential harm reduction programme with a peer-reviewed qualitative evaluation published in The American Journal of Drug and Alcohol Abuse (2024).

The programme provides regulated, medically supervised alcohol dispensing within a residential setting that guarantees access to housing, food, hygiene and integrated multidisciplinary care: medical, nursing, psychological and social. Its central aim is not abstinence but stabilisation: reducing the harms of chaotic consumption, improving health outcomes, and creating the conditions of safety and trust from which deeper engagement with care becomes possible.

Who is this practice for?

The programme targets people experiencing homelessness with severe AUD, with a particular focus on women, migrants, people with histories of incarceration, and those engaged in polydrug use. The design of the programme reflects an explicit

awareness that these groups face compounding barriers to services, to safety and dignity, and that a generic response will fail to reach them.

How does this practice work?

The programme currently operates within a residential setting that guarantees coverage of basic needs (housing, food and hygiene) as a precondition for therapeutic engagement. Alcohol is dispensed in regulated quantities following individualised medical guidelines expressed in standard drinking units, supervised by a multidisciplinary team that includes medical, nursing, psychology, social work and social education professionals. The model adapts continuously to participants' evolving needs through monthly team review meetings and regular user assemblies.

A gender-sensitive and intersectional framework is structurally embedded in the programme. This includes explicit zero-tolerance policies for sexist behaviours and gender-based violence, non-mixed residential spaces, psychoeducation sessions on coexistence, mutual support dynamics, and ongoing supervision by a gender specialist. These features are not optional add-ons but are treated as core components of the intervention.

What results has it brought?

The published qualitative evaluation, based on semi-structured interviews with eight participants (three women, five men) and four professionals, identified consistent positive changes:

- **Consumption**: Reduction in alcohol intake and in acute intoxication episodes; also reduction in use of other psychoactive substances.
- **Health**: Improved management of withdrawal symptoms and anxiety; re-engagement with mental health services, hepatitis C treatment, and sexual and reproductive health care.

- **Quality of life**: Improved safety, rest, and daily functioning. Participants reported feeling more stable and able to engage with structured daily routines.
- **Women's outcomes**: Particularly strong impact for women, linked to living in a violence-free environment and having access to gender-specific support structures.

This practice demonstrates that residential managed alcohol programmes grounded in harm reduction and gender-sensitive approaches can significantly improve health and quality of life for people experiencing homelessness with AUD. The qualitative evaluation reinforces the importance of integrating basic needs, safety and care as central components of effective harm reduction interventions.

What makes this practice work?

At the foundation lies the residential model itself. By ensuring a stable, safe living environment and covering basic needs (housing, food, hygiene, etc.) the programme removes the immediate survival pressures that typically prevent this population from engaging with health or social services.

- Supervised alcohol dispensing following individualised medical guidelines reduces chaotic consumption without imposing abstinence.
- Strong linkage with public health services enables access to specialist care (mental health, infectious disease, and reproductive health) that participants had previously been unable to sustain
- Gender-sensitive design and ongoing supervision by a gender specialist reduce the key barriers that prevent women from accessing and remaining in residential programmes
- Psychoeducation on withdrawal versus anxiety builds participants' capacity to understand and manage their own body's responses, fostering self-awareness and supporting more controlled consumption over time

What challenges or limitations have been identified?

Operational constraints:

- Initial adaptation period to medical alcohol guidelines among participants, which can involve resistance and uncertainty before stabilisation.
- Requires sustained institutional and policy support over time. Without ongoing commitment from health and social care systems, continuity is at risk. In contexts where supervised alcohol provision is legally restricted or politically contested, implementing the core harm reduction model presents significant regulatory challenges.
- Dependent on stable multidisciplinary staffing

Structural barriers:

- Regulatory frameworks in some contexts restrict or prohibit supervised alcohol provision
- Absence of integrated health and social care networks limits replicability
- Requires residential or supportive housing infrastructure, which may not be available

How can it be transferred to other contexts?

The programme shows high transferability potential to other urban contexts where homelessness and severe alcohol use disorder intersect. The evidence base supports the conclusion that residential models addressing basic needs are more effective than outpatient-only interventions for this population.

Successful replication depends on a set of enabling conditions:

- Residential or supportive housing infrastructure
- Harm reduction–oriented policy environment

- Multidisciplinary team capacity
- Gender-sensitive and violence-free framework

Contexts seeking to adapt the model should anticipate legal and regulatory barriers around supervised alcohol provision, which vary significantly across jurisdictions, and plan for the development of integrated care pathways before implementation. Where a full residential model is not immediately feasible, the gender-sensitive and basic-needs components offer meaningful standalone improvements that could be integrated into existing services.

Reference and more information:

a) Practice:

Fernández, Z., Muñoz, M., & Aranda, E. (2022). *Programa de mantenimiento de alcohol en un espacio residencial*. Àgora, Federació Catalana Drogodependències. Barcelona.

b) Evaluation of the practice:

Filomena Velandia, D., Aranda Rodríguez, E., Garrido Albaina, A., Clotas, C., Bartroli Checa, M., Pasarín Rua, M. I., & Gotsens, M. (2024). *"I drink less and that's no small matter": A qualitative descriptive study of a managed alcohol program evaluation in Barcelona*. The American Journal of Drug and Alcohol Abuse. https://doi.org/10.1080/00952990.2024.2404242

LABOUR AND EDUCATIONAL INSERTION

Section 2: Labour and Educational Insertion

This section presents practices that support people's transitions into employment and training. These transitions are understood not as endpoints but as processes of social reintegration embedded within broader pathways of personal recovery and inclusion. The practices respond to structural barriers that prevent vulnerable young people, migrants, people recovering from addiction and those experiencing long-term exclusion from accessing decent work and learning opportunities. They combine individual support, including career counselling, skills assessment and interview preparation, with structural tools such as vocational training in simulated professional environments and digital platforms connecting candidates with employers committed to equitable recruitment.

1. Employability Pathway

Organisation: Odyssea · Athens, Greece

Type: Employability support / Labour market integration / Social reintegration / Counseling

Overview:

The Employability Pathway developed by Odyssea constitutes a comprehensive employability support model aimed at facilitating sustainable labour market integration for individuals experiencing social exclusion, economic vulnerability and structural barriers to employment. Rather than treating job placement as an isolated event, the model frames labour market integration as a process in which each participant is guided through a sequence of individually tailored steps: orientation, skills development, confidence-building, employer connection and ongoing follow-up.

The model operates as a bridge between personal life trajectories, training experiences and employment opportunities. It recognises that many beneficiaries face cumulative disadvantages, including interrupted education, migration-related barriers, long-term unemployment or recovery processes, which cannot be addressed through standard employment services alone. By supporting gradual transitions into employment and reinforcing individuals' agency, the practice contributes to reducing vulnerabilities associated with exclusion, precarious living conditions and social isolation.

Who is this practice for?

The practice explicitly adopts an inclusive and intersectional approach, recognising that employability challenges are often shaped by gender inequalities, migration status, discrimination, limited social networks or previous exclusion from

education and employment systems. It is particularly relevant for people facing multiple barriers to employment or whose life trajectories have been affected by social exclusion or recovery processes:

- Young people and NEETs (Not in Education, Employment or Training)
- Migrants, refugees and asylum seekers
- Socially excluded and unemployed individuals
- Low-income and disadvantaged groups
- Vulnerable women and people with disabilities
- Young people affected by or recovering from substance use problems

How does this practice work?

The pathway moves through a sequence of connected phases, each building on the previous one and adjusted to the individual's situation and pace:

The intervention begins with an **individual assessment phase** aimed at identifying participants' existing skills, professional interests, strengths and barriers. This assessment forms the basis for tailored career orientation and realistic employment planning. Participants then engage in **one-to-one career counselling** sessions where employability professionals support them in defining career goals, understanding labour market expectations and developing job-search strategies adapted to their personal situations.

A central component of the pathway involves strengthening **professional preparedness**:

- Development and adaptation of CVs and cover letters: Participants receive practical support in developing or adapting their CVs and cover letters to the specific positions each person is pursuing, rather than producing a generic document that fits no job in particular
- Training in job-search techniques: It helps beneficiaries acquire competencies often taken for granted in conventional recruitment processes.
- Preparation for recruitment processes and mock interview sessions: It provides a safe learning environment where candidates can practice communication skills, receive feedback and build confidence before engaging with employers.

Once the preparation phase is done, participants enter into the job matching process which is facilitated through an established network of partner companies. Rather than leaving beneficiaries to navigate recruitment processes alone, the organisation mediates between candidates and employers, ensuring alignment between job requirements and participant capacities while promoting inclusive hiring practices.

Once employment is obtained, the practice continues through **in-work support**. It consists of assistance provided during the transition from unemployment or exclusion into a new working environment, addressing the difficulties that often cause early dropout from employment. Follow-up and professional guidance are maintained for up to **12 months**. It aims for professional development and employment retention and adaptation.

Evaluation mechanisms include monitoring participation levels, tracking employment outcomes and collecting qualitative feedback from both beneficiaries and employers. Continuous internal review allows adaptation of services to emerging needs.

What results has it brought?

The employability pathway has contributed to several significant outcomes:

- Improved employability and work readiness among participants
- Increased access to employment opportunities
- Smoother transitions from training or social exclusion into employment
- Strengthened autonomy and confidence in navigating labour markets
- Greater sustainability of employment outcomes beyond short-term placements

Participants benefit not only from employment access but from increased stability and self-efficacy, which are key protective factors in social reintegration processes. The emphasis on sustainability over placement speed is reflected in outcomes that extend beyond the first job and contribute to longer-term social inclusion.

What makes this practice work?

Several elements explain the effectiveness of the practice:

- Holistic support addressing multiple barriers simultaneously: the model does not treat employment as a single problem with a single solution, but as the intersection of confidence, skills, networks, timing and opportunity
- Strong links with employers and labour market actors make the job-matching component substantive rather than theoretical by connecting people to real opportunities rather than generic vacancy lists
- Emphasis on sustainability rather than short-term placement. The twelve-month follow-up is the clearest expression of this commitment, and it is what distinguishes the model from transactional placement services

- Integration within broader social reintegration pathways means the employability support is not isolated but connected to the other forms of support participants may be receiving, such as housing, health, addiction recovery. This creates a coherent rather than fragmented experience.

The practice succeeds because employability is treated as a social process requiring accompaniment, mediation and trust-building rather than a purely technical intervention.

What challenges or limitations have been identified?

Despite positive outcomes, several limitations have been identified:

- Labour market instability and limited availability of quality jobs: the model can prepare people excellently for employment that simply is not there, or that exists only in precarious forms. The quality and sustainability of employment outcomes depends partly on conditions outside the programme's control
- Structural barriers in participants' lives: housing instability, legal precarity, health conditions and caring responsibilities do not disappear when someone enters an employability pathway, and managing these alongside the programme requires significant individual support capacity
- Sustained employer engagement requires ongoing investment: maintaining an active network of willing and genuinely inclusive employers is a permanent operational demand, not something that can be established once and left to run

How can it be transferred to other contexts?

The employability pathway demonstrates high transferability potential across Mediterranean and European contexts where youth unemployment, migration and social exclusion intersect. The model is adaptable to different national contexts provided that partnerships with local employers and career support services are in place.

Successful replication requires:

- Organisations capable of providing personalised employability counselling
- Partnerships with local employers and labour market stakeholders
- Capacity to deliver follow-up and mediation support after job placement
- Commitment to inclusive, non-discriminatory and gender-responsive approaches

The main constraints are the resource requirements for personalised follow-up and the need to adapt the model to national employment and legal frameworks.

More information: https://odyssea.com/services/employability/

2. Odyssea Academy – Vocational Training in Simulated Work Environments

Organisation: Odyssea · Athens, Greece

Type: Vocational Education and Training (VET) / Skills development / Non-formal education / Social reintegration

Overview:

Odyssea Academy is a vocational education and training (VET) model designed to support the social integration and reintegration of vulnerable young people through labour-market-oriented vocational training delivered in simulated professional environments. The Academy provides cohort-based training programmes aligned with current labour market needs. By recreating real working conditions within training spaces, participants acquire technical competencies, professional behaviours and practical experience before entering employment.

The model is distinctive in its insistence on realism: rather than classroom-based theoretical instruction, participants train in fully equipped spaces that simulate actual workplaces like professional kitchens, hotel environments, digital fabrication workshops. Training is delivered by experienced sector professionals, and programmes are continuously updated based on employer input and shifting market demand. Successful completion leads to nationally recognised certification through EOPPEP, Greece's official qualification authority.

Who is this practice for?

The Academy targets young people and adults in vulnerable situations who lack the formal qualifications, work experience or professional networks that employers typically require and for whom conventional educational routes have not been accessible or effective.

- Young people and adults
- People who are NEET
- Migrants, refugees and asylum seekers
- Socially excluded and unemployed individuals
- Low-income and disadvantaged groups
- Vulnerable women
- People with disabilities
- Young people with problematic substance use

How does this practice work?

The pedagogical approach is built around learning by doing: practical exercises, project-based tasks and realistic simulations replace lecture-based instruction. Digital skills are integrated across all tracks as a cross-cutting employability competence. The coherence of the model lies in how it connects training to the broader employability pathway: participants are supported to progress from the Academy directly into Odyssea's employability and job-matching services, creating a continuum rather than a sequence of disconnected interventions.

Participants enrol in cohort-based training programmes delivered by experienced professionals and structured around sectors with demonstrated employment demand:

- HORECA: Hotel, Restaurant and Catering, as professional kitchen and hospitality environments
- Mechanical, Electrical and Plumbing: construction sector trades
- Technology and Information Technology
- Business Administration, Marketing and Sales: commercial and administrative competences

Training takes place in **fully equipped simulated work environments**, such as professional kitchens, technical workshops or digital fabrication spaces. These environments reproduce workplace dynamics, expectations and responsibilities.

Courses are continuously updated according to labour market trends and employer feedback. Programmes lead to recognised certification through ACTA and the National Organisation for the Certification of Qualifications and Vocational Guidance (EOPPEP).

The programme actively challenges gender stereotypes within vocational sectors, particularly in trades and technology that are historically male-dominated. The Academy provides childcare support in some sessions to enable mothers to participate. Enrolment and participation procedures are non-discriminatory by design.

What results has it brought?

The Academy has generated measurable improvements. Participants consistently report enhanced technical and soft skills, increased professional confidence and stronger motivation throughout the training process. Course completion rates are higher than those of comparable programmes, which the team attributes to the hands-on format and the realistic professional environment. These features sustain engagement more effectively than classroom-only settings. The transition

from training to employability services, and subsequently into employment, is smoother and more successful for Academy graduates than for participants entering employability support without prior vocational training or work experience.

Participants leave the programme better prepared to access employment opportunities and sustain participation in the labour market.

What makes this practice work?

Key success factors include:

- Strong alignment between training content and labour market demand. Courses are continuously updated based on employer input, ensuring that what participants learn corresponds to what the market actually needs
- Realistic simulation of professional environments removes the most common obstacle for people without work experience: the inability to demonstrate competence they have not yet had the chance to develop
- High participant engagement is achieved through hands-on learning. The practical format sustains motivation and reduces dropout rates more effectively than passive educational approaches.
- Integration within the broader employability model means the Academy is not a standalone training programme but a stepping stone within a coherent pathway from vulnerability to sustained employment
- National certification through EOPPEP gives training outcomes institutional recognition and makes participants' qualifications legible to employers across Greece

The simulated workplace setting allows participants to build confidence in a supportive environment before facing real employment pressures.

What challenges or limitations have been identified?

The implementation of the Academy faces several constraints:

- Resource-intensive infrastructure: fully equipped professional simulation spaces require significant initial investment and ongoing maintenance. This is a barrier for organisations without existing facilities or capital funding
- Continuous curriculum adaptation: the model's relevance depends on keeping training content current with labour market shifts, which is a permanent operational demand requiring sector expertise and employer relationships that take time to build
- Dependence on qualified trainers and sector experts: recruiting and retaining experienced professionals willing to teach in a social reintegration context is a recurring challenge, particularly in specialised sectors

These factors may limit scalability without adequate institutional support.

How can it be transferred to other contexts?

The model shows strong transferability across Mediterranean and European regions. These are the conditions enabling replication:

- Availability of adaptable training facilities or vocational infrastructure
- Access to sector professionals capable of delivering practice-based training
- Links with local employers to ensure labour market relevance
- Commitment to inclusive and non-formal education approaches

Constraints may arise from initial investment costs, regulatory differences in vocational certification systems and the need for continuous curriculum adaptation.

More information: https://odyssea.com/about/locations/academy-athens/

3. Odyssea's Talent Platform

Organisation: Odyssea · Athens, Greece

Type: Employability & social inclusion or reintegration

Overview:

Odyssea's Talent Platform is a digital employability infrastructure designed to bridge the gap between vulnerable young people who have completed vocational training and employability pathways, and employers seeking skilled, motivated candidates. Unlike conventional job portals, which place the full burden of visibility and navigation on the job seeker, the platform operates within a holistic integration model combining digital technology with human mediation. This blended approach reduces exclusionary recruitment practices and enhances equitable access to employment, with professional staff accompanying both beneficiaries and employers throughout the process.

Through the platform, participants create structured professional profiles that make their skills, training background and career interests visible to a network of engaged companies. An AI-powered algorithm supports candidate-employer matching, while Odyssea staff provide human mediation throughout. The result is a system that reduces the informal, network-dependent and often exclusionary dynamics of conventional recruitment, and replaces them with a skills-based, transparent and supported process.

Who is this practice for?

The platform targets young people aged 18 to 34 who face structural barriers to labour market access and who have participated in vocational training or employability pathways. It is designed for people who have the skills but lack the networks, visibility and recruitment literacy that conventionally determine who gets hired.

- Young people aged 18–34
- NEETs
- Migrants, refugees and asylum seekers
- Unemployed or underemployed youth
- Socially excluded young people transitioning from training or reintegration pathways
- Individuals facing structural barriers to labour market access

On the employer side, the platform offers companies access to a pool of pre-screened, supported candidates while also helping them strengthen their Diversity, Equity and Inclusion strategies and demonstrate measurable social impact. This dual value proposition is central to sustaining employer engagement over time.

How does this practice work?

The platform is embedded within the organisational support structures and functions differently for its two user groups, with Odyssea staff mediating between them throughout, and combines digital infrastructure with personalised employability support. This mediated approach reduces informal and exclusionary barriers such as migration background, long-term unemployment or social exclusion.

For beneficiaries

For beneficiaries, the process begins with the creation of a professional profile supported by employability staff. This process translates their skills, training outcomes and career interests into a format legible to employers. A psychometric assessment helps identify strengths and areas for development, and career professionals provide ongoing guidance as the matching process unfolds. Participants create professional digital profiles presenting:

- Skills and training background
- Career interests
- CV and professional information

AI-powered matching algorithm to support candidate-employer pairing, operating within a human-mediated framework that ensures algorithmic recommendations are contextualised by professional knowledge of both parties. Beneficiaries remain accompanied by Odyssea staff throughout recruitment and hiring processes.

For employers

Companies benefit from:

- Access to a pool of pre-screened candidates
- Reduced recruitment time and resources in candidate identification
- Support in advancing Diversity, Equity and Inclusion strategies
- Continuous mediation support from the programme staff

What results has it brought?

The platform has achieved significant outcomes:

- Over 2,000 professional profiles created
- More than 2,500 candidate–company connections
- Engagement of over 100 companies
- More than 500 hires facilitated

Beyond these volume figures, the platform has produced meaningful qualitative shifts in how vulnerable young people access the labour market. Participants report improved visibility and professional confidence, and the platform has contributed to a measurable increase in their access to employment opportunities through structured matching. Employers report stronger engagement with social inclusion objectives and reduced recruitment friction when accessing candidates through the platform.

What makes this practice work?

The effectiveness of the Talent Platform relies on:

- Combination of digital accessibility with human mediation: the platform lowers access barriers through digital infrastructure while preventing the depersonalisation and exclusion that purely algorithmic systems tend to reproduce.
- Reduction of informal and exclusionary recruitment pathways: by making skills visible and the process transparent, the platform directly counters the network-dependent dynamics that disadvantage people without established social capital.

- Scalability while maintaining personalised support: the digital infrastructure allows the model to reach more people than purely human-mediated services could, without abandoning the individualised accompaniment that makes outcomes sustainable.
- Integration within the broader employability and reintegration model: the platform works best for participants who have completed vocational training and employability pathway support. It is a culminating tool within a coherent system, not a standalone solution.
- Direct employer engagement and dual value proposition for employers: framing employer participation in terms of DEI strategy and measurable social impact, not just candidate quality, creates more durable engagement than purely transactional recruitment relationships.

What challenges or limitations have been identified?

Identified limitations include:

- **Digital literacy gaps among some beneficiaries**: creating and maintaining a professional digital profile requires a level of digital fluency that not all participants have at the outset, and support for profile development must account for this without becoming a new barrier to access
- **Continuous employer engagement**: the platform's value to beneficiaries depends directly on the active participation of companies with real opportunities. Maintaining an engaged employer network requires sustained relationship management and cannot be assumed to run on its own momentum
- **Dependence on complementary services**: the platform produces its best outcomes for participants who have been through the full employability pathway, including vocational training. For people without that preparation, the matching process is less effective. The tool amplifies a strong foundation but cannot substitute for one.

- **Technical and maintenance requirements of digital infrastructure**: this may present a pressing issue when replicating the strategy since it requires IT costs for its design, implementation and stable maintenance.

How can it be transferred to other contexts?

The Talent Platform has high transferability potential, particularly in contexts where digital infrastructure is available and where organisations already providing employability mediation and career support can host and manage the human dimension of the model.

Key enabling conditions include:

- The digital infrastructure, which will incur into technical development and maintenance costs of the platform itself
- Organisations with staff capacity to provide the mediation and follow-up support that makes the digital tool effective rather than merely accessible
- Partnerships with local employers and labour market actors committed to inclusive recruitment
- Commitment to inclusive, skills-based recruitment practices
- Considering employer engagement component as a dedicated strand of work from the outset
- Adaptation to the national labour market and legal frameworks, which will also require investment in local expertise.

More information: https://talent.odyssea.com/home

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