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What works in Europe? Developing a European *Communities that Care* database of effective prevention programmes

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Executive summary

Introduction

Communities that Care (CtC) is a method to help communities prevent problems such as crime, violence and alcohol and drug misuse. Most communities that use CtC implement evidence-based programmes (EBPs). For the purposes of developing CtC in Europe it was decided to identify programmes that have been tested and found effective in Europe, and to include these in an online database that could be used by CtC sites in Europe. This report describes the process of identifying, reviewing and rating programmes and studies to inform the online database and, essentially as a by-product, it analyses the programmes and studies that were included and seeks to draw out some initial findings and implications.

Methods

A search was undertaken via existing databases of programmes and the wider literature for randomised controlled trial (RCT) and quasi-experimental design (QED) studies conducted in Europe and published in English of prevention and early intervention programmes – home-grown or imported – that target children and young people aged 0 to 22 years and focus on improving outcomes in any of the following areas: education, behaviour, substance misuse, physical health, and emotional well-being.

Preliminary reviews were completed to determine whether programmes were suitable for full review and to prioritise the order in which full reviews were undertaken. Programmes that cleared the screening process were reviewed in full using the system developed by the well-respected programme database Blueprints for Healthy Youth Development. This involved completing a detailed form covering three aspects of the Blueprints standards of evidence: intervention specificity; evaluation quality; and impact.

Once full reviews were completed, programmes were rated by the research team in order to differentiate between those performing better or worse overall. Three sets of criteria were taken into account: evaluation quality; impact; and transportability (defined as whether or not the programme was tested and found effective in two or more European countries). The highest rating was for programmes with high-quality studies showing mainly positive effects in two or more European countries, while the lowest rating was for programmes with good-quality studies showing null or negative effects in two or more European countries.

Lastly, for each of the programmes reviewed in full a write-up was completed containing text for presentation on a searchable online database. The headings were as follows: programme name; overall rating; Blueprints rating (if available); outcomes targeted; age group; level of prevention; target group; programme setting; programme type; brief description; full description; outcomes affected; risk factors targeted; protective factors targeted; country of origin; countries where evaluated; references of studies reviewed; and contact information (for programme developer /purveyor).

Results

A total of 243 potentially relevant programmes were identified. Of these, 92 met the inclusion criteria and were reviewed in full. Two-thirds of these originate in Europe

(particularly the UK and Germany), with one third being imported (mostly from the US). Once a programme is imported it tends to be evaluated in several countries, but there is relatively little trade in programmes between European countries. There is also a very uneven distribution of programme evaluations across Europe: most programmes were evaluated in three countries only (the UK, Germany and the Netherlands), whereas in 10 countries there were no studies meeting the inclusion criteria.

Half (50%) of the programmes involve a universal element, either in whole or in part, meaning that the other half are targeted only. Most programmes cluster in middle childhood and adolescence, with far fewer targeting either infants or young people transitioning to adulthood.

Behavioural outcomes are the most commonly targeted (two-thirds of programmes), with much more modest numbers focusing on outcomes in the emotional well-being, education and positive relationships domains. Fewer than 10% of the programmes reviewed focus on physical health outcomes. Programmes are most likely to target risk and protective factors at the individual/peer and family levels, and unlikely to focus on factors in the community and economic domains.

In terms of evidence ratings, about one in five of the 92 programmes were regarded as worth considering implementing based on their impact and the quality of the evaluation. One in 20 should arguably be avoided given the lack of positive evidence for their effectiveness based on high-quality studies. The remaining three-quarters of programmes look promising but arguably need further testing because the results are not yet compelling. The distribution of programmes across these three levels is broadly the same for imported and home-grown programmes, although some differences emerge: for example, imported programmes are more likely to reach the very highest level, whereas in the 'promising but test further' category, home-grown programmes are more likely than imported programmes to demonstrate a broadly positive effect.

When programme ratings are mapped onto age groups and outcome categories targeted, it is apparent that the distribution of 'Implement' and 'Test further' programmes, which are the types of programme that commissioners are likely to be interested in, is very uneven. For some age-outcome combinations there appear to be no programmes to choose from, and for many others the choice for is very limited. The greatest choice is in the outcome area of behaviour and for middle childhood and adolescence in particular.

Programmes that are approved by Blueprints do not necessarily come out as 'tested and effective' when only European studies are considered.

Discussion and conclusions

The research achieved its goal of identifying, reviewing and rating programmes that could potentially be recommended to CtC sites in Europe but work is needed to include more programmes and studies (including those published in languages besides English), confirm the ratings and establish the dissemination readiness of the programmes identified. The analyses cast some light on the situation in Europe vis-à-vis EBPs, but by no means represent a definitive overview.

Europe is putting its own mark on the EBP movement, both developing and testing home-grown programmes but also adapting those developed elsewhere, blending them with locally and culturally sensitive practice. Equally, imported programmes are not universally unsuccessful; indeed, in general they appear to be no less successful than those originating in Europe.

Several challenges lie ahead. First, the issue of transportability presents difficulties when rating programmes. Using effectiveness in two or more European countries as a marker for transportability is imperfect because it does not take into account the nature of the countries concerned. Further, focusing only on European studies means that a programme demonstrated to be effective in multiple studies in North America but found to be ineffective in the single study in a European country gets a poor rating. This needs revisiting.

Second, the research demonstrates the need to improve the quality of studies conducted in Europe. The quality of studies overall was deemed to be 'good' – indicating that they arguably meet Blueprints standards – for just under a third (n=28, 30%) of the 92 programmes. More concerted efforts to apply standards of evidence and reporting standards should help to rectify this.

Third, in many countries, there are likely to be few if any tested-and-effective options at all, and even in countries with more programmes and studies, the options will probably be slim or non-existent for some age-groups and target outcome areas. A reasonable hypothesis, then, is that the future success of initiatives such as CtC will depend in large part on drawing out lessons about 'what works' from programme evaluations and applying those locally.

Introduction

Communities that Care (CtC) is a method to help communities prevent problems such as crime, violence and alcohol and drug misuse (Hawkins et al., 2002).¹ It seeks to mobilise communities to address adolescent health and development problems systematically by adopting a science-based approach to prevention. It begins with a survey of young people to identify risk and protective factors and existing community resources. Based on these data, CtC helps communities to identify priority risk and protective factors and select and implement tested and effective prevention programmes and policies that address those factors and that fill gaps in existing resources. Communities monitor and evaluate these interventions, measuring results and tracking progress to ensure that improvements are achieved. It has been implemented mainly in the US but also in Australia and several European countries, including Austria, Croatia, Cyprus, Germany, the Netherlands, Sweden and the UK.

Although there have been several studies of CtC, the best evidence for its impact comes from the sole randomised controlled trial (RCT), which was conducted in the US. The study involved 24 communities across seven states, with 4,407 children followed from Grade 5 (10-11 years) prior to the intervention to Grade 12 (17-18 years), three years after implementation support ended. In the 12 intervention (CtC) communities, two to five evidence-based prevention programmes were implemented each year when students were in Grades 5-9. By the end of Grade 12, young people exposed to CtC were significantly more likely than control group young people to never use any drugs, gateway drugs, alcohol, or cigarettes, and also significantly more likely to never engage in delinquent or violent behaviours (Hawkins et al., 2014).²

Most communities that use CtC implement evidence-based programmes (EBPs). A programme is a discrete, organised package of practices, spelled out in guidance (sometimes called a manual) that explains what should be delivered to whom, when, where and how. A programme is 'evidence-based' when it is 'tested and effective': 'tested' means that the programme has been put through its paces by a high-quality impact evaluation, and 'effective' means that there is strong evidence from that evaluation that the programme makes life better for children or families. The decision about which interventions deserve to be recommended is informed by standards of evidence, which vary in breadth and depth but typically cover four domains: whether the programme is well described (intervention specificity); whether it works (impact); how confident one can be in the results (evaluation quality); and whether the intervention can be replicated (system readiness).³

There are many online databases or 'clearinghouses' of EBPs – at least 30 in English alone. They tend to share several common features: brief descriptions of the programme (e.g. aims, target group, content); a summary of the outcomes that the programme has been shown to have a positive impact on; the resources required to deliver the programme; and contact details of the person or organisation to contact if one is interested in delivering the programme. They also vary: some are subject-specific whereas others are more diverse; some focus on one country only whereas others are regional or global in scope; some span a wide range of quality and effectiveness, whereas others focus only on what they consider to be the 'best'; and some provide much more detail than others, for example on specific issues such as cost-benefit or implementation.

Historically, CtC had a menu of proven programmes, but in recent years they have started pointing sites to Blueprints for Health Youth Development, widely regarded as having the highest standards available (it has only approved about 5% of the over 1300 programmes it has reviewed) (Mihalic and Elliott, 2015).⁴ While Blueprints could be used in a European context, and indeed has been, it focuses primarily on programmes that have been developed and tested in the US (Axford et al., 2012). This is unsurprising given that this is where it is located and where its funding comes from, and that programmes developed and tested outside the US often lack the infrastructure required for delivery in the US. But it also reflects the predominance of US-origin EBPs generally. The only programmes that have bucked the trend are the suite of Triple P parent training resources (developed in Australia), the school-based Olweus bullying prevention programme (developed in Norway), the EFFEKT alcohol misuse prevention programme (developed in Sweden) and, latterly, KiVa, another school-based bullying prevention programme (developed in Finland). Much more money and effort has arguably been invested in developing and testing EBPs in the US than it has in Europe, in large part a reflection of differences in the level and quality of regular public services (generally higher in Europe) and the role of philanthropy (greater in the US).

However, this pattern has caused some consternation in Europe, notably among academics and practitioners who complain at the tendency to ‘look west and not east’. The implication is that there is much valuable activity underway in Europe but a danger that an unjustified infatuation with all things American causes it to be overlooked. Added to this, there is accumulating evidence that at least some if not the majority of EBPs imported from the US are not as effective – even completely ineffective – in Europe (e.g. Sundell et al., 2008; Berry et al., 2016; Robling et al., 2016). There is much speculation as to why this is, with opinion seeming to coalesce around the twin ideas that the programmes under scrutiny are competing against better ‘services as usual’ in Europe (meaning that it is harder for something new to demonstrate added value) and that fidelity falters in real-world effectiveness studies (possibly as a result of the programme developer being less or not at all involved).

Meanwhile, there has also been the quiet emergence of home-grown European programmes, a growing number of which have been evaluated using comparison group studies. This arguably reflects – in part – the efforts of some researchers and intervention developers to learn lessons from and even copy the American experience. A good example would be the substantial philanthropic investment in children and young people in Ireland, which funded the import of several EBPs from the US but which also supported the development and testing of programmes locally (Little and Abunimah, 2007; Axford et al., 2008). Elsewhere, the emergence of European EBPs reflects efforts to domesticate US imports by adapting them significantly – even beyond recognition – for a local context. It is fair to say that there has also been a push towards more rigorous evaluations of intervention effectiveness; while this trend is not universal, a stronger focus on outcomes, combined with the global financial crisis and the decision of some governments to address this by cutting public services, have stimulated the greater use of experimental (randomised controlled trial – RCT) and quasi-experimental evaluations.

Collectively, these developments meant that for the purposes of developing CtC in Europe it made sense to identify programmes that have been tested and found effective in Europe, and to include these in an online database that could be used by sites in Europe employing the CtC methodology. These were the twin aims of this part of the project funded by the European Commission. It complements the other two parts of the project insofar as, first, the analysis of outcomes and risk and protective factors (Farrington and Jonkman, forthcoming) points to priority areas that need to be addressed by programmes, and, second, some of the lessons from the analysis of implementing CtC in Europe (Groeger-Roth et al., 2016) can be applied to implementing the programmes identified and disseminated via the database.

This report has two functions. It describes the process of identifying, reviewing and rating programmes and studies to inform the online database and, essentially as a by-product, it analyses the programmes and studies that were included and seeks to draw out some initial findings and implications. The remainder of this report is in three sections. First, there is a description of the methods, covering the criteria for selecting programmes, the process of searching for and selecting programmes, the criteria applied to assess them and the process of applying those criteria through review work and giving each programme a global rating against standards of evidence. Second, the results are presented, giving a breakdown of the programmes identified and reviewed in terms of their country of origin, level(s) of prevention, target age group, target outcome areas and global rating against the standards. Lastly, the report includes a discussion section, reflecting on strengths and limitations of the methods, what may be concluded from patterns in the results, and recommended next steps for programme developers, evaluators and policy makers and practitioners.

Methods

The aim of the research was to find and review evidence-based social interventions tested and found effective in Europe. This included interventions imported from outside Europe and those that are 'home-grown', meaning that they were developed in Europe. The intention was always to share information about tested and effective programmes in Europe with CtC sites via an online database so that sites could select programmes to address the risk and protective factors prioritised in their areas based on the surveys.

The criteria used were wide ranging. Programmes needed to be for children and young people in the age range 0 to 22 years and focus on improving outcomes in any of the following areas: education, behaviour, substance misuse, physical health, and emotional well-being. Although CtC focuses primarily on reducing crime and anti-social behaviour, the other outcome areas are related in that improvements in them are likely to have wider effects. In order to be included, there needed to be some evidence that programmes are available, meaning that they actually exist and are therefore potentially ready for dissemination (as it proved, this is often difficult to establish). Programmes that constitute prevention or early intervention as opposed to treatment were also prioritised.

The criteria also required that there be at least one study of the programme in Europe that constituted an RCT or a quasi-experimental design, and that at least one of these studies was published in the English language. As defined by the United Nations, Europe includes 49 states and territories: the 28 European Union member states, an additional three members of the European Free Trade Association, and 18 others that are geographically part of the

continent (some are transcontinental).⁵ There were no requirements regarding the nature of the publication, meaning that studies could be published as peer-reviewed articles, book chapters, reports or other grey literature. Given that the aim of the research was to identify programmes that could be listed on a publicly accessible online database that CtC sites could search with a view to selecting one or more for implementation, priority was given to programmes found to be effective in at least one relevant European study (it did not make sense to focus on programmes not found to be effective in Europe).

The search process was designed to identify programmes and studies meeting the criteria described above. It was not intended to be a comprehensive search, not least because the resources for the project did not permit this,⁶ but the aim was to identify a good spread of programmes and studies in terms of the criteria and to ensure that key studies in respective European countries were identified. As such, the search involved: systematically examining existing databases of evidence-based programmes, including several at both national and international levels; hand-searching a series of journals known to be repositories of the kinds of study that are the focus of the research, as well as those concerned with the outcomes of interest in Europe (focusing on the period 2000 to present);⁷ asking representatives in other countries involved in the project to nominate relevant programmes and studies that they knew about; following up references from all of the above sources (including going to the designated websites of programmes if they existed); and capitalising on opportunities presented by other parallel studies by members of the research team.⁸ A list of the sources can be found in Appendix A.

The net was cast wide and then programmes and studies were screened to identify those that met the criteria. In order to ensure that all relevant studies were included for those programmes identified as meeting the criteria, programme websites (where available) were checked, and a focused programme-specific search for other studies was completed. The project was set up to have a two-stage review process. In the first stage, rapid preliminary reviews were conducted to check whether the above criteria were met. This helped with deciding whether the programme was suitable for full review and then with prioritising the order in which reviews were undertaken.⁹ At this stage, some programmes were excluded owing to a lack of positive impact. For the remaining programmes, all English-language studies were reviewed, irrespective of the initial brief assessment of evaluation quality. Reviewers were given guidance and training on how to complete the reviews. A copy of the preliminary review form can be seen in Appendix B.

In the second stage, programmes that cleared the screening process were reviewed in detail using the system developed by the well-respected programme database Blueprints for Healthy Youth Development. This involves completing a detailed form covering three aspects of the Blueprints standards of evidence: *intervention specificity* (is the intervention focused, practical, logical and designed based on the best available evidence about what types of factors affect child outcomes and what works in improving outcomes?); *evaluation quality* (is the evaluation design and execution robust enough to permit confidence in the results?); and *intervention impact* (what do robust evaluations tell us about how much impact the intervention has on key developmental outcomes for children?). A summary checklist is completed on each study to help with forming an overall judgement about the programme. In order to ensure the high quality and consistency of reviews, a separate

checklist was completed by a second reviewer, who also checked the original review. If necessary, the checklist and the review were amended. Reviewers were given guidance and training on how to complete the reviews. A description of the fields completed in the review process, and the summary checklist, can be seen in Appendices C and D respectively.

Once full reviews were completed, programmes were rated in order to differentiate between those performing better or worse overall. Three sets of criteria were taken into account in this process: *evaluation quality* (assessed according to whether or not the Blueprints criteria on this dimension were deemed to have been met); *impact* (distinguishing between mainly positive effects, mainly null or negative effects, and mixed effects); and *transportability* (defined as whether or not the programme was tested and found effective in two or more European countries). At the upper and lower ends of the rating system, a distinction was made between RCTs and QED design studies, with the former being regarded as stronger. Thus, the highest rating was for programmes with high-quality studies showing mainly positive effects conducted in two or more European countries, while the lowest rating was for programmes with good-quality studies showing null or negative effects in two or more European countries. Owing to constraints of resource and time, for one third of the programmes (n=31) the ratings were completed by two members of the research team (NA and SS) working independently in the first instance before discussing decisions, with the remaining programmes rated by one person only (SS).¹⁰ The rating system used for this project is described in Appendix E. A summary of the Blueprints standards can be seen at the following location: <http://www.blueprintsprograms.com/criteria>.

Lastly, for each of the programmes a write-up was completed containing text for presentation on a searchable online database. The headings were as follows: programme name; overall rating; Blueprints rating; outcomes targeted; age group; level of prevention; target group; programme setting; programme type; brief description; full description; outcomes affected; risk factors targeted; protective factors targeted; country of origin; countries where evaluated; references of studies reviewed; and contact information (for programme developer /purveyor). The write-ups were deliberately brief and focused to increase the likelihood of them being read by busy policy makers and commissioners. A full list of the outcome categories can be found in Appendix F, and the risk and protective factors are listed in Appendix G.

Results

A total of 243 potentially relevant programmes were identified in the first instance (Table 1). All were concerned with relevant outcomes, targeted children and young people in the 0 to 22 years age range and had been evaluated in at least one RCT or quasi-experimental study in Europe. Of these, 81 were excluded because they did not have a relevant evaluation that had been published in English or it was not possible to obtain the relevant English-language publication.¹¹ A further 46 programmes were excluded because it was unclear if they were available.¹² Lastly, 24 were excluded because on closer scrutiny it was apparent that they did not constitute prevention or early intervention (i.e. they focused only on treatment) and/or they did not have a positive impact in a European evaluation.¹³ This left 92 programmes that met the inclusion criteria. The programmes that were screened out are listed in Appendix H under the relevant categories described above. It is difficult to say

how many studies out of the 243 programmes that were screened were in languages other than English, as it is not clear if articles refer to different studies or rather are different articles on the same study, but 51 programmes had a non-English name and of these 16 were reviewed in full. The most common languages for these 51 programmes (nearly 90% collectively) were German, Dutch, Croatian and Spanish.

Table 1: Screening process

| Number of programmes | Selection criteria met at screening stage | Reason for exclusion |
|----------------------|-------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------|
| 243 | 1. QED/RCT in Europe 2. Relevant outcomes 3. 0-22 years | |
| 162 | 4. Publication in English that is available | <i>81 programmes were excluded as articles were not in English or no study article was available</i> |
| 116 | 5. Programmes likely to be available | <i>46 programmes were excluded as it was not clear if they were available</i> |
| 92 | 6. Focus on early intervention and prevention 7. Programmes have a positive impact in Europe | <i>24 programmes were excluded since they focused only on treatment or had no impact.</i> |

Since the reviews were completed using the Blueprints system it is instructive to see how the programmes identified map onto that (Table 2). Of the 92 programmes reviewed in full, 40 had already been reviewed by Blueprints. All European studies had already been reviewed by Blueprints for 15 of these, but new European studies needed to be added for the other 25 (for four programmes none of the European studies had been included by Blueprints). The remaining 52 programmes had not been reviewed by Blueprints. Thus, 15 programmes included in this study had already been reviewed by Blueprints completely,¹⁴ 25 programmes were reviewed partially by Blueprints and partially by the research team for this study, and 52 programmes were reviewed completely by the research team.

Table 2: Number of programmes by reviewer and Blueprints ratings

| | |
|-------------------------------------------------------------------------------------------------------------|----|
| Number of programmes with all European studies reviewed by DSRU | 52 |
| Number of programmes with all European studies reviewed by Blueprints | 15 |
| Number of programmes with some European studies reviewed by DSRU and some by Blueprints | 21 |
| Number of programmes with non-European studies reviewed by Blueprints and European studies reviewed by DSRU | 4 |

Origin

Two-thirds of the 92 programmes (n=60, 65%) that met the inclusion criteria originated in a European country, meaning that they may be considered to be home-grown (Table 3). The UK (n=20) and Germany (n=13) made up over half of these between them. The other third of the programmes had been imported from outside of Europe, with most (n=28, 30%)

originating in North America (n=25 USA and n=3 Canada) and the remainder (n=4, 5%) coming from Australia.

Table 3: Programmes by country of origin

| Country | Number of programmes originating from country |
|--------------------------------|-----------------------------------------------|
| 'Imported' programmes | 32 (35%) |
| Australia | 4 |
| Canada | 3 |
| United States of America | 25 |
| 'Home-grown' programmes | 60 (65%) |
| Austria | 1 |
| Denmark | 1 |
| Finland | 2 |
| Germany | 13 |
| Ireland | 5 |
| Italy | 1 |
| Netherlands | 5 |
| Norway | 4 |
| Romania | 1 |
| Spain | 2 |
| Sweden | 4 |
| Turkey | 1 |
| United Kingdom | 20 |

In terms of countries of evaluation, two-thirds (n=62, 67%) of the 92 programmes reviewed were evaluated in one country only (Table 4). In most cases (n=51, 82%) this was the country of origin, and in most of the other cases (n=10, 16%) the programme was imported from outside of Europe. The other third of programmes (n=30, 33%) were evaluated in two or more European countries. In just over half of these (n=16, 53%) two countries only were involved, indicating that just under half (n=15, 47%) involved multiple countries, ranging from three to eight. These figures do not necessarily mean that standalone studies were conducted in each country; in some cases, a pan-European study involved several countries. Of the 30 programmes evaluated in two or more countries, 22 (75%) originated outside of Europe, suggesting that once a programme is imported it tends to go to several countries. There is relatively little trade in programmes between European countries.

Table 4: Number of countries in which programmes were evaluated

| Number of countries where evaluated | Number of 'home-grown' programmes | Number of 'imported' programmes | Total number of programmes |
|-------------------------------------|-----------------------------------|---------------------------------|----------------------------|
| 1 | 52 | 10 | 62 (67%) |
| 2 | 4* | 12 | 16* (17%) |
| 3 | 1 | 4 | 5 (5%) |
| 4 | 1 | 4 | 5 (5%) |
| 5 or more | 2** | 2 | 4** (4%) |

*This includes two studies where an evaluation was conducted across two countries

**This includes two studies where a pan-European evaluation was conducted in 5 or more countries

There is also a very uneven distribution of programme evaluations across Europe (Table 5). In 10 countries no programmes were evaluated in studies meeting the criteria, and in a further 16 countries only between one and five programmes were evaluated. Most programmes were evaluated in three countries only: the UK (35), Netherlands (22) and Germany (21). A detailed list of the programmes evaluated in each European country can be seen in Appendix I.

Table 5: Countries by number of programmes evaluated

| Number of programmes evaluated | Countries |
|--------------------------------|--------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| 0 | Bulgaria, Estonia, France, Hungary, Latvia, Malta, Poland, Slovakia, Slovenia, Liechtenstein (EEA) |
| 1-5 | Austria, Belgium, Croatia, Cyprus, Czech Republic, Denmark, Finland, Greece, Iceland (EEA), Italy, Lithuania, Luxembourg, Portugal, Romania, Switzerland, Turkey (Other) |
| 6-10 | Spain |
| 11-15 | Ireland, Norway (EEA), Sweden |
| 16-20 | |
| 20+ | Germany (21), the Netherlands (22), United Kingdom (35) |

Level of prevention

Table 6 shows the level of prevention at which the 92 programmes that met the inclusion criteria operate. The numbers do not add up to 100% because some programmes operate at more than one level. Half (50%) of the programmes involve a universal element, either in whole or in part, meaning that the other half are targeted only. However, 10 of the programmes with a universal element (11% of all programmes) operate at both universal and targeted levels. About a third of programmes operate at the selective (30%) and indicated (35%) levels respectively. A small proportion (5%) of programmes have a treatment element: all of these are programmes with selective or indicated prevention elements as well.

Table 6: Breakdown of programmes by level of prevention

| Level of prevention | Number of programmes | Percentage of programmes |
|----------------------------|-----------------------------|---------------------------------|
| Universal | 46 | 50% |
| Selective | 28 | 30% |
| Indicated | 32 | 35% |
| Treatment | 5 | 5% |

Age groups

By definition, all 92 programmes that were reviewed in full target children and young people in the 0 to 22 years age range. However, the distribution of programmes across this spectrum varies, with most programmes clustering in middle childhood and adolescence and far fewer targeting either infants or older young people transitioning to adulthood (Table 7). For example, 18% of programmes target children aged 0 to 2 years, and 2% are concerned with young people aged 19 and over. By contrast, 62% of programmes target children in the 6 to 11 years age range and 48% involve adolescents. This pattern arguably reflects the outcomes and risk and protective factors of interest, and the focus of CtC, as will be seen in the following sections.

Table 7: Breakdown of programmes by target age

| Age (years) | Number of programmes | Percentage of programmes |
|--------------------|-----------------------------|---------------------------------|
| 0-2 | 17 | 18% |
| 3-5 | 45 | 49% |
| 6-11 | 57 | 62% |
| 12-14 | 44 | 48% |
| 15-18 | 28 | 30% |
| 19+ | 2 | 2% |

Outcomes targeted

Between them the 92 programmes that met the inclusion criteria target outcomes that fall into five broad outcome domains, with programmes again unevenly distributed across them (Table 8). Programmes often target outcomes in more than one domain, hence the figures in the table do not add up to 100%. Behavioural outcomes are the most commonly targeted (69% of programmes), with much more modest numbers focusing on outcomes in the emotional well-being (35%), education (27%) and positive relationships (23%) domains. Fewer than one in 10 (9%) of the programmes reviewed focus on physical health outcomes, although this is more likely to represent the nature of the search process than reality.

Table 8: Breakdown of programmes by target outcome domain

| Outcome domain targeted | Number of programmes | Percentage of programmes |
|--------------------------------|-----------------------------|---------------------------------|
| Behaviour | 63 | 69% |
| Education | 25 | 27% |
| Emotional well-being | 32 | 35% |
| Physical health | 8 | 9% |
| Positive relationships | 21 | 23% |

Risk and protective factors targeted

The risk and protective factors targeted by programmes are also organised under five different headings (Tables 9 and 10). A clear pattern emerges, in which programmes are most likely to target risk and protective factors at the individual/peer and family levels, and unlikely to focus on factors in the community and economic domains. For example, 41% of programmes target family-level risk factors, followed by 37% focusing on factors at the individual/peer level. A similar proportion of programmes (39%) target family-level protective factors, and over half (58%) target individual/peer protective factors. By contrast, fewer than one in 10 programmes target risk factors at the community or economic levels (both 8%) or protective factors that operate at these levels (7% and 1% respectively). These findings arguably reflect the nature of programmes as a form of intervention: policies or other forms of intervention are required to change factors that operate at the environmental or macro-economic levels, whereas programmes are well placed to effect change at the individual and family levels.

Table 9: Breakdown of programmes by target risk factor domain

| Risk factor domain targeted | Number of programmes | Percentage of programmes |
|------------------------------------|-----------------------------|---------------------------------|
| Family | 38 | 41% |
| School and work | 16 | 17% |
| Individual/peers | 34 | 37% |
| Community | 7 | 8% |
| Economic | 7 | 8% |

Table 10: Breakdown of programmes by target protective factor domain

| Protective factor domain targeted | Number of programmes | Percentage of programmes |
|------------------------------------------|-----------------------------|---------------------------------|
| Family | 36 | 39% |
| School and work | 13 | 14% |
| Individual/peers | 53 | 58% |
| Community | 6 | 7% |
| Economic | 1 | 1% |

Evidence ratings

Based on full reviews, the 92 programmes broadly fall into three main categories according to the ratings that they were given (Table 11). First are programmes that it is worth considering implementing based on their impact and the quality of the evaluation (n=17, 18%). Of these, four reach the highest level on the basis that they have been tested in two or more European countries in two or more high-quality studies with strong evidence of a positive impact on all or a majority of outcomes. Second are programmes that should arguably be avoided – or at least considered very carefully before implementing – given the lack of positive evidence for their effectiveness based on high-quality studies (n=6, 6%). Third are programmes that look promising but which arguably need further testing because the results are not yet compelling. The vast majority of programmes (n=69, 74%) fall into this latter category. It includes programmes with a strong evaluation but limited signs of effectiveness, as well as those with positive effects but a weaker evaluation.

Table 11: Programmes by rating

| Rating | Number of programmes | Percentage of programmes |
|-----------------------|----------------------|--------------------------|
| 'Implement' | 17 | 18% |
| A | 4 | 4% |
| B1 | 12 | 13% |
| B2 | 1 | 1% |
| 'Test further' | 69 | 75% |
| C1 | 9 | 10% |
| C2 | 21 | 23% |
| D1 | 1 | 1% |
| D2 | 10 | 11% |
| D3 | 4 | 4% |
| D4 | 16 | 17% |
| E1 | 3 | 3% |
| E2 | 5 | 5% |
| 'Avoid' | 6 | 7% |
| F1 | 3 | 3% |
| F2 | 0 | 0% |
| F3 | 3 | 3% |
| F4 | 0 | 0% |

The distribution of programmes across the three broad levels is broadly the same for imported and home-grown programmes: 'implement' (16% of imported, 20% of home-grown), 'test further' (75% of both) and 'avoid' (9% and 5% respectively) (Table 12). However, at a finer level of detail there are some notable differences. Two are particularly striking. First, imported programmes are more likely to reach the top level (A: 9% vs. 2%), meaning that they have been tested and found effective in high-quality studies in two or more European countries, whereas a much higher proportion of home-grown programmes are at the next levels down (B1/B2: 19% vs. 6%), indicating one high-quality study in one European country only showing a positive effect. This arguably reflects the tendency identified earlier for home-grown programmes not to be diffused as widely within Europe as those imported from North America or Australia. Second, in the 'test further' category, home-grown programmes are more likely than imported programmes (C1/C2: 39% vs. 22%) to demonstrate a broadly positive effect, whereas imported programmes are more likely to have mixed effects (D1-D4: 44% vs. 28%).

Table 12: Breakdown of ratings by home-grown or imported

| Rating | Number and percentage of 'imported' programmes | Number and percentage of 'home-grown' programmes |
|-----------------------|------------------------------------------------|--------------------------------------------------|
| 'Implement' | 5 (16%) | 12 (20%) |
| A | 3 (9%) | 1 (2%) |
| B1 | 2 (6%) | 10 (17%) |
| B2 | 0 (0%) | 1 (2%) |
| 'Test further' | 24(75%) | 45 (75%) |
| C1 | 5 (16%) | 4 (7%) |
| C2 | 2 (6%) | 19 (32%) |
| D1 | 1 (3%) | 0 (0%) |
| D2 | 7 (22%) | 3 (5%) |
| D3 | 1 (3%) | 3 (5%) |
| D4 | 5 (16%) | 11 (18%) |
| E1 | 3 (9%) | 0 (0%) |
| E2 | 0 (0%) | 5 (8%) |
| 'Avoid' | 3 (9%) | 3 (5%) |
| F1 | 2 (6%) | 1 (2%) |
| F2 | 0 (0%) | 0 (0%) |
| F3 | 1 (3%) | 2 (3%) |
| F4 | 0 (0%) | 0 (0%) |

When programme ratings are mapped onto age groups and outcome categories targeted (Table 13), it is apparent that the distribution of 'Implement' and 'Test further' programmes, which are the types of programme that commissioners are likely to be interested in, is very uneven. In 11 of the 30 cells where 'Implement' programmes could potentially appear, there is nothing listed. The same goes for six of the 30 cells where 'Test further' programmes could appear. In other words, for these age-outcome combinations there appear to be no programmes to choose from. In many other instances, the choice for many outcome-age combinations is very limited, notably for the lower and upper (especially) ends of the age spectrum and the outcome area of physical health. For example, there are only two programmes to choose from for improving the emotional well-being of children aged 12-14 years. The greatest choice is in the outcome area of behaviour and for middle childhood and adolescence in particular. Since the table only shows broad outcome domains targeted, the choice is likely to be even more limited once the specific outcome is taken into account (there are different outcomes within each outcome domain) and once the analysis of effectiveness of interventions in terms of improving outcomes is added.

Table 13: Number of programmes by rating, outcome targeted and age group

| | | 0 to 2 | 3 to 5 | 6 to 11 | 12 to 14 | 15 to 18 | 19+ |
|-------------------------------|--------------|--------|--------|---------|----------|----------|-----|
| Physical health | Implement | 0 | 0 | 0 | 1 | 1 | 0 |
| | Test further | 4 | 3 | 3 | 0 | 0 | 0 |
| Emotional well-being | Implement | 2 | 7 | 8 | 2 | 0 | 0 |
| | Test further | 2 | 9 | 18 | 7 | 6 | 0 |
| Positive relationships | Implement | 4 | 3 | 3 | 1 | 0 | 0 |
| | Test further | 5 | 6 | 9 | 4 | 3 | 0 |
| Behaviour | Implement | 8 | 8 | 10 | 7 | 4 | 0 |
| | Test further | 3 | 18 | 26 | 27 | 18 | 2 |
| Education | Implement | 2 | 2 | 3 | 1 | 0 | 0 |
| | Test further | 4 | 10 | 10 | 4 | 2 | 0 |

Finally, it is interesting to compare the ratings in this study with those of Blueprints. The evidence ratings for this work are based solely on European evaluations, while the Blueprints review may have included all, some or none of the European evaluations. Of the 92 programmes reviewed in full, 18 have been approved by Blueprints. However, as Table 14 shows, only five of these reached the highest level used for this study (categories A or B) and three others were judged to have a broadly positive effect (C). The remaining 10 have little or no effect (D, E or F). Closer scrutiny of the figures reveals that this relates to which studies inform the Blueprints rating and where they were conducted. Specifically, for all of the Blueprints-approved programmes that did not achieve the highest evidence rating in the present study, Blueprints took into account studies conducted elsewhere – most likely in North America. It must be assumed that these studies were rated favourably in terms of evaluation quality and impact, and therefore that the preponderance of evidence was judged by Blueprints to be in the programmes' favour. Put simply, 13 programmes that were 'tested and effective' elsewhere were not 'tested and effective' in Europe. The fact that not all EBPs that have a positive impact elsewhere in the world have a similar impact in Europe clearly raises issues about their transportability.

Table 14: Comparison of 18 Blueprints-approved programmes with ratings for this project

| Studies in Blueprints review | A/B | C | D/E | F |
|------------------------------------------------------|------------|----------|------------|----------|
| All European studies + no other studies | 2 | 0 | 0 | 0 |
| All European studies + studies from other countries | 0 | 1 | 3 | 0 |
| Some European studies + no other studies | 0 | 0 | 0 | 0 |
| Some European studies + studies from other countries | 3 | 2 | 5 | 1 |
| No European studies + studies from other countries | 0 | 0 | 1 | 0 |

Looking at the 22 programmes examined for this study that were reviewed but *not* approved by Blueprints, for nine programmes all of the European studies had been considered by Blueprints (Table 15). Surprisingly, one of these programmes has been given the highest rating in the present study. The Blueprints review was based solely on the European studies. So why the difference? The most likely explanation is that the programme was not dissemination ready for the US. Of the other programmes that were not approved by Blueprints, none made the highest ratings in the present study (A or B) and only four of the remaining 20 had a positive effect (C) in a European evaluation.

Table 15: Comparison of 22 Blueprints ‘not approved’ programmes with ratings for this project

| Studies in Blueprints review | A/B | C | D/E | F |
|-------------------------------------------------------------|------------|----------|------------|----------|
| All European studies + no other studies | 1 | 2 | 2 | 3 |
| All European studies + studies from other countries | 0 | 0 | 1 | 0 |
| Some European studies + no other studies | 1 | 1 | 3 | 0 |
| Some European studies + studies from other countries | 0 | 1 | 3 | 1 |
| No European studies reviewed + studies from other countries | 0 | 0 | 2 | 1 |

Discussion

This is the first piece of research known to the research team that focuses on identifying prevention and early intervention programmes tested and found effective in Europe. A surprisingly large number of programmes was identified (over 200), with nearly 100 deemed worth reviewing in full. Of these, two-thirds were home-grown and a third were imported, mostly from North America. The imported programmes are more likely to be tested in two or more countries, whereas there is less dissemination of home-grown ones. Countries in northern Europe, including to some extent Scandinavia, dominated in terms of the number of programmes and evaluations, with far fewer originating from and being tested in southern and eastern Europe (Spain being the exception). In terms of age group targeted, the majority of programmes clustered around middle childhood and adolescence, with behaviour being the main focus in terms of outcomes. Programmes were far more likely to target risk and protective factors at the individual and family levels than at the community and economic levels. Based on ratings that take into account evaluation quality, impact and transportability, about one in five programmes were in the highest of three broad categories, with only four at the very highest level (high-quality evaluations in two or more countries showing a positive effect). Three-quarters of programmes were in the second broad category, suggesting a need for more testing, and fewer than one in 10 were in the lowest category on the basis of good-quality evaluations showing null or harmful effects. Imported programmes are more likely than those that are home-grown to reach the highest level, but more likely at the next broad level down to have mixed effects. For some outcome-age combinations, there is no or only very limited choice in terms of programmes. Programmes that are approved by Blueprints do not necessarily come out as ‘tested and effective’ when only European studies are considered.

As indicated earlier, the purpose of the research was to identify tested and effective programmes that could be recommended for Communities that Care sites in Europe. The analysis in this report is effectively a by-product of that work. Nevertheless, as a piece of research it has several strengths. First is the large number of programmes and studies identified and the inclusion of both home-grown and imported programmes. Although the search was not intended to be comprehensive, and the dearth of programmes in some areas, notably physical health, reflects this, the combination of systematic searching of key sources and consultation with experts in respective countries means that there can be confidence that key programmes and studies were included. Second, a rigorous screening process operated to ensure that the most relevant programmes were reviewed in depth, and reviews were rigorous, following the Blueprints process in terms of the type of critical

appraisal undertaken. Third, the rating system that was applied combined the traditional focus on evaluation quality and impact with a focus on Europe and attention to transportability. Specifically, ratings were based solely on studies conducted in Europe, and took into account the extent to which programmes were tested and found effective in two or more European countries. As such, it sought to address the concern that programmes found to work in one context – typically North America – may not work this side of the Atlantic. This is seen in the comparison of Blueprints ratings and the ratings used in the research reported here.

Equally, the research presented in this report has notable limitations, some of which stem from the analysis being secondary to the primary aim of identifying tested and effective programmes in Europe. First, it focused on studies published in English. Numerous RCT and QED studies published in other languages were identified but they were not reviewed in depth. For the most part this means that it was not possible to cover certain programmes in the in-depth reviews, which naturally skews the overall patterns, but it also means that for some programmes that were reviewed in depth there are missing studies that could affect the overall rating. Second, the ratings must be seen as provisional in the sense that two-thirds were rated by one member of the research team only, albeit after one third of programmes were rated by two people and with a high degree of agreement. Even having two raters look independently at the same programme is not the same as convening a panel of experts in a range of relevant subject areas and discussing each study in depth. Further, the ratings are based solely on European studies and could be perceived wrongly to ignore studies of the same programmes conducted elsewhere. Third, besides seeking to establish whether programmes are available, the extent to which programmes are ready for dissemination in regular service systems was not analysed. There is also a difference between being dissemination ready in the country of origin and being dissemination ready in additional countries. It may be inferred that programmes tested and found effective in two or more countries are somewhat likely to be dissemination ready, but further scrutiny is needed.

To sum up, the research achieved its goal of identifying, reviewing and rating programmes that could potentially be recommended to CtC sites in Europe but work is needed in the future to include more programmes and studies (including those published in languages besides English), confirm the ratings and establish the dissemination readiness of the programmes identified. Additionally, the analyses in this report should be viewed in the context of the aforementioned limitations. While they cast some light on the situation in Europe vis-à-vis evidence-based programmes, they by no means represent a definitive overview. It could be argued that if the additional work identified above were completed, the overall picture would not change much, but this needs to be tested. With these important caveats in mind, the remainder of this section offers some reflections on the findings reported above.

There have been numerous critiques of EBPs in a European context. One line of argument is that the concept of a programme does not sit well in Europe, where in many countries there is stronger universal provision than in the US and therefore less of a need, arguably, to insert specific interventions into the lives of children and families deemed to be 'at risk'. This applies particularly to welfare regimes that are social democratic (notably Scandinavian

countries) or conservative/corporatist (large parts of continental Europe) (Grietens, 2010). Another criticism, based on empirical evidence (see earlier), is that programmes imported from elsewhere (mostly the US) tend not to work as well in Europe, meaning that the effects seen in the context where they originated are not replicated. Related to this is the argument that imported programmes tend not to be culturally relevant, yet the prescription of fidelity at all costs prevents making necessary adaptations.

These and other critiques have been addressed elsewhere (e.g. Ferrer-Wreder et al., 2012; Axford and Morpeth, 2013; Burkhart, 2013), and it was not the purpose of this research to defend EBPs. Nevertheless, the evidence summarised in this paper does cast light on some of the issues.

To start with, Europe is putting its own mark on the EBP movement, both developing and testing home-grown programmes but also adapting those developed elsewhere, blending them with locally and culturally sensitive practice (Grietens, 2013) and adapting them to take into account the social and political organisation of society (Burkhart, 2015). The adaptation involved is apparent from reading studies of imported programmes, and tends to be at the surface level.

Next, imported programmes are not universally unsuccessful; indeed, in general they appear to be no less successful than those originating in Europe. However, there are subtle but important differences. At the very highest level of the rating system used in this research (A), taking evaluation quality and transportability into account, there are disproportionately more imported programmes than home-grown ones, but if the focus is on impact only, home-grown programmes are more likely to show a broadly positive effect (A-C2: 59% vs. 37%) and less likely to show a generally negative or null or harmful effect (D1-F4: 41% vs. 62%) (Table 12).

The research also highlights issues with the transportability of programmes. A third (n=30, 33%) of the programmes had been tested in two or more European countries.¹⁵ These were disproportionately more likely to be imported programmes. Conversely, there is little trade between European countries: it is rare for a programme developed in, say, Germany to be tested in, say, Italy. It is fair to assume that this is largely because of language issues, but also potentially resources, with programmes published in English in the US *and* promoted with the support of an international infrastructure more likely to be adopted. Of these, and not taking into account evaluation quality, fewer than half (n=13, 43%) had a broadly positive effect, compared with just over half (n=34, 55%) of those with one evaluation only. This indicates that it is harder to demonstrate effectiveness in more than one country and suggests that some of those with a positive effect in one country may not transport well.

The issue of transportability also presents difficulties when rating programmes. It is hard enough, often, making a rating when trying to take into account the variable quality and impact on multiple outcomes of two or more studies. When those studies are in different countries it adds a new dimension. Moreover, there are conceptual questions about how much weight to put on having two or more evaluations in different European countries and whether or not to also take evidence of the effectiveness of programmes outside of Europe into account. For example, a programme that is effective in Germany and the Netherlands

may well be unsuitable – let alone effective – in Greece or Croatia. In other words, using effectiveness in two or more countries as a marker for transportability is imperfect because it does not take into account the nature of the countries concerned. Similarly, the current rating system means that a programme demonstrated to be effective in multiple studies in North America but found to be ineffective in the single study in a European country gets a poor rating. Is this fair? Related to this is the fact that several Blueprints-approved programmes do not emerge as ‘tested and effective’ when only European studies are taken into account, suggesting that they may not transport well across the Atlantic.

The research also demonstrates the need to improve the quality of studies conducted in Europe. The quality of studies overall was deemed to be ‘good’ – indicating that they arguably meet Blueprints standards – for just under a third (n=28, 30%) of the 92 programmes. This might be considered positive insofar as Blueprints is acknowledged to have very high standards and has approved only about 5% of the programmes it has examined. Even so, the greater use of standards of evidence such as those used by Blueprints and others when designing and implementing RCTs and quasi-experimental studies (e.g. Gottfredson et al., 2015), together with the wider adoption by journals of reporting guidelines, notably CONSORT (Schulz et al., 2010) and TREND (Des Jarlais et al., 2004), should help to improve the quality of published research in this area.

Lastly, the research demonstrates some of the challenges for policy makers and services commissioners who may look to databases of EBPs when deciding which services to implement. In this context, this applies to CtC sites in Europe seeking to select programmes to address the outcomes and risk and protective factors prioritised as a result of the analysis of the community survey results. To start with, there are very few programmes that address community or economic risk factors, and relatively few programmes at either end of the age spectrum. In other words, in some areas the choice is limited. This is exacerbated if it is regarded as feasible only to implement programmes tested in one’s own country, or those tested in two or more other countries (indicating the potential for transportability but the need for translation). When evaluation quality and evidence of effectiveness are taken into account the choice becomes even more constrained. Thus, in many countries, there are likely to be few if any options at all, and even in countries with more programmes and studies, the options will probably be slim or non-existent for some age-groups and target outcome areas.

Conclusions

This research has demonstrated that there are numerous home-grown evidence-based programmes in Europe, contrary to assertions that an EBP is essentially an American concept. Further, it has shown that some imported programmes are effective: some programmes do seem to transport well in terms of implementation and impact.

The study has also highlighted important challenges. Arguably the most significant is that, all things considered, and notwithstanding the limitations of this research in terms of scope, there appear to be relatively few effective programmes in Europe, certainly if evaluation quality is taken into account, and even fewer that show evidence of being transportable. While more indigenous programmes are likely to be developed and tested, some successfully, and while there will be further imports and adaptations, again with some

proving effective, sites using CtC in many European countries will arguably struggle to do much about priority risk and protective factors and outcomes if they rely solely on programmes. This links to the wider debate about the future of such programmes, and the increasing interest in non-programmatic forms of intervention, such as the common elements approach (Axford, 2015). A reasonable hypothesis, then, is that the future success of initiatives such as CtC and variations on it such as Evidence2Success, which adopts a similar approach but with a greater focus on integration with the regular service system (see Utting, 2016), will depend in large part on drawing out lessons about 'what works' from programme evaluations and applying those locally.

A final comment is merited on how the information on the programmes that were reviewed will be used. The write-ups will be published on a publicly accessible online database that can be searched by policy makers and commissioners wishing to implement evidence-based programmes for particular outcomes, risk and protective factors and age groups. This approach is in line with what is done in many other databases. However, there is a growing awareness of the limitations of existing clearinghouses. Criticisms include the failure to include forms of intervention beyond programmes, the associated focus on RCTs and quasi-experimental studies to the exclusion of other study designs, the difficulty often of using the databases, the dearth of guidance and support with selecting and implementing programmes and the lack of information about peer experience of using the interventions listed (Neuhoff et al., 2015). The project that this report is based on was deliberately limited to programmes and comparison group studies, but the other issues identified can be addressed. Specifically, the design and functionality of the database can be fine-tuned with input from potential users, and if used in the context of CtC sites will receive considerable assistance with selection and implementation. There is also the potential, in time, to include ratings and comments from those who have implemented the programmes.

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¹ www.communitiesthatcare.net

² The study has generated many papers, some of which are available at <http://www.communitiesthatcare.net/research-results/>

³ <http://investinginchildren.eu/standards-evidence>

⁴ www.blueprintsprograms.com

⁵ The 28 European Union countries are as follows: Austria, Belgium, Bulgaria, Croatia, Republic of Cyprus, Czech Republic, Denmark, Estonia, Finland, France, Germany, Greece, Hungary, Ireland, Italy, Latvia, Lithuania, Luxembourg, Malta, Netherlands, Poland, Portugal, Romania, Slovakia, Slovenia, Spain, Sweden and the UK. The European Economic Area includes these countries plus Iceland, Liechtenstein and Norway (which are part of the European Free Trade Association). Relevant studies were also identified in Switzerland and Turkey, both of which are geographically part of Europe (the latter is a transcontinental country, as it is mainly in Asia).

According to the UN, other European states and territories are: Albania, Andorra, Belarus, Bosnia and Herzegovina, Faroe Islands, Gibraltar, Greenland, Macedonia, Moldova, Monaco, Montenegro, San Marino, Serbia, Vatican City State, Russian Federation and Ukraine. No relevant studies were found in these countries.

⁶ The project as originally set up to review 100 programme in brief and 20 programmes in depth.

⁷ Most of the searching took place in 2013-2014, although some additional studies were identified following that period. In some cases, key terms were used, and in others, where it became obvious after searching a small number of editions that the journal did not contain the type of studies that are the focus of this research, the search was stopped.

⁸ For example, in parallel to this research members of the research team were working on two rapid reviews and coding programmes for inclusion in a cost-benefit analysis.

⁹ This was to ensure that programmes with studies of the highest quality were considered first (at the outset it was not anticipated that it would be possible to review in full all programmes that passed the screening stage).

¹⁰ It is important to be clear that the ratings were undertaken by members of this research team for this project. Although the full reviews were completed using the Blueprints system, and the Blueprints criteria were used to assess evaluation quality and impact, the Blueprints Board did not rate programmes for this research and nor do the ratings arrived at for this research have any bearing on how the programmes are rated by Blueprints. That said, the *reviews* completed for this research are in the Blueprints review system and may, subject to further quality control by Blueprints, feed into decisions by the Blueprints Board should the programmes be considered (or reconsidered) by the Board in the future.

¹¹ It would be deemed not possible to find the publication if seeking to obtain it through electronic sources available to the research team at the time proved unsuccessful. It may have been possible with additional effort to obtain the publication – for example, by contacting authors direct – but given the purpose of the research, the time and resources available and more than sufficient number and variety of other programmes and studies successfully identified and obtained this was not thought to be necessary.

¹² It is often difficult to know if a programme is available, either in the original or adjusted form. It is possible that some programmes excluded on this basis do actually exist, but for the purposes of this project it was not deemed necessary to explore this further because the aim was not to review all programmes identified but rather to review a sufficient spread of programmes (and the number reviewed far exceeded expectations).

¹³ The programme may have had a positive impact on one or measures of one or more outcomes but on balance it was deemed that there was little or no impact – certainly insufficient to warrant a full review given that the ultimate aim of the project was to identify tested and effective programmes in Europe that could potentially be used by CtC sites in Europe.

¹⁴ This does not mean that the Blueprints rating for those programmes was based solely on European studies; if they existed, other studies – for example conducted in North America – would also have been taken into account, which is not the case for the present research.

¹⁵ This refers to programmes in categories A, C1, D1, D2, E1, F1, F2.

Appendix A: List of Sources

List of journals searched

Addiction
Child and Adolescent Mental Health
European Child and Adolescent Psychiatry
European Early Childhood Education Research Journal
European Education
European Journal of Clinical Psychology and Psychiatry
European Journal of Criminology
European Journal on Criminal Policy and Research
European Journal of Developmental Psychology
European Journal of Education
European Journal of Education and Psychology
European Journal of Educational Studies
European Journal of Psychiatry
European Journal of Psychological Assessment
European Journal of Psychology
European Journal of Psychology of Education
European Journal of Public Health
European Journal of Social Psychology
European Journal of Social Quality
European Journal of Social Sciences
European Journal of Social Work
European Journal of Special Needs Education
European Psychiatry
European Review of Applied Psychology
Innovation: The European Journal of Social Science Research
Journal of Adolescence
Journal of Child Psychology and Psychiatry
Journal of Children's Services
Journal of Cognitive Psychology
Journal of European Social Policy
Paediatrics and Child Health
Prevention Science
Scandinavian Journal of Psychology
Spanish Journal of Psychology

List of online programme databases searched

| Name | Web address |
|-----------------------------------------------------------------------------------------------|---------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Alcohol Abuse among Adolescents in Europe – Effective Environmental Strategies for Prevention | http://www.aaaprevent.eu/index |
| Best Evidence Encyclopaedia | http://www.bestevidence.org.uk/ |
| Database of Effective Youth Interventions | http://nji.nl/nl/Databank/Databank-Effectieve-Jeugdinterventies |
| EDDRA Exchange on Drug Demand Reduction Action | http://www.emcdda.europa.eu/themes/best-practice/examples |
| eXe: Strategies and Concepts of External Evaluation in Child and Youth Services | www.dji.de/cgi-bin/projekte/output.php?projekt=333&Jump1=RECHTS&Jump2=3 |
| EIPEE – The Evidence Informed Policy in Education in Europe database | http://eppi.ioe.ac.uk/webdatabases/Intro.aspx?ID=23 |
| European Alliance for Families | http://familieeuropa.de/index_en.html |
| European Crime Prevention Network | http://www.eucpn.org/goodpractice/index.asp |
| European Platform for Investing in Children | http://europa.eu/epic/practices-that-work/evidence-based-practices/index_en.htm |
| EU-Compass for Action on Mental Health and Well-being | http://ec.europa.eu/health/mental_health/eu_compass/index_en.htm & https://webgate.ec.europa.eu/sanco_mental_health/ |
| Green List Prevention | www.gruene-liste-praevention.de |
| Movisie | http://nji.nl/nl/Databank/Databank-Effectieve-Jeugdinterventies |
| Prevençion basada en la evidencia | http://www.prevençionbasadaenlaevidencia.net/index.php?page=intervenciones-evaluadas |
| The Healthy Nightlife Toolbox | http://www.hnt-info.eu |
| Ungsinn.no – Effective Interventions for Child and Adolescent Mental Health | http://ungsinn.uit.no |

Appendix B: Fields in Preliminary Review Form

Programme

Country of origin

Developmental outcome(s) targeted

Level of intervention

Nature of programme

Programme is available

At least 1 RCT or 2QEDs

Likely to score 10+ on evaluation quality

At least 2 RCTs or 1 RCT and 1 QED

Positive impact

No iatrogenic effect

Follow-up of 12 months or more after the end of the programme

Comment

References

Appendix C: Fields in Full Review Form

Programme Name:

Contact Information:

Programme Type:

Programme Setting:

Continuum of Intervention:

Programme Goals:

Age:

Population Demographics:

Risk/Protective Factor Domain:

Outcomes (Primary or Secondary focus, achieved or not):

Brief Description:

Description:

Theoretical Rationale:

Theoretical Orientation:

Methodology

Outcomes –Brief

Outcomes

Mediators

Effect sizes

Generalizability

Limitations

References

For each study,

Design

Sample and Recruitment:

Assignment and Intervention:

Assessment and Attrition:

Sample

Measures

Analysis

Intention-to-treatment and missing data:

Correct unit of analysis:

Baseline controls:

Outcomes

Implementation Fidelity:

Baseline Equivalence:

Differential Attrition:

Post-test:

Long-term:

Limitations

Appendix D: Study Checklist

Program Name:

Author(s):

Primary Criteria

Yes ? No

- 1. *High-Quality Design:*
- 2. *Sample Ns Tracked:*
- 3. *Measures Independent:*
- 4. *Measures Valid/Reliable:*
- 5. *Measures General:*
- 6. *Intent-to-Treat:*
- 7. *Proper Level:*
- 8. *Baseline Outcome Controls:*
- 9. *Baseline Equivalence:*
- 10. *Differential Attrition Minimal:*
- 11. *Posttest Effects:*
- 12. *Iatrogenic Free:*

Secondary Criteria

- 13. *Effects on R&P Factors:*
- 14. *Sample General:*
- 15. *Fidelity of Implementation:*
- 16. *Effect Sizes:*
- 17. *Mediation Analysis:*

Model Criteria

- 18. *Long-Term Effects:*
- 19. *High-Quality Replication:*

Summary

- 20. *Recommended for BP Board:*

Appendix E: Ratings Table

| | Rating | Tested in 2+ European Countries? | Good Evaluation Quality? | RCT? | Positive Impact? ¹ |
|--------------|--------|----------------------------------|--------------------------|------|-------------------------------|
| Implement | A | Yes | Yes | | Yes/Mixed Plus |
| | B1 | No | Yes | Yes | Yes/Mixed Plus |
| | B2 | No | Yes | No | Yes/Mixed Plus |
| Test Further | C1 | Yes | No | | Yes/Mixed Plus |
| | C2 | No | No | | Yes/Mixed Plus |
| | D1 | Yes | Yes | | Mixed Minus |
| | D2 | Yes | No | | Mixed Minus |
| | D3 | No | Yes | | Mixed Minus |
| | D4 | No | No | | Mixed Minus |
| | E1 | Yes | No | | No/Negative |
| | E2 | No | No | | No/Negative |
| Avoid | F1 | Yes | Yes | Yes | No/Negative |
| | F2 | Yes | Yes | No | No/Negative |
| | F3 | No | Yes | Yes | No/Negative |
| | F4 | No | Yes | No | No/Negative |

¹ Three broad categories were used to capture impact. It is difficult to set hard-and-fast rules, but broadly they were operationalised as follows: (1) *Yes / Mixed Plus* – there is a statistically significant effect on all or a majority of relevant outcomes; generally this would be more than 50% measures, and it would also be based on the most relevant outcomes – for example, some effects on child outcomes, and not only effects on parent outcomes; (2) *Mixed minus* – there are effects on some outcomes; for example, there is an effect only on parent outcomes or only on about 30% of outcomes. (3) *No/Negative* – there is a positive effect on less than 20% of outcomes, or a negative (harmful) effect.

Appendix F: List of Outcomes by Domain

| Domain | Outcome |
|------------------------|------------------------------------------|
| Behaviour | Not using alcohol or illicit drugs |
| | Not smoking (tobacco) |
| | Not involved in violence |
| | Not involved in crime/delinquency |
| | Not bullying |
| | Not involved in teenage partner violence |
| | Not involved in hate crimes |
| | Not involved in gambling |
| | Not involved in gangs |
| | No risky sex |
| | Other behaviour |
| Education | Doing well in school |
| | School ready |
| | Talking and reading |
| | Other education |
| Emotional well-being | Not depressed/anxious |
| | No suicidal ideation |
| | Regulating emotions |
| | Other emotional |
| Physical health | No chronic ill-health |
| | Healthy birth |
| | Healthy weight |
| | Other health |
| Positive relationships | Good relations with parents |
| | Good relations with peers |
| | Not abused or neglected |
| | Other relationships |

Appendix G: List of Risk and Protective Factors by Area

| | Risk Factors | Protective Factors |
|-----------------------|------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------|
| FAMILY | Family history or involvement with substance abuse / problem behaviour | Opportunities / rewards for prosocial involvement with parents |
| | Family management problems | Attachment to and support from parents |
| | Family conflict | Parent involvement in learning /education |
| | Parental attitudes favourable to alcohol/drug use | Parent social support |
| | Parental attitudes favourable to anti-social behaviour | Verbal reasoning / non-violent parent-child discipline |
| | Transitions within the family and home | Attachment to and support from romantic partner |
| | Mother single at child's birth | Family other |
| | Mother substance use during pregnancy | |
| | Neglectful parenting | |
| | Parent aggravation | |
| | Parental depression or mental health difficulties | |
| | Unintended child birth (parent) | |
| | Aggressive or violent parenting | |
| | Age of mother at first live birth | |
| | Overcrowded living situation | |
| | Family other | |
| SCHOOL | Low commitment/attachment to school | Opportunities for prosocial involvement in education |
| | Repeated a grade | Rewards and disincentives in school |
| | Identified special educational needs | Commitment and attachment to school |
| | School other | Rewards at work |
| | | Opportunities for prosocial involvement at work |
| | | Commitment and attachment to work |
| INDIVIDUAL/ PEERS | | School other |
| | Early initiation of anti-social behaviour | Skills for social interaction |
| | Early initiation of drug/alcohol use | Religiosity |
| | Rebelliousness and alienation | Interaction with prosocial peers |
| | Favourable attitudes towards anti-social behaviour | Opportunities and rewards for prosocial peer involvement |
| | Favourable attitudes towards alcohol/drug use | Clear morals and standards of behaviour |
| | Sensation-seeking | Regular exercise |
| | Peer reward for problem behaviour | Problem-solving skills |
| | Interaction with antisocial peers | Refusal skills |
| | Peer alcohol/drug use | Academic self-efficacy |
| | Gang involvement | Interaction with prosocial romantic partner |
| | Romantic partner violence | Individual/peer other |
| | Interaction with anti-social romantic partner | |
| | Perceived risk of drug use | |
| | Victim of bullying | |
| | Romantic partner substance use | |
| Bullies others | | |
| Hyperactivity | | |
| Individual/peer other | | |
| COMMUNITY | Community disorganisation (crime, drugs, graffiti, abandoned buildings etc.) | Opportunities and rewards for prosocial involvement in the community (including religiosity) |
| | Perceived availability of handguns | Collective efficacy |
| | Laws and norms favourable to drug use and antisocial behaviour | Primary care-giver / young adult current education status |
| | Low neighbourhood attachment | Primary care-giver / young adult employment |

| | | |
|-----------------|-------------------------------------------|-----------------------------------------------|
| | Perceived availability of drugs/alcohol | Primary care-giver highest level of education |
| | Transitions and mobility in the community | Community other |
| | Extreme economic deprivation | |
| | Perceived racism/discrimination | |
| | Community other | |
| ECONOMIC | Family / individual poverty | Food security |
| | Difficulty paying rent/mortgage/bills | Medical coverage |
| | Dependent on benefits | Adolescent/young adult employment |
| | Economic other | Economic other |

Appendix H: List of Programmes Screened Out

Programmes excluded because reference article was not available or was not in English

Action Orientated Youth Services
Aggression Regulated by Size
Anti-Aggression Training
Authoritative Management Style Helps Prevent Behaviour Problems (ALFA)
Bistrog uma bez alkohola (BUBA)/ Clear mind without alcohol
Bremer Family Crisis Help
BUDDY
Child Assault Prevention (CAP)
Clever & Cool
Community prevention program in the Prague 6 district
Das Friedensstifter- Training
Das Konzept der Mobilen Jugendarbeit
Dejame que te cuente algo sobre ... LOS PORROS/Let me tell you about ... ?dope/joints
Drug-reason-impact program
Drugsbeleid op School (DOS) / Drug policy at school
Early intervention for children at risk (TIBIR) - Parents group intervention
Eight Columns
Eltern – AG
En la Huerta con mis amigos (In the Garden With My Friends)
EVAS
Everyone has a Mental Health
Family Activation Home Intervention
FASA
Fit for Life
Friend1
Gesunde Kitas – starke Kinder
Gesundheit und Optimismus (GO!)
Gordon Family Training (GFT)
Growing up Healthy
HaLT
Health Building- Promoting Personal and Social Development
JobFit Training
Kaleidoscoop (Perry Pre-school Project)
Kids, Adults, Together (KAT)
Klasse2000
La Aventura de la Vida (The Adventure of Life)
La Mallette des Parents' (The Parents' Briefcase)
Leren van Delict (Learning from Crime)
Lions Quest
Lubo from Space- 1 and 2 Class
Mental Health Promotion and Life Skills Development Programme
Mobbingfreie Schule
Opstapje
Ouder-baby interventie
Outside Program Work-Wise
Papilio
Parents Plus Adolescents' Programme
PARENTS-AG
PLUS
Prekini lanac/Stop the chain
Prevenir para Vivir
Preventing obesity
Preventing violence in youth relationships

PRIMA-methode
 Program 18 of the Children and Youth Plan
 Program Domowych Detektywow (PDD) and Fantastyczne Mozilwosci
 PROGRAMA DE PREVENCIÓN DEL CONSUMO DE DROGAS EN LA ESCUELA (PPCDE)
 Programa Juego
 Prve tri su najvažnije/First three are most important
 Rastimo zajedno/Let's grow up together
 Respect Limits
 Responding in Peaceful and Positive Ways (RIPP)
 School of Quality Parenting
 Second Language Acquisition for Germany as Foreign Language
 Škola bez nasilja/Schools Without Violence
 SKOLL (selbstkontrolltraining)
 Social Early Warning Systems
 Socio-Educational Diagnosis Tables
 SOS children's villages
 Starke Eltern - Starke Kinder
 STEEP
 Stemmingmakerij
 Take A Ball, Not Drugs (ZOBER LOPTU NIE DROGY)
 The Prevention Programme WAY to Emotional Maturity
 Tko je to u ogledalu/Who is that in the mirror
 Tools4
 Trampolin
 Veiledning og Informasjon om Psykisk helse (VIP)/Very Important Problems (VIP) (Guidance and Information for Mental Health)
 Wellcome
 WHO ACTUALLY WINS (Tko zapravo pobjeđuje)
 Youth Work and Schools in the Social Space

Programmes that may not be available

Bibliotherapeutic Intervention with Telephone Support
 Bulli & Pupe
 Comet
 Computer Assisted Career Guidance
 Discover Summer School
 European Early Promotion Project
 Fair play program
 Family Support Programme
 Flemish Anti-Bullying Programme
 Greek Anti-Bullying Programme
 Greek Bullying Prevention Programme/Stop School Bullying
 Icelandic prevention programme for MDD
 In Control/No Alcohol!
 Intervention to prepare for transition to parenthood
 Just be Smokefree
 Local Alcohol Policy (PAKKA) model
 Mindfulness Group Program for Reducing Depression in Adolescents
 Mother Infant Transaction Programme
 Mother Infant Transaction Programme (Modified Version) (MITP)
 Museum Education Pack
 Netherlands parent-child home-visiting programme
 Peer Education Intervention for HIV
 Peer Support Intervention
 Portfolio
 Positive Behaviour, Interactions and Learning Environments in School (PALS)

Qigong for Children
 RESPECT
 SAVE Antibullying Spain
 Self-Discovery Programme
 Self-Regulation Intervention Programme
 SMILE: School Matters in Lifeskills Education
 Smokefree Kids
 Smoking Intervention
 Social and Emotional Training (SET)
 Social Cognitive Intervention Program (SCIP) for aggressive children
 Social Communication Intervention for Children with Autism
 Social Skills Training Group Based Programme
 Social-Emotional Prevention Program (SEP)
 Star Camp / Moon Camp
 Stress Management and Relaxation Techniques
 Strong and Clear
 Support Group Intervention
 TORERA
 Towards Working Life
 Video Feedback Intervention to promote positive parenting and sensitive discipline (VIPP-SD)
 Young People's Development Programme

Programmes that had no impact in Europe or are treatment-only programmes

Baby Triple P
 Behavioral Parent Training Groningen (BPTG) voor kinderen met ADHD
 Booktime
 Chatterbooks
 Eager and Able to Learn
 Early Years Programme of the Childhood Development Initiative
 EMDR
 Family Links Nurturing Programme
 Grammar for writing
 Healthy Schools Programme
 Joint Attention Intervention for Children with Autism
 Mate-Tricks
 New Forest Parent Training Programme
 Parent Management Training (PMT)
 Parenting UR Teens
 Pellser Voeding en Gedrag-dieet/Pelsser Nutrition and Behaviour Diet
 Positive Systemic Practice
 Preparing for Life
 Reading and language intervention
 Rhythm for Reading
 Selective Mutism Programme
 Short enhanced cognitive-behavioral parent training (CBPT)
 Wizards of Words (WoW)
 Zero Bullying

Appendix I: List of Programmes by Country of Evaluation

| | |
|-----------------------------------------------------------------------------------------------------------------------|-------------------------------------------------------------------|
| European Union countries | |
| Austria | Eigenständig werden |
| Unplugged | fairplayer.manual |
| Vienna Social Competence Training (ViSC) | FearNOT! |
| Belgium | FRIENDS |
| Unplugged | IPSY Life Skills Program |
| Good Behaviour Game | Media Heroes |
| EQUIP | Nobody Slips Through the Net/ Keiner fällt Durchs Netz |
| Bulgaria | Nurse Family Partnership/Pro-Kind |
| Croatia | Parental training for Lone Mothers guided by Educators (PALME) |
| Project Northland | Promoting Alternative Thinking Strategies (PATHS)/Preschool PATHS |
| Cyprus | Second Step Violence Prevention/Faustlos |
| PREP-PASS Reading Enhancement Programme | Triple P Level 4 |
| Czech Republic | Triple P System |
| Unplugged | Unplugged |
| Denmark | Vienna Social Competence (ViSC) training |
| I'm OK when I say no way | Greece |
| Prevençió de les Addiccions a Substancies a l'Escola (PASE.bcn)/European Smoking Prevention Framework Approach (ESFA) | Unplugged |
| Zippy's Friends | Hungary |
| Estonia | Ireland |
| Finland | Big Brothers Big Sisters |
| Be Smart Don't Start/Smoke Free Class Competition | Community Mothers Programme |
| Family Talk Intervention | Doodle Den |
| Kiva | FRIENDS |
| Let's Talk About the Children | Functional Family Therapy (FFT) |
| Prevençió de les Addiccions a Substancies a l'Escola (PASE.bcn)/European Smoking Prevention Framework Approach (ESFA) | Incredible Years – Child Treatment |
| France | Incredible Years – Parent |
| Germany | Incredible Years - Teacher Classroom Management |
| Aktion Glaskar | Olweus Bulling Prevention program/Be Prox |
| Allgemeine Lebenskompetenzen und Fertigkeiten (ALF) (General Life Competencies and Skills) | Parents Plus - Parenting When Separated |
| Balu und Du/Baloo and You | Parents Plus Children's Programme |
| Be smart - don't start/Smokefree class competition | Parents Plus Early Years Programme |
| EFFEKT | Strengthening Families 10-14 |
| EFFEKT-E | Zippy's Friends |
| | Italy |
| | Coping Power/Utrecht Coping Power |
| | Connect |
| | IPSY Life Skills Programme |
| | Unplugged |
| | Latvia |
| | Lithuania |
| | Zippy's Friends |
| | Luxembourg |
| | Behavioural Training for Preschool Children |

| | |
|----------------------------------------------------------------------------------------------------------------------|----------------------------------------------------------------------------------------------------------------------|
| Malta | |
| Netherlands | |
| Alles Kidzzz/ Stay Cool Kids | |
| Be smart - don't start/Smokefree class competition | |
| Bookstart | |
| Coping Cat/De Dappere Kat | |
| Coping Power/ Utrecht Coping Power Program (UCPP) | |
| EFFEKT/Orebro Prevention Program | |
| EQUIP | |
| FRIENDS | |
| Good Behaviour Game | |
| Home-Start | |
| Incredible Years - Parent | |
| Learn Young, Learn Fair | |
| Lifestyle Tripe P | |
| Multisystemic Therapy | |
| Newborn Individualized Developmental Care and Assessment Programme | |
| Nurse Family Partnership/ Voorzorg/Pro-Kind Penn Resiliency Programme/Op Volle Kracht' (OVK) | |
| Prevençió de les Addiccions a Substancies a l'Escola (ESFA) (PASE.bcn) | |
| Prevention of Alcohol Use in Students/Preventie Alcoholgebruik Scholieren (PAS) | |
| Promoting Alternative Thinking Strategies (PATHS)/Preschool PATHS | |
| TIGER (Kanjertraining) | |
| Triple 4 Level 4 | |
| Poland | |
| Portugal | |
| FRIENDS | |
| Incredible Years – Parent | |
| Prevençió de les Addiccions a Substancies a l'Escola (PASE.bcn)/European Smoing Prevention Framework Approach (ESFA) | |
| Romania | |
| Bucharest Early Intervention Project | |
| Slovakia | |
| Slovenia | |
| Spain | |
| Competencias Para Adolescentes Con Una Sexualidad Saludable (COMPAS) | |
| EQUIP | |
| PREP-PASS Mathematical Remedial Programme | |
| | Prevençió de les Addiccions a Substancies a l'Escola (ESFA) (PASE.bcn) |
| | PREP- PASS Reading Enhancement Program |
| | <u>Sobre Canyes i Petes (formally xkpts.com)</u> |
| | Unplugged |
| | Sweden |
| | Aggression Replacement Therapy (ART) |
| | Community Parent Education Program (COPE) |
| | Connect |
| | EFFEKT/Orebro Prevention Program |
| | Everybody's Different |
| | Functional Family Therapy (FFT) |
| | Incredible Years - Parent |
| | Marte Meo |
| | Multisystemic Therapy |
| | Multidimensional Treatment Foster Care (MTFC) / Treatment Foster Care Oregon |
| | Newborn Individualized Developmental Care and Assessment Programme |
| | Strengthening Families 10-14/12-16 |
| | Unplugged |
| | United Kingdom |
| | A Stop Smoking in Schools Trial (ASSIST) |
| | Bookstart |
| | Bookstart Plus |
| | Catch Up Numeracy |
| | FearNot! |
| | FRIENDS |
| | Future foundations summer school |
| | Home-Start |
| | Improving Writing Quality |
| | Incredible Years – Child Treatment |
| | Incredible Years - Parent |
| | Incredible Years - Teacher Classroom Management |
| | Lifestart |
| | Media Initiative for Children Respecting Difference Programme |
| | Mellow babies |
| | Multisystemic Therapy |
| | Multidimensional Treatment Foster Care (MTFC) / Treatment Foster Care Oregon |
| | Nuffield Early Language Intervention |
| | Nurse Family Partnership/Pro-Kind |
| | Olweus Bulling Prevention program/Be Prox |
| | Penn Resiliency Programme/Op Volle Kracht (OVK) |
| | Preventure/Personality targeted substance misuse intervention |
| | Prevençió de les Addiccions a Substancies a l'Escola (PASE.bcn)/European Smoing Prevention Framework Approach (ESFA) |
| | Promoting Alternative Thinking Strategies (PATHS) |
| | Pyramid Club |

School Health and Alcohol Harm Reduction Program (SHAHRP)
Sheffield REAL (Raising Early Achievement in Literacy) Project
Strengthening Families 10-14/12-16
Success For All
Switch-on Reading
Talking Time
Teens and Toddlers
Time to Read
Timid to TIGER
Triple 4 Level 4

EEA – non EU

Iceland

Parent Management Training Oregon Model (PMTO)

Liechtenstein

Norway

Aggression Replacement Training (ART)
BE SmokeFREE

Brief Parent Training (BPT)
Incredible Years - Child Treatment
Incredible Years - Parent
Incredible Years - Parent (short version)
International Child Development Programme (ICDP)
Multisystemic Therapy
Olweus Bullying Prevention Program
Parent Management Training Oregon Model (PMTO)
Second Step Violence Prevention/Steg for Steg
Zippy's Friends

Other

Switzerland

Be Smart – Don't Start/Smokefree Competition
Promoting Alternative Thinking Strategies (PATHS)
Triple P Level 4

Turkey

Turkish Preschool Programme