TECHNICAL REPORT

Methods and study characteristics in the systematic rapid evidence assessment

Interventions to improve the coordination of service delivery for High Cost High Harm Household Units (HCHHHU)

Technical report written by Mark Newman, Mukdarut Bangpan, Jeff Brunton, Jan Tripney, Teresa Williams, Ann Thieba, Theo Lorenc, Adam Fletcher, Cesar Bazan

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The results of this systematic review are available in four formats. See over page for details.

The results of this systematic review are available in four formats:

BRIEFING SUMMARY	A 1 page summary that has key findings from the review
EXECUTIVE SUMMARY	A 3 page summary that has a summary of the methods used in the review and the key findings
REPORT	A report which details the main findings of the SREA
TECHNICAL REPORT	**A Technical Report which provides details of the methods used in the SREA and a detailed summary of the studies included in the SREA**

All documents are available from http://eppi.ioe.ac.uk/cms/Default.aspx?tabid=2312

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CONTENTS

CHAPTER ONE

Introduction

1.1 About this project

Budget 2006 announced the Children and Young People's (CYP) Review, to be led jointly by HM Treasury and the Department for Education and Skills. One strand of this Review was to focus on the subgroup of families and children identified in the Social Exclusion Task Force's 'Action Plan on Social Exclusion' who are at risk of becoming locked in a cycle of low achievement, high harm and high cost, the so called High Cost High Harm Household Units (HCHHHU).

A key question for the strand of the CYP review looking at HCHHHU was to consider whether we can better align existing local services to improve identification of, and effective intervention with, such families to support them in exiting the cycle of low achievement. Between June and August 2006 the EPPI-Centre and the Government Social Research Unit completed the Systematic Rapid Evidence Assessment (SREA) described in this report to contribute part of the evidence base in tackling this question, by undertaking a systematic synthesis of published international research studies.

The reporting format of the SREA was specified by the funders in an attempt to provide the information in a format that was useful to the main policymaking audience for this report.

1.2 About this document

This document provides a detailed account of the methods used in the SREA and a detailed summary of the characteristics of the studies included in the SREA. The results are contained in a separate report:-

Newman M, Bangpan M, Brunton J, Tripney J, Williams T, Thieba A, Lorence T, Fletcher A, Bazan C (2007) Interventions to improve the co-ordination of service delivery for High Cost High Harm Household Units (HCHHHU). A systematic rapid evidence assessment. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

CHAPTER TWO

Methods of the Systematic Rapid Evidence Assessment

2.1 Review type

The review was a Systematic Rapid Evidence Assessment (SREA). The SREA is a focused limited-search review. In this approach:

- the SREA question was very specifically focused on a particular subgroup and particular type of intervention for this subgroup only;

- the search was restricted in scope – bibliographic databases were searched using only a limited range of search terms rather than extensive search of all variants, and only a limited search for grey literature was undertaken;

- a simple descriptive map of included studies was produced to aid decisions on finalising the scope for the in-depth review.

Thus the SREA may not be as comprehensive and detailed as a full systematic review. However, the processes involved are carried out systematically, hence the use of the term systematic rapid evidence assessment as opposed to just rapid evidence assessment.

The EPPI-Centre tools and guidelines for undertaking systematic reviews were used throughout the conduct of the review in order to limit bias at all stages.

2.2 Review question

How effective are interventions that aim to improve the delivery of services to HCHHHU through integration/co-ordination mechanisms at producing improved outcomes (broadly defined)?

What evidence is there if any of the relative cost-benefit of any approaches?

2.3 User involvement

The HM Treasury policy team was consulted throughout the SREA.

2.4 Identifying and describing studies

2.4.1 Defining relevant studies: Inclusion and exclusion criteria

For a paper to be included in the systematic map, it had to meet the inclusion criteria developed by the review team in consultation with the SREA advisory group.

Inclusion criteria

- The study report must be published after 1992.

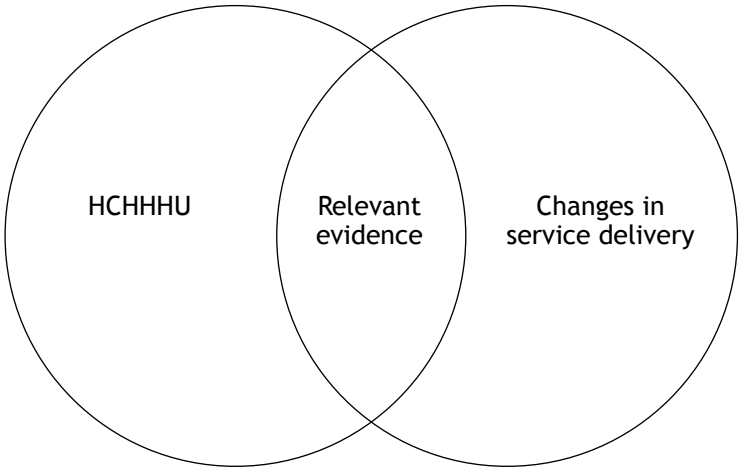
- The study must be published in English.

- The 'evidence' must be a report of an evaluation of an intervention with data or outcomes (of any kind).

- The subjects of the intervention must be service providers or services that are targeted specifically or have the aim of providing services to the target group (see HCHHHU definition below); OR HCHH Household Units in which members are subject to multiple forms of intervention to address various problems which might include more than one of the following: antisocial behaviour; offending; addiction problems; child-welfare problems; lack of education/employment; poor health; OR communities or localities in which HCHH household units are present.

- The intervention must be the co-ordination/ integration of multiple services and/or agencies. The intervention is intended to change the way that multiple services are delivered to or

Figure 2.1 Search structure



accessed by the targeted group by increasing or improving co-ordination/integration

For a paper to be included in the systematic map, it should not have been excludable under any of the criteria given below.

Exclusion criteria

1. The study was published before 1993.

2. The study was NOT published in English.

3. The 'evidence' is NOT a report of an evaluation of an intervention with data or outcomes (of any kind).

4. The intervention is NOT the delivery/co-ordination/integration of multiple services and or agencies. The intervention is not intended to change the way that multiple services are delivered to or accessed by the targeted group.

5. The subjects of the intervention are NOT Service providers or services that are targeted specifically or have the aim of providing services to Target group (See HCHHHU definition); OR

   The subjects of the intervention are NOT HCHH Household units in which members are subject to multiple forms of intervention to address various problems which might include more than one of the following: antisocial behaviour; offending; addiction problems; child-welfare problems; lack of education/employment; poor health; OR

   The subjects of the intervention are NOT Communities or localities in which HCHH household units are present.

6. The study must not report on an evaluation of a project aimed at preventing children from developing problems of any kind even if targeted at so called 'high risk' families and involving co-ordination/integration of services. (Early years education projects and universal school-based prevention projects would come under this heading)

Definitions

The following definitions were employed:

High Cost High Harm Household Units (HCHHHU): These are taken to be household 'units' in which members are subject to (and have been, with little success, for more than one generation) multiple forms of intervention to address multiple problems, which might include more than one of the following: antisocial behaviour; offending; addiction problems; child-welfare problems; lack of education/employment; poor health.

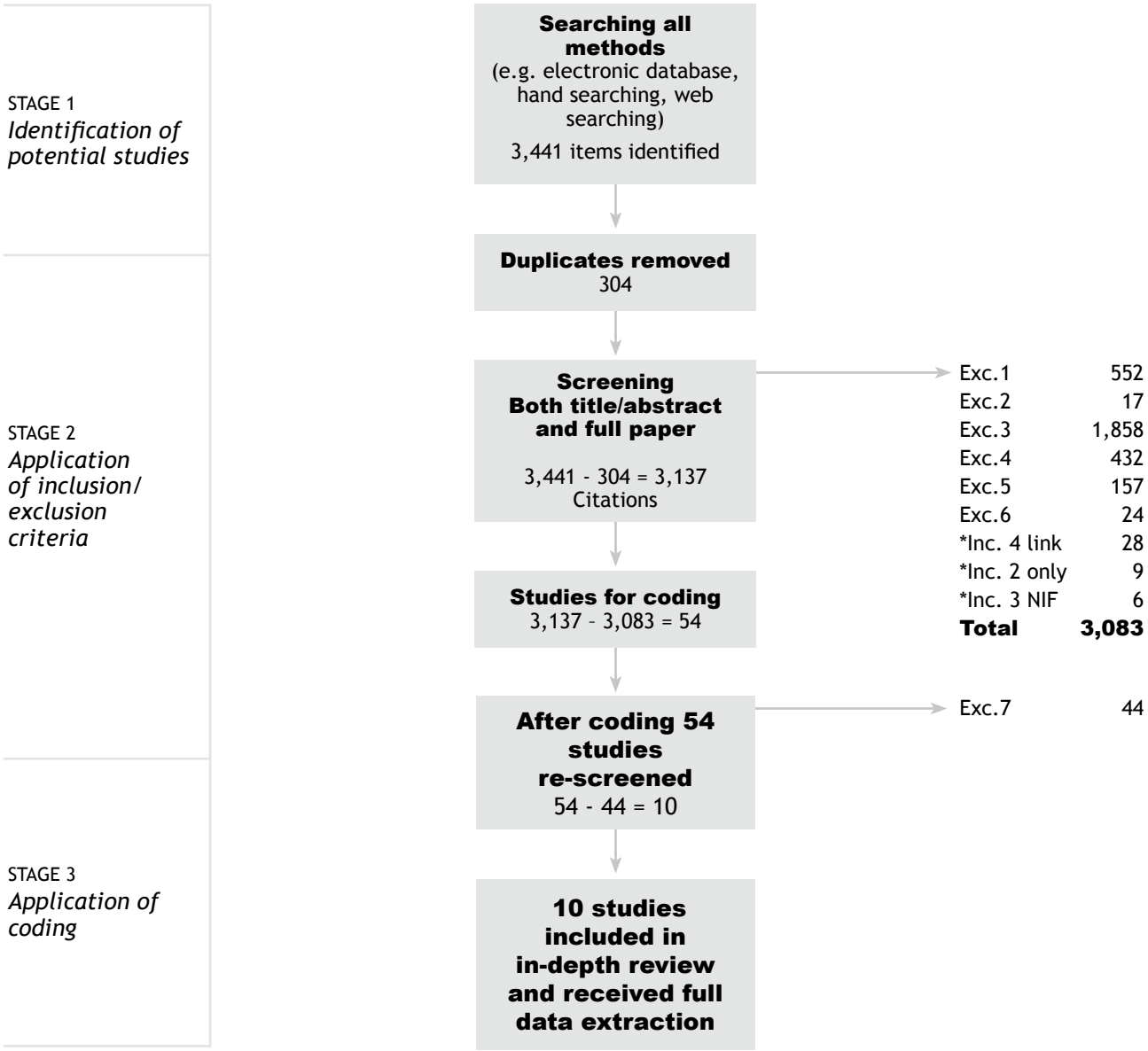
Interventions: In this context 'interventions' refers to initiatives or programmes which aim to redesign, reconfigure, co-ordinate, or integrate (referred to from hereon as co-ordinate) the delivery of services to HCHHHU.

Outcomes: Outcomes will follow from the interventions considered. The specific outcome of interest is 'breaking the cycle of high cost high harm'. Such a concept is difficult to operationalise and, even if possible to operationalise, difficult to measure. It was therefore considered likely that outputs (i.e. improvements in service delivery) and/or specific outcomes, such as increased attendance at school, would be the major outcomes included in the review.

2.4.2 Identification of potential studies: searching and screening

The exclusion and inclusion criteria were applied to the papers identified using the search strategy.

Figure 2.2 Identification and selection of studies



* Inc. 2 only – citations marked for full report screening but unable to locate
* Inc. 4 link – represents items linked to other included items
* Inc. 3 NIF – represents items for inclusion in the map but unable to locate

The search was not exhaustive but was narrow in scope using a limited number of sources and limited range of search terms. The search was driven by the population keywords combined with the intervention keywords (see figure 2.1).

A limited 'pearl growing' exercise was undertaken on the two key conceptual drivers, and this was used to form the search strings. The keywords and descriptors were adapted according to the conventions of each specific database searched. To identify unpublished literature a 'grey literature' database was searched, a limited number of experts in the field were contacted, and a number of relevant websites were searched. In addition an internet search using the Google search engine was carried out with a limited subset of the keywords. Full details of the search strategy are given in Appendix 2.1.

Title and abstracts were imported and entered into EPPI-Reviewer, the EPPI-Centre's web-based software programme for systematic research synthesis. Inclusion and exclusion criteria were applied successively to titles and abstracts. Full reports were obtained for those studies that appeared to meet the criteria or where we had insufficient information to be sure. The inclusion and exclusion criteria were re-applied to the full text reports once obtained (see figure 2.2 for details).

2.5 Data extraction

The studies remaining after application of the criteria were data-extracted using a set of questions developed specifically for this SREA (see Appendix 2.2). All data-extraction was carried out on EPPI-Reviewer.

2.6 Quality assurance process

All report authors were involved in screening and coding. Prior to screening, the inclusion criteria were discussed and modified by all the team members. A screening exercise was then completed where the whole team applied the criteria to ten different papers that could possibly have been included in the review. The results were compared and discussed and final modifications to the inclusion criteria made. During the course of the screening the Principal Investigator (MN) double-screened a random sample of 10 papers coded by each team member. One disagreement was identified for five out of the seven coders and none for the other two. The majority of the differences were in fact errors (usually the fact the publication date was prior to the cut-off point had been overlooked).

Prior to the coding, a similar exercise was undertaken whereby all members of the team coded one paper included in the review. Differences in interpretation were discussed and the coding framework modified. Papers were re-screened for inclusion during the process of coding, usually by a different member of the team. The Principal Investigator reviewed screening and coding decisions on one third of the potentially included papers at this stage.

The data produced from the coding were checked again prior to analysis. Any coding errors were identified and corrected by checking against the study report.

2.7 In-depth review

2.7.1 Moving from broad characterisation (mapping) to in-depth review

Although they addressed the broad review question, the studies in the map were quite diverse, addressing a number of distinct sub-questions. It was therefore necessary to identify and prioritise a specific question for the in-depth review. A refined in-depth review question with an additional inclusion/exclusion criterion was developed after the review team consulted with advisory group members on the results of the mapping analysis.

The initial selection criteria included a need to focus on families where multiple problems spanned multiple generations. However it was recognised that in many of the studies in the map the second generation in question were young children and thus the extent to which the 'problems' could be considered truly multi-generational was questionable. It was therefore decided that the in-depth review would focus on studies where there were clearly two distinct generations of the household with multiple problems.

The in-depth review question was

> *How effective are interventions that aim to improve the delivery of services to multi-generational HCHHHU through integration/co-ordination mechanisms at producing improved outcomes (broadly defined)?*

Studies were excluded from in-depth analysis if:

- The 'target group' for the service provision in the study did NOT explicitly include families in which 'problem' or 'poor outcomes' span two or more generations of secondary school age or above (N.B. studies that referred to the younger of the two generations as youth, juvenile, adolescent, teenager were included)

2.7.2 Detailed description of studies in the in-depth review

Studies identified as meeting the additional set of inclusion criteria were coded using the in-depth analysis coding framework. The in-depth analysis coding framework was an expanded version of the coding framework used at the mapping stage. An additional set of questions were added to extract more details on characteristics of HCHHHU and service delivery, sampling designs, methods used in studies, and study results.

2.7.3 Assessing quality of studies and weight of evidence for the review question

Studies that were included in the in-depth review were assessed for quality and relevance. Three components of Weight of Evidence (WoE) were used to help in making explicit the process of apportioning different weights to the findings and conclusions of different studies. A study's WoE was based on the following:

i. The soundness of studies (internal methodological coherence), based upon the study only (WoE A)

ii. The appropriateness of research design and analysis for addressing question, or sub questions of this SREA using the Scientific Methods (Maryland) scale (WoE B)

The University of Maryland's Department of Criminology and Criminal Justice developed the Maryland scale, a five-point scale to rank the

overall internal validity of studies from 1 (weakest) to 5 (strongest). This scale aims to answer 'effectiveness' questions. The higher the score, the better a study generally controls for four main threats to internal validity: causal relation, history, selection bias, and chance factor. The following is the five-point scale employed in this SREA:

Level 1 Single group single point (post-test only or correlational study)

Level 2 Single group pre- and post-test OR non-equivalent control group (with no adjustment in analysis)

Level 3 Cluster randomised trial with only one cluster in each arm OR non-random cluster OR non-equivalent control group pre- and post-test design where outcome = change in pre/post-test score (with no other adjustment in analysis)

Level 4 Non-randomised controlled trial where groups are demonstrated to be equivalent on important variables (includes studies where post-hoc analyses are used to create equivalent groups – e.g. path analysis or structural equations modelling)

Level 5 Randomised controlled trial with cluster or individual allocation of multiple individuals/clusters into groups

The Maryland scale scores were translated into 'High', 'Medium' and 'Low' scores for Weight of Evidence B using the framework given in Appendix 2.3.

iii. The relevance of the study topic focus (from the sample, measures, scenario, or other indicator of the focus of the study) to the SREA question (WoE C)

iv. An overall weight taking in account A, B, C (WoE D) using weight average of WoE A, B, C, except that WoE D cannot be higher than WoE B

2.7.4 Synthesis of evidence on outcomes

Three steps were undertaken to synthesise the evidence on outcomes.

Step one

The first stage of the analysis was to compare the different studies to assess whether they were sufficiently homogenous in terms of their contexts (i.e. family and service characteristics) to allow synthesis across studies. This was done prior to analysing the results from the individual studies. It is argued that the characteristics of the household units and the types of services that are co-ordinated/integrated, although varied, are sufficiently similar for a synthesis of the impact of co-ordination/integration of services efforts for these household units to be carried out across all the studies in the review.

Step Two

The second stage consisted of the synthesis of results from the individual studies. The variety of types of outputs and outcomes measured precluded the calculations of outcomes in standard formats and thus meta-analysis. A narrative numerical approach to synthesis was therefore used. Synthesis across study outcomes took place within categories identified in the stage one analysis. Alls the outcomes for each study were included in their relevant category and coded as either positive or negative.

A positive finding indicates that the study result favours the intervention or control group i.e. the co-ordination/integration effort produced a better result. A negative coding means simply the opposite. Whether or not studies were statistically significant (where relevant) was noted but not used as part of the judgment. A coding of a positive or negative result could only be undertaken for outcomes where some indication of a change in that outcome has been measured. For studies that used a single group post-test or cross-sectional design (i.e. the outcomes were only measured on completion of the project without any possibility of comparative data), this was not possible. In some of the studies the review team was able to create comparison data using the intervention group as its own control by examining the reports for any baseline data that may be used for this purpose. Otherwise the outcome was excluded from the synthesis.

The synthesis within each category took into account each study's Weight of Evidence score. This was used as a means of exploring patterns of results within each category.

[2] Sherman LW, Gottfredson DC, MacKenzie DL, Eck J, Reuter P, Bushway SD (1998) Preventing crime: what works, what doesn't, what's promising. National Institute of Justice Research in Brief. Washington: US Department of Justice.

Step Three

The synthesis in this stage explored the relationship between different factors in the design and operation of the co-ordination/integration effort and study outcomes. A narrative numerical synthesis approach was used. Each study in the review was given an overall results code: Positive (where all or the majority of results were positive), Negative (where all or the majority of the results were negative), or Mixed (where the results were an equal mix of positive and negative). The definition of positive and negative used above was used here. These results were compared across the different ways in which the co-ordination/integration effort was organised and delivered in studies in the review to identify possible key factors in such efforts. This analysis was exploratory only, the intention being to identify factors that could be investigated in future studies and or supported by reference to the wider literature on the topic. However, given the paucity of high quality studies, the limited measures of outcome used and the lack of detail in reporting of the actual mechanisms used to improve the co-ordination of service delivery, it was not possible to identify a basis for exploring similarities and differences between projects and linking these to patterns of outcomes.

2.7.5 Synthesis of economic analysis

Three studies in the in-depth review conducted an economic analysis that estimated the financial impacts of the project. The differences in the way that the projects had undertaken the analysis meant that it was not possible to synthesise the results from individual studies. Instead the findings from these studies are described along with an assessment of the quality of the economic analysis undertaken.

2.8 In-depth review: quality assurance process

A training exercise was held for all review team members to discuss the inclusion criteria and data extraction for in-depth analysis to ensure overall consistency. During the session, all team members completed one in-depth data extraction on the same study and compared their results.

Each review team member was allocated a set of studies that were included in the systematic map and subsequently applied the in-depth criteria. Data-extraction and assessment of the Weight of Evidence was then conducted by a pair of review team members working independently initially before comparing their decisions and coming to a consensus. An agreed version of the data extraction of each study was entered into the EPPI-Reviewer homepage for synthesis.

CHAPTER THREE

Descriptive information about studies in the map

Total number of papers identified = 3,441

Duplicate papers =304

Total number of studies identified as meeting inclusion criteria = 89

Number of linked items (N=28) and unavailable items (N=7) = 35

Total number of studies coded for map = 54

Papers were published between 1994 and 2006, with 45 (83%) published from 2000 onwards.

Table 3.1
What is/are the topic focus/foci of the study? (the intervention) (not mutually exclusive)

Attribute	Number
Reorganisation of existing services toward multi-/integrated service delivery	17
Partnership arrangements between existing services	26
Co-ordination of service delivery (Use for link/key worker/case mgt only)	27
Other (please specify)	3

Table 3.2
What is the specific support provided if any? (not mutually exclusive)

Attribute	Number
Advocacy	13
Advice/feedback	7
Criminal Justice (prison, community sentence, probation, ASBO, youth justice)	8
Counselling (non-specific)	17
Support with service and resource access (including benefits)	30
Specific education intervention	13
Incentives (e.g. reward schemes)	4
Parent training	21
Skill development	14
Professional training	4
Rehabilitation (substance misuse)	14
Psychological therapy (specific)	13
Personal/social/family support	33
Health services (not psychology/counselling)	21
Assessment	24
Respite/day care	8
Other (please specify)	16
Not specified	1

Table 3.3
Which services/agencies are part of the service delivery? (not mutually exclusive)

Attribute	Number
Voluntary services (please specify)	9
Penal services (e.g. prison, YOI)	1
School	13
Housing services	13
Child welfare/children and family services (Social Services)	31
Youth services	5
Local Education Authority Services (e.g. pupil referral units, education welfare officer)	12
Nursery school/other early years setting	5
Health care services	35
Employment services (e.g. Job Centre)	7
Criminal justice services (police, courts, probation, diversion schemes, youth justice – not prison)	14
Child/respite care services	6
Other (please specify)	13
Unspecified/not clear	4

Table 3.4
Country where studies completed

Attribute	Number
USA	32
England	9
Scotland	4
UK	2
Wales	1
Australia	1
New Zealand	1
Israel	1
Spain	1
India	1
Sweden	1

Table 3.5
What groups of target population are included in the actual sample? (not mutually exclusive)

Attribute	Number
Not applicable – study of service providers	3
Children (0–10)	5
Young people (11–21)	11
Parents	5
Whole family	24
Community	6
Adults/elders (if not covered by other categories)	10
Not stated/unclear	1

Table 3.6
How are the results of the study presented? (Not mutually exclusive)

Attribute	Number
Service outputs (e.g. service use)	22
Service inputs (e.g. changes in way services are delivered)	15
Impact on service user outcomes	41
Perceptions of stakeholders about service delivery/provision	17

Table 3.7
What is the method used in the study? (not mutually exclusive)

Attribute	Number
Randomised controlled trial	10
Non-randomised controlled trial	5
One group pre-post test	17
One group post-test only	8
Cohort studies	2
Case-control studies	2
Surveys	5
Views studies	7
Ethnography	2
Systematic review	2
Case study	6
Document study	3
Action research	1

Table 3.8
What economic analysis was completed?

Attribute	Number
Cost of intervention only	2
Cost–benefit analysis	5
Cost effectiveness analysis	2

CHAPTER FOUR

Studies selected for the in-depth review

Ten out of 54 studies in the systematic map met the second set of inclusion criteria and were therefore included in the in-depth analysis. Table 4.1 below provides details of the authors, location and name of the programme studied. Further details on the services and nature of client's problems in each study can be found in appendix four.

Table 4.1 Study, location, programme

Study	Location	Programme
De Paul and Arruabarrena (2003)	Spain	The Gipuzkoa Program
Dillane et al. (2001)	Scotland	Dundee Families Project
Harrell et al. (1999)	USA	Children at Risk Program
Hunter et al. (2004)	USA	Wraparound Milwaukee Program
Jones et al. (2006)	England	Shelter Inclusion Project
Nelson et al. (2000)	USA	SET (Structural Ecosystems Therapy)
Nixon et al. (2006)	England	Rehabilitation projects for families at risk of losing their homes as a result of anti-social behaviour
Pritchard (2001)	England	The Dorset Healthy Alliance Project
Sen and Goldbart (2005)	India	Family-Based Intervention for Children with Disability
Tischler et al. (2004)	England	A family support service for homeless children and parents

CHAPTER FIVE

References for studies included in the SREA

* *indicates study included in the in-depth review*

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Appendix 1.1: Authorship of this report

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Conflicts of interest

There were no conflicts of interest in the writing of this report

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Appendix 2.1: Details of search strategy

Table 1: Keywords and descriptors used

Service integration/co-ordination	HCHH
service provision	"high risk famil*"
service cooperation	"imperfect famil*"
service collaboration	"needy famil*"
service coordination	"problem famil*"
service partnership	"disintegrating famil*"
multi agency	"troubled famil*"
inter agency	"disadvantaged famil*"
inter disciplinary	"high cost famil*"
inter professional	"high needs famil*"
social support	"high cost high harm famil*"
joined up	"cross generation"
intervention	"low achievement"
social support	"children at risk"
	"child abuse"
	"child neglect"
	vulnerab*
	"multiple complex problems"
	"multiple problems"

Bibliographic Database searched

Medline, ERIC, Sociological Abstracts, Econlit, ASSIA, CINAHL, Social Services Abstracts, NCJRS, PAIS, International Bibliography of Social Science, PsychInfo, EMBASE, Cochrane Library, C2 SPECTRE, HDA Database, SIGLE, and British Library Catalogue

Grey literature searching

1. Contact with experts

The following experts were contacted:

Professor Berry Mayall, Social Science Research Unit (SSRU), Institute of Education, University of London

Professor Priscilla Alderson, SSRU, Institute of Education, University of London

Professor Helen Roberts, City University

Mike Fisher, Social Care Institute of Excellence

Dr Ann Buchanan, Department of Social Policy and Social Work, University of Oxford

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Professor Kathy Sylva, Oxford Centre for Research into Parenting and Children University of Oxford

Professor Edward Melhuish, Birkbeck College, University of London

Professor Julia Little, Bryn Maw University and Chair of the Campbell Social Welfare Group

2. Searching of websites

National and local government websites in the UK were searched.

A number of specific websites were also searched

- Research in practice for adults (www.ripfa.org.uk/aboutus/archive/)
- Evidence based decision making (www.evidencebased.net/)
- Netting the evidence (www.shef.ac.uk/scharr/ir/netting/)
- Department for education and skills (www.dfespublications.gov.uk)
- Office of Juvenile Justice and Delinquency Prevention (http://ojjdp.ncjrs.org/)
- Social Services Research Group (www.ssrg.org.uk/index.asp)
- The Social Care Institute for Excellence (www.scie.org.uk)
- Centre for Evidence-based Social Services, Exeter University – so far a number of useful reviews are available on the website (www.ex.ac.uk/cebss/)
- Center for the Study and Prevention of Violence (CSPV), University of Colorado (www.colorado.edu/cspv/)
- US National Institute on Drug Abuse NIDA – website summarising research (www.drugabuse.gov/NIDA_Notes/NNIndex.html)
- Barnado's (www.barnardos.org.uk/resources/research_and_publications.htm)
- The Evidence-based Practice Program of the Agency for Healthcare Research and Quality (AHRQ) evidence reports (www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat1.part.88879)
- Bandolier (www.jr2.ox.ac.uk/Bandolier/)
- Joseph Rowntree Foundation: social policy research and development charity: (www.jrf.org.uk)
- Kings Fund (www.kingsfund.org.uk)
- NHS Service Delivery and Organization (www.sdo.lshtm.ac.uk)
- Campbell Collaboration (http://www.campbellcollaboration.org/)
- Social Policy Research Unit (University of York) (http://www.york.ac.uk/inst/spru/)
- Centre for Market and Public Organisation (University of Bristol) (http://www.bristol.ac.uk/cmpo/)

Keyword strings for specific databases

IBSS

[((problem or disintegrating or troubled or disadvantaged or "high cost" or "high needs" or "high risk" or imperfect or needy) and (famil$ or individual$ or household$) and (intervention or "multi agency" or "inter agency" or "inter disciplinary" or "inter professional" or "social support" or "service provision" or "service cooperation" or "service collaboration" or "service coordination" or "service partnership" or "joined up service$")).mp. [mp=abstract, title, subject heading, geographic heading]]

GSI

[((problem or disintegrating or troubled or disadvantaged or "high cost" or "high needs" or "high risk" or imperfect or needy) and (famil* or individual* or household*) and (intervention or "multi agency" or "inter agency" or "inter disciplinary" or "inter professional" or "social support" or "service provision" or "service cooperation" or "service collaboration" or "service coordination" or "service partnership" or "joined up service*"))

Interface: CSA (ERIC, Sociological Abstracts, Econlit, ASSIA, NCJRS, PAIS)

DE="("problem famil*" or "disintegrating famil*" or "troubled famil*" or "disadvantaged famil*" or "high cost famil*" or "high needs famil*") and (intervention or service or multi agency or inter professional)"
AND
("high risk famil*" or "imperfect famil*" or "needy famil*") and (intervention or service or multi agency or inter professional)
AND
(agency cooperation) and ("problem famil*" or "disintegrating famil*" or "troubled famil*" or "disadvantaged famil*" or "high cost famil*" or "high needs famil*")
AND
(((problem or disintegrating or troubled or disadvantaged or imperfect or "high cost" or "high needs" or "high risk" or "high harm" or "complex and multiple needs" or "multiple complex problems" or "multiple problems") and (famil* or individual* or household*)) and ("multi agency" or "inter agency" or "interdisciplinary" or "inter professional" or "agency cooperation" "service provision" or "service cooperation" or "service collaboration" or "service coordination" or "service partnership" or "joined up service*")) and ("cross generation" or "low achievement" or "children at risk" or "child abuse" or "child neglect" or vulnerab*)

Psychinfo

Set	Description
S1	(SERVICE()PROVISION) OR (SERVICE()COOPERATION) OR(SERVICE- ()CO()OPERATION) OR (SERVICE()COLLABORATION) OR (SERVICE()COO-RDINATION) OR (SERVICE()CO()ORDINATION) OR (SERVICE()PARTNERSHIP)
S2	(INTER()AGENCY) OR (MULTI()AGENC?) OR (INTER()DISCIPLINARY) OR (INTER()PROFESSIONAL) OR (SOCIAL()SUPPORT) OR (JOINED()UP)
S3	S1 OR S2
S4	(HIGH()RISK()FAMIL?) OR (IMPERFECT()FAMIL?) OR (NEEDY()FAMIL?) OR (DISINTEGRATING()FAMIL?) OR (TROUBLED()FAMIL?)
S6	(DISADVANTAGED()FAMIL?) OR (HIGH()COST()FAMIL?) OR (HIGH()-NEED?()FAMIL?) OR HIGH()COST()HIGH() HARM()FAMIL?)
S7	S4 OR S6
S8	S3 AND S7

Medline

((((SERVICE ADJ COOPERAT$ OR SERVICE ADJ COLLABORAT$ OR SERVICE ADJ COORDINAT$ OR SERVICE ADJ PARTNERSHIP) OR (MULTI$ ADJ AGENC$ OR INTER ADJ AGENC$ OR INTER ADJ DISCIPLINARY OR INTER ADJ PROFESSIONAL OR JOINED ADJ UP OR AGENCY ADJ COOPERATION OR INTEGRATED ADJ SERVICE$ OR SERVICE ADJ NETWORK OR SERVICE ADJ INTEGRATION)) OR ((INTERINSTITUTIONAL-RELATIONS.MJ.) OR (INTERDEPARTMENTAL-RELATIONS.MJ.))) YEAR > 1993) AND ((((HIGH ADJ RISK ADJ FAMIL$ OR NEED* ADJ FAMIL$) OR (PROBLEM ADJ FAMIL$ OR TROUBLED ADJ FAMIL$) OR (DISADVANTAGED ADJ FAMIL$) OR (MULTIPLE ADJ PROBLEMS OR MULTIPLE ADJ COMPLEX ADJ PROBLEMS)) YEAR > 1993) OR (((Antisocial-Personality-Disorder.MJ.) OR (United-States-Substance-Abuse-and-Mental-Health-Services-Admini.MJ. OR United-States-Substance-Abuse-and-Mental-Health-Services-Admini.MJ. OR United-States-Substance-Abuse-and-Mental-Health-Services-Admini.MJ. OR Child-Abuse.MJ. OR Substance-Abuse-Detection.MJ. OR Street-Drugs.MJ. OR Marijuana-Abuse.MJ. OR Health-Services-Misuse.MJ. OR Substance-Abuse-Intravenous.MJ. OR Child-Abuse-Sexual.MJ. OR Substance-Related-Disorders.MJ. OR Substance-Abuse-Treatment-Centers.MJ.) OR (Juvenile-Delinquency.MJ.) OR (Student-Dropouts.MJ. OR Student-Dropouts.MJ.) OR (Mental-Health.MJ. OR United-States-Substance-Abuse-and-Mental-Health-Services-Admini.MJ. OR Community-Mental-Health-Centers.MJ. OR Mental-Health-Services.MJ. OR Mental-Health-Services-Administration.MJ. OR National-Institute-Of-Mental-Health-U-S.MJ.) OR (Child-Abuse.MJ.) OR (Parenting.W..MJ.) OR (Unemployment.W..MJ.) OR (Domestic-Violence.MJ.)) YEAR > 1993))" in all the available information:

Cochrane

ID	Search
#1	MeSH descriptor Economics explode tree 1
#2	MeSH descriptor Health Planning explode all trees
#3	MeSH descriptor Organizations explode all trees
#4	MeSH descriptor Health Services, this term only
#5	MeSH descriptor Student Dropouts explode all trees
#6	MeSH descriptor Government explode all trees
#7	MeSH descriptor Public Sector explode all trees
#8	MeSH descriptor Mental Health Services explode all trees
#9	MeSH descriptor Mental Health explode all trees
#10	MeSH descriptor Child Welfare explode all trees
#11	MeSH descriptor Family Relations explode all trees
#12	MeSH descriptor Employment explode all trees
#13	MeSH descriptor Antisocial Personality Disorder explode all trees
#14	MeSH descriptor Social Problems explode all trees
#15	(#1 AND OR #2 OR #3 OR #4 OR #6 OR #7 OR #8)
#16	(#5 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14)
#17	(#15 AND #16), from 1993 to 2006

C2 SPECTRE

All non-indexed fields {{high risk family} or {problem family} or {troubled family} or {disadvantaged family} or {multi problem} or {abuse} or {antisocial} or {delinquency} or {dropout} or {mental health} or {misuse} or {parent} or {employ} or {violence}} AND

All non-indexed fields {{multi agency} or {inter agency} or {multiagency} or {interagency} or {integrated service} or {service network} or {service integration} or {service cooperate} or {service collaborate} or {service coordinate} or {interdisciplinary} or {interprofessional} or {join up} or {service partnership} or {partnership}

British Library

Words= (high risk famil?)

Words= (problem famil?)

Words= (troubled famil?)

Words= (disadvantaged famil?)

Words= (multiple problems)

Words= (service integration)

Words= (integrated service?)

Words= (interprofessional)

Words= (interagenc?)

Words= (inter agenc?)

Words= (multi agenc?)

Words= (service coordinat?)

Words= (service cooperat?)

Words= (joined up)

Words= (interprofessional) AND Words= (employment)

Words= (interprofessional) AND Words= (parent)

Words= (interprofessional) AND Words= (mental health)

Words= (interprofessional) AND Words= (abuse)

Words= (interprofessional) AND Words= (mental health)

Words= (interprofessional) AND Words= (children)

Words= (interprofessional) AND Words= (family)

Words= (integrated service?) AND Words= (mental health)

Words= (integrated service?) AND Words= (children)

Words= (integrated service?) AND Words= (family)

Words= (integrated service?) AND Words= (violence)

Words= (joined up)) AND (Words=(mental health))

Words= (joined up)) AND (Words=(famliy or children or violence))

Words= (service cooperat?) AND Words= (misuse)

Words= (service cooperat?) AND Words= (parent)

Words= (service coordinat?) AND Words= (mental health)

Words= (service coordinat?) AND Words= (children or family or violence)

Words= (multi agenc?) AND Words= (antisocial or delinquency or dropout)

Words= (multi agenc?) AND Words= (mental health)

Words= (multi agenc?) AND Words= (family or children or violence)

Words= (interagenc?) AND Words= (delinquency)

Words= (interagenc?) AND Words= (violence)

Words= (interagenc?) AND Words= (mental health)

Words= (interagenc?) AND Words= (children)

Words= (interagenc?) AND Words= (family)

EMBASE

Set	Description
S1	(SERVICE()PROVISION) OR (SERVICE()CO()OPERATION) OR (SERVICE()COOPERATION) OR (SERVICE()COLLABORATION) OR (SERVICE()CO(-)ORDINATION) OR (SERVICE()COORDINATION) OR (SERVICE()PARTNERSHIP?)
S2	(MULTI()AGENC?) OR (INTER()AGENCY) OR INTER()DISCIPLINARY) OR (INTER()PROFESSIONAL) OR (SOCIAL()SUPPORT) OR (JOINED()UP)
S3	S1 OR S2
S4	(HIGH()RISK()FAMIL?) OR (IMPERFECT()FAMIL?) OR (NEEDY()FAMIL?) OR (PROBLEM()FAMIL?) OR (DISINTEGRATING()FAMIL?)
S5	(TROUBLED()FAMIL?) OR (DISADVANTAGED()FAMIL?) OR (HIGH()COST()FAMIL?)
S6	(TROIBLED()FAMIL?) OR (DISADVANTAGED()FAMIL?) OR (HIGH()COST()FAMIL?) OR (HIGH()NEEDS()FAMIL?) OR (HIGH()COST()HIGH()HARM()FAMIL?)
S7	(TROUBLED()FAMIL?) OR (DISADVANTAGED()FAMIL?) OR (HIGH()COST()FAMIL?) OR (HIGH()NEEDS()FAMIL?) OR (HIGH()COST()HIGH()HARM()FAMIL?)
S8	S4 OR S7
S9	S3 AND S8

Social Services Abstracts

Set	Description
S	(SERVICE()PROVISION) OR (SERVICE()CO()OPERATION) OR (SERVICE()COOPERATION) OR (SERVICE()COLLABORATION) OR (SERVICE()CO(-)ORDINATION) OR (SERVICE()COORDINATION) OR (SERVICE()PARTNERSHIP?)
S2	(HIGH()RISK()FAMIL?) OR (IMPERFECT()FAMIL?) OR (NEEDY()FAM-IL?) OR (PROBLEM()FAMIL?) OR (DISINTEGRATING()FAMIL?)
S3	S1 OR S2
S4	(HIGH()RISK()FAMIL?) OR (IMPERFECT()FAMIL?) OR NEEDY()FAM-IL?) OR (PROBLEM()FAMIL?) OR (DISINTEGRATING()FAMIL?)
S5	(TROUBLED()FAMIL?) OR (DISADVANTAGED()FAMIL?) OR (HIGH()CO-ST()FAMIL?) OR (HIGH()NEEDS()FAMIL?) OR (HIGH()COST()HIGH()HARM()FAMIL?)
S6	S4 OR S5
S7	S3 AND S6
S8	S7 AND PY=1993:2006
S9	S8 AND FAMIL?/TI

Appendix 2.2 Coding framework

Section A: Administrative details

Use of these guidelines should be cited as: EPPI-Centre (2006) Coding framework for Extracting Data for the High Cost High Harm Rapid Evidence Assessment. London: EPPI-Centre, Social Science Research Unit, Institute of Education, University of London.

A.1 Name of the reviewer

A.1.1 Details

A.2 Date of the review

A.2.1 Details

A.3 Please enter the details of each paper which reports on this item/study and which is used to complete this data extraction.

(1): A paper can be a journal article, a book, or chapter in a book, or an unpublished report.

(2): This section can be filled in using bibliographic citation information and keywords 1, 2, and 4 from the EPPI-Centre Core Keywording Strategy (V0.95)

A.3.1 Paper (1)

Fill in a separate entry for further papers as required.

A.3.2 Unique Identifier:

A.3.3 Authors:

A.3.4 Title:

A.3.5 Source (Website owner):

A.3.6 Status (published or unpublished):

A.3.7 Language:

A.3.8 Identification of report:

A.3.9 Paper (2)

A.3.10 Unique Identifier:

A.3.11 Authors:

A.3.12 Title:

A.3.13 Source:

A.3.14 Status:

A.3.15 Language:

A.3.16 Identification of report:

A.4 Main paper

Please classify one of the above papers as the 'main' report of the study and enter its unique identifier here.

NB(1): When only one paper reports on the study, this will be the 'main' report.

NB(2): In some cases the 'main' paper will be the one which provides the fullest or the latest report of the study. In other cases the decision about which is the 'main' report will have to be made on an arbitrary basis.

A.4.1 Unique Identifier:

A.5

Please enter the details of each paper which reports on this study but is NOT being used to complete this data extraction.

NB (1): A paper can be a journal article, a book, or chapter in a book, or an unpublished report.

NB (2): This section can be filled in using bibliographic citation information and keywords 1, 2, and 4 from the EPPI-Centre Core Keywording Strategy (V0.95).

A.5.1 Paper (1)

Fill in a separate entry for further papers as required.

A.5.2 Unique Identifier:

A.5.3 Authors:

A.**5.4** Title:

A.5.5 Source:

A.5.6 Status:

A.5.7 Language:

A.5.8 Identification of report:

A.5.9 Paper (2)

A.5.10 Unique Identifier:

A.5.11 Authors:

A.5.12 Title:

A.5.13 Source:

A.5.14 Status:

A.5.15 Language

A.5.16 Identification of report:

A.6

If the study has a broad focus and this data extraction focuses on just one component of the study, please specify this here.

A.6.1 Not applicable (whole study is focus of data extraction)

A.6.2 Specific focus of this data extraction (please specify)

A.7 Identification of report (or reports)

Please use AS MANY KEYWORDS AS APPLY.

A.7.1 Citation

Please use this keyword if the report was identified from the bibliographic list of another report.

A.7.2 Contact

Please use this keyword if the report was found through a personal/professional contact.

A.7.3 Handsearch

Please use this keyword if the report was found through handsearching a journal.

A.7.4 Unknown

Please use this keyword if it is unknown how the report was found.

A.7.5 Electronic database

Please use this keyword if the report was found through searching on an electronic bibliographic database.

In addition, if the report was found on an electronic database please use ONE OR MORE of the following keywords to indicate which database it was found on:

A.8 Status

Please use one keyword only.

A.8.1 Published

Please use this keyword if the report has an ISBN or ISSN number.

A.8.2 In press

Please use this keyword if the report has been accepted for publication

but has not yet been published.

A.8.3 Unpublished

Please use this keyword for reports which do not have an ISBN or ISSN number

(e.g. 'internal' reports; conference papers).

A.9 Language

A.9.1 Details of Language of report

Section B: Contextual information - Study aims and rationale

B.1 What are the broad aims of the study?

Please write in authors' description if there is one. Elaborate if necessary, but indicate which aspects are reviewers' interpretation. Other, more specific questions about the research questions and hypotheses are asked later.

B.1.1 Explicitly stated (please specify)

B.1.2 Implicit (please specify)

B.1.3 Not stated/unclear (please specify)

B.2 What is the purpose of the study?

A: Description

Please use this keyword for studies in which the aim is to produce a description of a state of affairs or a particular phenomenon, and/or to document its characteristics. In these types of studies there is no attempt to evaluate a particular intervention programme (according to either the processes involved in its implementation or its effects on outcomes), or to examine the associations between one or more variables. These types of studies are usually, but not always, conducted at one point in time (i.e. cross-sectional). They can include studies such as an interviews of head teachers to count how many have explicit policies on continuing professional development for teachers; a study documenting student attitudes to national examinations using focus groups; a survey of the felt needs of parents using self-completion questionnaires, about whether they want a school bus service.

B: Exploration of relationships

Please use this keyword for a study type which examines relationships and/or statistical associations between variables in order to build theories and develop hypotheses. These studies may describe a process or processes (what goes on) in order to explore how a particular state of affairs might be produced, maintained and changed.

These relationships may be discovered using qualitative techniques, and/or statistical analyses. For instance, observations of children at play may elucidate the process of gender stereotyping, and suggest the kinds of interventions which may be appropriate to reduce any negative effects in the classroom. Complex statistical analysis may be helpful in modelling the relationships between parents' social class and language in the home. These may lead to the development of theories about the mechanisms of language acquisition, and possible policies to intervene in a causal pathway.

These studies often consider variables such as social class and gender which are not interventions, although these studies may aid understanding, and may suggest possible interventions, as well as ways in which a programme design and implementation could be improved. These studies do not directly evaluate the effects of policies and practices.

C: What works

A study will only fall within this category if it evaluates the effectiveness of an intervention or a programme.

D: Methods development

Studies where the principal focus is on methodology.

E: Reviewing/Synthesising research

B.2.1 Description

B.2.2 Exploration of relationships

B.2.3 What works?

B.2.4 Methods development

B.2.5 Reviewing /synthesising research

B.3 Do authors report how the study was funded?

B.3.1 Explicitly stated (please specify)
B.3.2 Implicit (please specify)
B.3.3 Not stated/unclear (please specify)

B.4 When was the study carried out?

If the authors give a year, or range of years, then put that in. If not, give a 'not later than' date by looking for a date of first submission to the journal, or for clues like the publication dates of other reports from the study.

B.4.1 Explicitly stated (please specify)
B.4.2 Implicit (please specify)
B.4.3 Not stated/unclear (please specify)

B.5 What are the study research questions and/or hypotheses?

Research questions or hypotheses operationalise the aims of the study. Please write in authors' description if there is one. Elaborate if necessary, but indicate which aspects are reviewers' interpretation.

B.5.1 Explicitly stated (please specify)
B.5.2 Implicit (please specify)
B.5.3 Not stated/unclear (please specify)

Section C: Contextual information - Services in the study

C.1 What is the specific support provided if any?

Please use codes C.2.20 or C.2.21 to indicate whether your answer is based on author report or your interpretation

C.1.1 Advocacy
C.1.2 Advice/feedback
C.1.3 Criminal Justice –(Prison, community sentence, Probation, ASBO, Youth Justice)
C.1.4 Counselling (non specific)
C.1.5 Support with service and resource access (including benefits)
C.1.6 Specific education intervention
C.1.7 Incentives (e.g. Reward Schemes)
C.1.8 Financial sanctions (e.g. benefit withdrawal, eviction)
C.1.9 Parent training
C.1.10 Skill development
C.1.11 Professional training
C.1.12 Rehabilitation (Substance misuse)
C.1.13 Psychological therapy (specific –please name)
C.1.14 Personal/Social/Family support
C.1.15 Health services (Not psychology/ counselling)
C.1.16 Assessment
C.1.17 Respite/day care
C.1.18 Other (please specify)
C.1.19 Not specified
C.1.20 Coding is based on: Authors' description
C.1.21 Coding is based on: Reviewers' inference

C.2 Which services/agencies are part of the service delivery?

Please use codes C.3.14 or C.3.15 to indicate whether your answer is based on author report or your interpretation

C.2.1 Voluntary Services (please specify)

C.2.2 Penal services (e.g. Prison, YOI)

C.2.3 School

C.2.4 Housing Services

C.2.5 Child welfare/ Children & family services (Social Services)

C.2.6 Youth services

C.2.7 Local Education Authority Services) (e.g. pupil referral units, Education welfare officer)

C.2.8 Nursery school/ other early years setting

C.2.9 Health care services

C.2.10 Employment services (e.g. Job –Centre)

C.2.11 Criminal justice services (Police, Courts, Probation, Diversion schemes, Youth Justice – not prison)

C.2.12 Child/respite care services

C.2.13 Other (please specify)

C.2.14 Unspecified/ not clear

C.2.15 Coding is based on: Authors' description

C.2.16 Coding is based on: Reviewers' inference

C.3 What are the characteristics of the service providers/agencies

Please use codes C.5.13 or C.5.14 to indicate whether your answer is based on author report or your interpretation

C.3.1 State/ Government/ Public service

C.3.2 Private company

C.3.3 Not for Profit Organization (may be a charity/ NGO & /or private company but uses paid staff to provide services)

C.3.4 Voluntary / Non Governmental Organization (services provided by volunteers)

C.3.5 Other (please specify)

C.3.6 Unspecified/ not clear

C.3.7 Coding is based on: Authors' description

C.3.8 Coding is based on: Reviewers' inference

C.4 Who provides the services?

Please use codes B.2.5.k or B.2.5.l to indicate whether your answer is based on author report or your interpretation

C.4.1 Criminal Justice System staff (Probation officer, Court Welfare Officer,Prison staff etc.)
C.4.2 Community /outreach worker
C.4.3 Counsellor/therapist
C.4.4 Social worker
C.4.5 Teacher/ Education support staff
C.4.6 Psychologist
C.4.7 Residential Care worker
C.4.8 Health care worker
C.4.9 Psychiatrist
C.4.10 Family support workers
C.4.11 Management/administrator
C.4.12 Employment advisor/case worker
C.4.13 Other (please specify)
C.4.14 Unspecified/ not clear
C.4.15 Coding is based on: Authors' description
C.4.16 Coding is based on: Reviewers' inference

C.5 In which country or countries was the study carried out?

Provide further details where relevant e.g. region or city

C.5.1 Explicitly stated (please specify)
C.5.2 Implicit (please specify)
C.5.3 Not stated/unclear (please specify)

C.6 Please describe in more detail of what specific services are provided and how they work.

The description should include

A) How were families identified by the service providers as HCHHHU i.e. as potential beneficiaries of the integrated service provision (i.e. how those that provide the services decide that these particular families needed these services). This may include self- referral but if families are referred by other agencies or identified by the service provider(s) want to know on what basis or how diagnosis of need was made. Please note if this information is not given

B) What entry 'entry criteria' exist for the services

Please describe in full. Please note if none or if not given state not given

C) How were service recipients 'recruited' to and 'maintained' in service

i.e. How were families 'persuaded' to participate in service and to continue participating in service . This may include incentives, sanctions, compulsion, through mechanisms such as pro-active contact on the part of service staff, use of techniques such as participant involvement in management organization of services , peer support etc. Please give as much detail as possible

D) Where were services located

Please give exact location of services (i.e. country and town)

C.6.1 Details

Section D: Detail of description of coordination / integration intervention

D.1 What is/are the topic focus/foci of the study? (The intervention)

Please use codes C.1.5 or C.1.6 to indicate whether your answer is based on author report or your interpretation

D.1.1 Reorganization of existing services toward multi/ integrated service delivery

D.1.2 Partnership arrangements between existing services

D.1.3 Coordination of service delivery (Use for link/ key worker/case mgt only)

D.1.4 Other (please specify)

D.1.5 Coding is based on: Authors' description

D.1.6 Coding is based on: Reviewers' inference

D.2 If a programme or intervention is being studied, does it have a formal name?

D.2.1 Not applicable (no programme or intervention)

D.2.2 Yes (please specify)

D.2.3 No (please specify)

D.2.4 Not stated/unclear (please specify)

D.3 Who or what are the instigators of/driving force behind the initiative to coordinate/integrate services

What is the history of this initiative, where did it come from, whose idea was it

Please provide as much detail as possible.

D.3.1 Details

D.4 Which agencies/individuals are responsible for the operational aspects of the coordinated service delivery

Who makes this work on a day to day basis. For example who manages the staff, who manages the budget, who is accountable for the delivery of services to the target client group

Please provide as much detail as possible

D.4.1 Details

D.5 How are strategic management issues dealt with

For example how are decisions about strategy, funding and input from the different services made. How are disputes over resources and inputs resolved

Please provide as much detail as possible

D.5.1 Detail

D.6 What incentives and /or sanctions are used to encourage / support the cooperation/ integration effort

i.e. how were the different services/ agencies persuaded to work together

NB this question refers to the agencies / services - not the clients

Please provide as much detail as possible

D.6.1 Details

D.7 For coordination/ integration interventions which consist mainly of 'brokerage' activity who is the 'case' worker

'Brokerage' = 'case management', 'link worker' , 'casework' or similar

Please give as much information as possible about background, qualifications, training, remuneration, employer, position, grade etc.

D.7.1 Details

D.8 How is the coordination/ integration initiative funded

Please give as much information as possible about who the fenders are, what type of funding was provided , what if any strings are attached to funding, what the funding pays for, whether funding is time limited or recurrent etc.

D.8.1 Details

D.9 What actions/ activities were required/ used to improve the coordination/ integration of services

Consider things like, reorganization of existing teams, development of new management structures, changes in funding mechanisms, development of new assessment tools, changes in staff working practices (could include , pay, hours of work etc.) development of 'new' service/ agency, involvement of 'other' agencies/ services (e.g. 3rd sector agency to act as coordinators)

D.9.1 Details

Section E: Contextual information - Actual sample

E.1 What was the total number of participants in the study (the actual sample)?

If more than one group is being compared, please give numbers for each group.

E.1.1 Not applicable (e.g. study of policies, documents etc)

E.1.2 Explicitly stated (please specify)

E.1.3 Implicit (please specify)

E.1.4 Not stated/unclear (please specify)

E.2 Which country/countries are the individuals in the actual sample from?

If UK, please distinguish between England, Scotland, N. Ireland and Wales, if possible. If from different countries, please give numbers for each.

E.2.1 Not applicable (e.g. study of policies, documents etc)

E.2.2 Explicitly stated (please specify)

E.2.3 Implicit (please specify)

E.2.4 Not stated/unclear (please specify)

E.3 What groups of target population are included in the actual sample?

'Whole Family' Is primary item response - If this code used do not tick another

Please tick If more than one group is being compared, please describe for each group.

Please use codes D.3.8 or D.3.9 to indicate whether your answer is based on author report or your interpretation

E.3.1 Not applicable –study of service providers
E.3.2 Whole Family
E.3.3 Adults/Elders (if not covered by other categories)
E.3.4 Children (0-10)
E.3.5 Young people (11-21)
E.3.6 Parents
E.3.7 Community
E.3.8 Not stated/unclear (please specify)
E.3.9 Coding is based on: Authors' description
E.3.10 Coding is based on: Reviewers' inference

E.4 What is the sex of the individuals in the actual sample?

Please give the numbers of the sample that fall within each of the given categories. If necessary refer to a page number in the report (e.g. for a useful table).

If more than one group is being compared, please describe for each group.

E.4.1 Not applicable (e.g. study of policies, documents etc)
E.4.2 Single sex (please specify)
E.4.3 Mixed sex (please specify)
E.4.4 Not stated/unclear (please specify)
E.4.5 Coding is based on: Authors' description
E.4.6 Coding is based on: Reviewers' inference

E.5 What is the socio-economic status of the individuals within the actual sample?

If more than one group is being compared, please describe for each group.

E.5.1 Not applicable (e.g. study of policies, documents etc)
E.5.2 Explicitly stated (please specify)
E.5.3 Implicit (please specify)
E.5.4 Not stated/unclear (please specify)

E.6 What is the ethnicity of the individuals within the actual sample?

If more than one group is being compared, please describe for each group.

E.6.1 Not applicable (e.g. study of policies, documents etc)
E.6.2 Explicitly stated (please specify)
E.6.3 Implicit (please specify)
E.6.4 Not stated/unclear (please specify)

E.7 Definition of High Cost High Harm Household Unit

Please describe

Please use codes D.7.5 or D.7.6 to indicate whether your answer is based on author report or your interpretation

E.7.1 Household units with multiple adverse outcomes
E.7.2 Household unit where multiple adverse outcomes present in more than 1 adolescent/ adult generation of unit members
E.7.3 Other (please specify)
E.7.4 Coding is based on: Authors' description
E.7.5 Coding is based on: Reviewers' inference

E.8 Problems experienced by individuals in the sample

Please use codes D.8.13 or D.8.14 to indicate whether your answer is based on author report or your interpretation

E.8.1 Unemployment
E.8.2 Anti-social behaviour
E.8.3 Exclusion / non attendance at school
E.8.4 Criminal Convictions
E.8.5 Child abuse/ neglect
E.8.6 Poor health outcomes
E.8.7 Substance misuse
E.8.8 Mental health problems
E.8.9 Family breakdown – (looked after children, temporary accommodation)
E.8.10 Socio-economic deprivation
E.8.11 Poor quality of physical environment
E.8.12 Other (please specify)
E.8.13 Not clear/specified
E.8.14 Coding is based on: Authors' description
E.8.15 Coding is based on: Reviewers' inference
E.8.16 Domestic Violence

E.9 Describe the characteristics of the 'multiple generations' in detail

For each included generation.

Give as much information as possible to include where available

Age, Gender, health status, employment status, educational attainment and details of 'problems' or 'poor outcomes' that have brought them to the attention of the service providers

As this information is coming from studies which include a number of families information is likely to be in the form of averages or ranges

E.9.1 Details

Section F: Methods and results – Methods – Study method

F.1 Study timing

Please indicate all that apply and give further details where possible.

• If the study examines one or more samples, but each at only one point in time it is cross-sectional.

• If the study examines the same samples, but as they have changed over time, it is retrospective, provided that the interest is in starting at one timepoint and looking backwards over time.

• If the study examines the same samples as they have changed over time and if data are collected forward over time, it is prospective provided that the interest is in starting at one timepoint and looking forward in time.

F.1.1 Cross-sectional

F.1.2 Retrospective

F.1.3 Prospective

F.1.4 Not stated/unclear (please specify)

F.2 If the study is an evaluation, when were measurements of the variable(s) used for outcome made, in relation to the intervention?

If at least one of the outcome variables is measured both before and after the intervention, please use the before and after category.

F.2.1 Before and after

F.2.2 Only after

F.2.3 Other (please specify)

F.2.4 Not stated/unclear (please specify)

F.3 What is the method used in the study?

Please use codes F3.18 or F.3.19 to indicate whether your answer is based on author report or your interpretation

F.3.1 Randomized controlled trial

F.3.2 Non-randomized controlled trial

F.3.3 One group pre-post test

F.3.4 One group post-test only

F.3.5 Interrupted Time Series*

F.3.6 Cohort studies

F.3.7 Case-control studies

F.3.8 Surveys

F.3.9 Views studies

F.3.10 Ethnography

F.3.11 Systematic review

F.3.12 Other review (non systematic)

F.3.13 Case study

F.3.14 Document study

F.3.15 Action research

F.3.16 Methodology study

F.3.17 Secondary analysis

F.3.18 Coding is based on: Authors' description

F.3.19 Coding is based on: Reviewers' inference

F.4 If comparisons are being made between two or more groups, please specify the basis of any divisions made for making these comparisons.

Please give further details where possible.

F.4.1 Not applicable (not more than one group)

F.4.2 Prospective allocation into more than one group (e.g. allocation to different interventions, or allocation to intervention and control groups)

F.4.3 No prospective allocation but use of pre-existing differences to create comparison groups (e.g. receiving different interventions, or characterised by different levels of a variable such as social class)

F.4.4 Other (please specify)

F.4.5 Not stated/unclear (please specify)

F.5 How do the groups differ?

F.5.1 Not applicable (not more than one group)

F.5.2 Explicitly stated (please specify)

F.5.3 Implicit (please specify)

F.5.4 Not stated/unclear (please specify)

F.6 Number of groups

For instance, in studies in which comparisons are made between groups, this may be the number of groups into which the dataset is divided for analysis (e.g. social class, or form size), or the number of groups allocated to, or receiving, an intervention.

F.6.1 Not applicable (not more than one group)

F.6.2 One

F.6.3 Two

F.6.4 Three

F.6.5 Four or more (please specify)

F.6.6 Other/unclear (please specify)

F.7 If prospective allocation into more than one group, what was the unit of allocation?

Please indicate all that apply and give further details where possible.

F.7.1 Not applicable (not more than one group)

F.7.2 Not applicable (no prospective allocation)

F.7.3 Individuals

F.7.4 Groupings or clusters of individuals (details) (e.g. classes of schools)

F.7.5 Other (e.g. individuals or groups acting as their own controls) (please specify)

F.7.6 Not stated/unclear (please specify)

F.8 Study design summary

In addition to answering the questions in this section, describe the study design in your own words. You may want to draw upon and elaborate the answers you have already given.

F.8.1 Details

Specify whether the study was a randomised controlled trial, non-randomised trial, cohort study, one group before-after study

You could also mention how many groups were studied, whether it was carried out retrospectively or prospectively, whether it was a cluster randomised trial, or any other detail the study mentions about it's design

N.B. This questions will be used in the tabular analysis

F.9 Planned sample size

If more than one group, please give details for each group separately. F.9.1 Not applicable (please specify)

F.9.2 Explicitly stated (please specify)

F.9.3 Not stated/unclear (please specify)

F.10 Which methods are used to recruit people into the study?

e.g. letters of invitation, telephone contact, face-to-face contact.

F.10.1 Not applicable (please specify)

F.10.2 Explicitly stated (please specify)

F.10.3 Implicit (please specify)

F.10.4 Not stated/unclear (please specify)

F.11 Was consent sought?

Please comment on the quality of consent if relevant

F.11.1 Not applicable (please specify)

F.11.2 Participant consent sought

F.11.3 Parental consent sought

F.11.4 Other consent sought

F.11.5 Consent not sought

F.11.6 Not stated/unclear (please specify)

F.12 Details of data collection methods or tool(s).

Please provide details including names for all tools used to collect data, and examples of any questions/items given. Also, please state whether source is cited in the report.

F.12.1 Explicitly stated (please specify)

F.12.2 Implicit (please specify)

F.12.3 Not stated/unclear (please specify)

F.13 Do the authors describe any ways they addressed the reliability of their data collection tools/methods?

e.g. test - re-test methods

(Where more than one tool was employed, please provide details for each.)

F.13.1 Details

E.g. Did they look at inter-rater reliability? Or re-test a sample of results to see if they got the same answers?

F.14 Do the authors describe any ways they have addressed the validity of their data collection tools/methods?

e.g. mention previous validation of tools, published version of tools, involvement of target population in development of tools.

(Where more than one tool was employed, please provide details for each.)

F.14.1 Details

F.15 Was there concealment of study allocation or other key factors from those carrying out measurement of outcome – if relevant?

Not applicable – e.g. analysis of existing data, qualitative study.

No – e.g. assessment of reading progress for dyslexic pupils done by teacher who provided intervention.

Yes – e.g. researcher assessing pupil knowledge of drugs - unaware of pupil allocation.

F.15.1 Not applicable (please say why)

F.15.2 Yes (please specify)

F.15.3 No (please specify)

F.16 Which methods were used to analyse the data?

Please give details e.g. for in-depth interviews, how were the data handled? Details of statistical analysis can be given next.

F.16.1 Explicitly stated (please specify)

F.16.2 Implicit (please specify)

F.16.3 Not stated/unclear (please specify)

F.17 For evaluation studies that use prospective allocation please specify the basis on which data analysis was carried out.

'Intention to intervene' means that data were analysed on the basis of the original number of participants as recruited into the different groups.

'Intervention received' means data were analysed on the basis of the number of participants actually receiving the intervention.

F.17.1 Not applicable (not an evaluation study with prospective allocation)

F.17.2 'Intention to intervene'

F.17.3 'Intervention received'

F.17.4 Not stated/unclear (please specify)

F.18 Please comment on any other analytic or statistical issues, if relevant.

Please comment on any other analytic or statistical issues, if relevant.

F.18.1 Details

Section G: Methods - Economic Analysis

G.1 What economic analysis was completed

Cost of intervention = Where total cost or cost per unit of output only given

Cost Benefit Analysis (CBA) = All costs and all benefits of intervention are identified and weighed against each other in common units (normally £)

Cost Effectiveness Analysis (CEA) = All costs and all benefits identified in intervention and compared with other possible interventions to achieve the same goal – usually requires the same standard outcome measure for example cost per n reduction in arrests

Cost Utility Analysis (CUA) = Can be either CBA or CEA but in addition outcomes are converted into measure which takes account of their quality or utility for example Quality Adjusted Life Years (QALYS)

Please use codes F.4.6 or F.4.7 to indicate whether your answer is based on author report or your interpretation

G.1.1 None

G.1.2 Cost of intervention only

G.1.3 Cost Benefit analysis

G.1.4 Cost effectiveness analysis

G.1.5 Cost Utility analysis

G.1.6 Coding is based on: Authors' description

G.1.7 Coding is based on: Reviewers' inference

G.2 Are estimates given as marginal costs/benefits

i.e. the additional cost /benefit that would be gained/ lost over and above what might usually be provided / might be the usual outcome

G.2.1 Details

G.3 What inputs and or outcomes are measured in financial terms

Please report all items that are included reporting inputs and outcomes separately

G.3.1 Details

G.4 What are the sources of data for the financial estimates

Please describe for inputs and outcomes included in the analysis

If not given please state

G.4.1 Details

G.5 How are the financial values given for inputs and outputs derived

Example of direct financial cost is budget of service per year

Example of costs where monetary value has to be estimated = cost of practitioner training

Example of benefit where monetary value has to be estimated = value to community of reduction in crime

Please describe for all relevant costs and benefits reported

Please state if not given

G.5.1 details

G.6 What adjustments are made for differential timing in realization of costs and benefits

If none, Not applicable or not given please state

Data should be given as constant values adjusted to the same year for costs and benefits

Example 1: Service costs may be expressed as cost of service based on its expenditure during operation. Benefits may be expressed financial savings that would accrue from e.g. reduction in crime. However the savings from reduction in crime will occur at a future point in time and adjustments should be made for this.

Example 2: Data on costs and/or benefits maybe based on projections which are derived from previous similar exercises for example projected annual earnings. Data maybe adjusted to take into account changes in average earnings over the period of time between the source data and the study

G.6.1 Details

G.7 What sensitivity analysis was undertaken to estimate the effect of uncertainty in costs of inputs/outcomes

Where costs or benefits are based on estimates sensitivity analysis maybe undertaken to test the effect on the results that changing some of the parameters of the estimates makes.

Where costs or benefits are based on a client outcome the outcome will be a point estimate which should have a confidence interval the economic analysis should reflect this

G.7.1 Details

Section H: Results & Conclusions

H.1 How are the results of the study presented?

Please tick all that apply

H.1.1 Service Outputs (e.g. service use)

H.1.2 Service inputs (e.g. changes in way services are delivered)

H.1.3 Impact on service user outcomes

H.1.4 Perceptions of stakeholders about service delivery/ provision (Please specify which group(s) of stakeholders)

H.1.5 Other (please describe)

H.2 What are the results of the study as reported by authors?

Please give as much detail as possible and refer to page numbers in the report(s) of the study, where necessary (e.g. for key tables).

Please use facility for extracting data/ outcomes where appropriate

H.2.1 Details

H.3 Where economic analysis completed what are the results

Please give all relevant data

All data relating to costs

All data relating to benefits

For studies where costs and benefits compared between two alternatives please report all costs and benefits for both alternatives

H.3.1 Details

H.4 For cost benefit analysis financial costs are lower in

H.4.1 The experimental or intervention group

H.4.2 The control group

H.5 For cost benefit analysis benefits are lower or harm greater in

H.5.1 The experimental (intervention) group

H.5.2 The Control (or comparison group)

H.6 Are there any obvious shortcomings in the reporting of the data?

H.6.1 Yes (please specify)

H.6.2 No

H.7 Do the authors report on all variables they aimed to study as specified in their aims/research questions?

This excludes variables just used to describe the sample.

H.7.1 Yes (please specify)
H.7.2 No

H.8 What do the author(s) conclude about the findings of the study?

Please give details and refer to page numbers in the report of the study, where necessary.

H.8.1 Details

Section I: Quality of the study - Methods and data

I.1 Are there ethical concerns about the way the study was done?

Consider consent, funding, privacy, etc.

I.1.1 Yes, some concerns (please specify)
I.1.2 No concerns

I.2 Were participants in the study adequately involved in the design of the study

I.2.1 Yes (a lot)
I.2.2 Yes (a little)
I.2.3 No

I.3 What is the quality of the study according to the Maryland Scale?

Level 1

Single group single point (post-test only or correlational study)

Level 2

Single group pre & post test OR
Non equivalent control group (with no adjustment in analysis)

Level 3

Cluster randomised trial with only 1 cluster in each arm OR
Non -random cluster OR

Non equivalent control group pre and post test design where outcome = change in pre test /post score (with no other adjustment in analysis)

Level 4

Non Random controlled trial where groups are demonstrated to be equivalent on important variables (includes studies where post-hoc analysis used to create equivalent groups e.g. Path analysis or Structural Equations modelling

Level 5

Randomised Controlled trial with cluster or individual allocation

I.3.1 Level 1
I.3.2 Level 2
I.3.3 Level 3
I.3.4 Level 4
I.3.5 Level 5

I.4 Weight of evidence - A: Taking account of all quality assessment issues, can the study findings be trusted in answering the study question(s)?

In some studies it is difficult to distinguish between the findings of the study and the conclusions. In those cases, please code the trustworthiness of this combined results/conclusion.

Consider your answers to questions F9, F13, F14, F15, F17, H3 & H4

I.4.1 High trustworthiness (please specify)
I.4.2 Medium trustworthiness (please specify)
I.4.3 Low trustworthiness (please specify)

I.5 Have sufficient attempts been made to justify the conclusions drawn from the findings so that the conclusions are trustworthy?

I.5.1 Not applicable (results and conclusions inseparable)
I.5.2 High trustworthiness
I.5.3 Medium trustworthiness
I.5.4 Low trustworthiness

I.6 In light of the above, do the reviewers differ from the authors over the findings or conclusions of the study?

Please state what any difference is.

I.6.1 Not applicable (no difference in conclusions)
I.6.2 Yes (please specify)

I.7 Weight of evidence B: Appropriateness of research design and analysis for addressing the question, or sub-questions, of this specific systematic review.

Please specify basis for this judgement.

I.7.1 High
Maryland Scale score = 5
I.7.2 Medium
Maryland scale score = 3 & 4
I.7.3 Low
Maryland Scale Score = 1 or 2

I.8 Weight of evidence C: Relevance of particular focus of the study (including conceptual focus, context, sample and measures) for addressing the question or sub-questions of this specific systematic review.

This question is about the relevance of the study to the in-depth review question.

Take into account your answers in Section D (i.e. information about the coordination/ integration effort) and question E9 (the HCHHHU)

Studies where little information is provided to answer these questions and/or coordination/ integration is only a small part of the study should be graded lower

I.8.1 High
I.8.2 Medium
I.8.3 Low

I.9 Weight of evidence D: Taking into account your answers to Weight of Evidence A, B, & C, what is the overall weight of evidence this study provides to answer the question of this specific systematic review?

Overall Weight of Evidence D =
WOE A + WOE B + WOE C/ 3
Where High = 3, Medium = 2, Low = 1
Except that WOE D cannot be higher than Weight of Evidence B

I.9.1 High
I.9.2 Medium
I.9.3 Low

Section J: Economic analysis Quality Assessment

J.1 Were all important costs and /or benefits identified

J.1.1 High (Yes all)

J.1.2 Medium (Most but not all)

J.1.3 Low (minimal)

Likely to lead to serious deficiencies in estimates

J.2 Was measurement of costs and benefits sufficiently accurate

J.2.1 High

Source data credible & appropriate

Imputation of financial values for non cash costs reasonable

J.2.2 Medium

Some doubts about sources of financial estimates and or process of deriving cash values

J.2.3 Low

Sources of finance data lack credibility and/or process of deriving cash values likely to lead to systematic bias (over or under estimates)

J.3 Was appropriate adjustment made for differential timing

J.3.1 High

Not applicable or appropriate adjustments made

J.3.2 Medium

Some adjustments made but not on all costs/ benefits

J.3.3 Low

No adjustments made when were required leading to bias in financial estimates (over or under estimating)

J.4 Was appropriate sensitivity analysis undertaken

J.4.1 High

Sensitivity analysis on all key costs/ benefits estimates undertaken

J.4.2 Medium

Sensitivity analysis undertaken for some estimates

Estimates given with confidence intervals

J.4.3 Low

No sensitivity analysis undertaken

J.5 Overall rating for quality of economic analysis

Should reflect answers to questions above

J.5.1 High

J.5.2 Medium

J.5.3 Low

Appendix 2.3 Framework for assessing Weight of Evidence B

Maryland Scale score	WoE B
Level 5 Randomised controlled trial with cluster or individual allocation of multiple individuals/clusters into groups.	High
Level 3 Cluster randomised trial with only one cluster in each arm OR non-random cluster OR non-equivalent control group pre and post test design where outcome = change in pre/post-test score (with no other adjustment in analysis). **Level 4** Non-random controlled trial where groups are demonstrated to be equivalent on important variables (includes studies where post-hoc analysis used to create equivalent groups e.g. path analysis or structural equations modelling adjustment in analysis)	Medium
Level 2 Single group pre- and post- test OR non-equivalent control group (with no adjustment in analysis) **Level 1** Single group single point (post-test only or correlational study)	Low

APPENDIX 4 Summary of in-depth studies

Table 1 HCHHHU Characteristics

Item	What was the total number of participants in the study (the actual sample)?	Problems experienced by individuals in the sample	Describe the characteristics of the 'multiple generations' in detail
De Paul and Arruabarrena (2003) Evaluation of a treatment program for abusive and high-risk families in Spain	133 families containing 289 children Hispanic	• Unemployment • Anti-social behaviour • Low education level (parents) • Child abuse/neglect • Poor health outcomes • Substance misuse • Mental health problems • Family breakdown • Socio-economic deprivation • Other (social isolation, marital discord, conflict with relatives)	"CPS referred 107 families (80.5%) to the treatment program because of the substantiation of child maltreatment, 42 cases of physical neglect (39.3%), 22 cases of parental failure to control the child's behaviour (20.6%), 16 cases of physical abuse (14.9%), and 11 cases of emotional abuse or neglect (10.3%). CPS referred 26 other families (19.5%) to treatment because they were thought highly likely to maltreatment their children in the near future." (p 419) "The children participating in the program ranged from infancy to 18 years old. At the beginning of the treatment, 85.1 (N=246) of the children were living at home with their parents, 10.1% (N=32) were in residential care, 0.3% (N=1) were living with a foster family, 2.8% (N=8) were with relatives, and 0.6% (N=2) were with other people." (p 420) 34.8% of families were totally dependant on social welfare, and 9.8% partially dependant; 81.3% of mothers and 82.4% of fathers had only a primary school education; 18.5% of mothers and 34.8% of fathers abused alcohol; 9.7% of mothers and 14.1% of fathers abused drugs. (For additional details, see Table 1, p 421)

Dillane et al. (2001) Evaluation of the Dundee Families Project	20 families containing 83 children/young people Ethnicity not stated	• Unemployment • Anti-social behaviour • Exclusion/non-attendance at school • Criminal convictions • Poor health outcomes • Substance misuse • Mental health problems • Family breakdown (looked after children, temporary accommodation) • Socio-economic deprivation • Domestic violence • Other (significant rent arrears and/or other housing issues, including conflict with neighbours)	Main behavioural issues relating to the parents (or family as a whole) included "poor anger control, alcohol and drug misuse, social exclusion, lack of parenting skills/ role models, issues-instability, lack of routines, low self-esteem, isolation, learning disabilities, health-related issues, poor hygiene and nutrition, mental health problems (notably depression and anxiety), traumatised behaviour, offending/criminal behaviour, negative attitudes". "In relation to children, educational issues were prominent, including truancy, difficulty concentrating and school exclusion. Offending and behaviour issues were also common." (p 28) "In two thirds of cases, anti-social behaviour (ASB) was given as at least part of the reason for referral…In more than half of the 24 cases where the perpetrators of the ASB were identified, it involved children in the family and in exactly half one of the adults was implicated. …Virtually all the families were poor…Only two parents were stated to be in paid employment. …At the time of referral four of the families had all their children living away from their parents. A further 12 families had at least one child living away – with relatives or looked after by the local authority." (p 40–41)
Harrell et al. (1999) Evaluation of the Children at Risk Program: results one year after the end of the program	338 participating Children at Risk (CAR) youths and their families (with 333 youth in the control, and 203 in the comparison groups) Black (58%), Hispanic (34%), White or Asian (8%) (participating CAR youths)	• Unemployment • Anti-social behaviour • Exclusion/non-attendance at school • Criminal convictions • Substance misuse • Mental health problems • Socio-economic deprivation • Poor quality of physical environment • Domestic violence • Other (lack of parental supervision and disciplinary practices, low levels of parental attachment and support, low family cohesion and organisation, and problem behaviours among parents and older sibling	"In general, caregiver educational levels were low, and family dependence on public support was widespread…fewer than half were employed when they joined the study." (p 3) The average age of the participating youths at the time they entered the sample was 12.4 years; 52% were male. "The youths chosen for intensive interventions lived in severely distressed neighborhoods and were selected because they already had exhibited problems associated with predictors of drug activity in later life. The programs targeted small geographical areas with the highest rates of crime, drug use, and poverty in each city." Youths were deemed eligible if they lived in the target area and exhibited risk in one of three domains: school, family, or personal factors. "School risk was defined by exhibiting three of the seven following indicators: special education, grade retention, poor academic performance, truancy, tardiness, out-of-school suspension, or disruptive behaviour in school. Family risk was defined as having a history of family violence or having a gang member, a drug user or dealer, or a convicted offender at home. Personal risk was defined by use or sale of drugs, juvenile court contact, delinquency or mental illness, association with gang members or delinquent peers, a history of abuse or neglect, or parenthood or pregnancy." (p 3–4)

Hunter et al. (2004) Strengthening community-based programming for juvenile sexual offenders: key concepts and paradigm shifts	245 males, 15 females (and their families) African American (67%), Caucasian (23%), Latino (9%), Native American (1%)	• Exclusion/non-attendance at school (educational problems/ special educational needs) • Criminal convictions • Child abuse/neglect • Substance misuse • Mental health problems • Family breakdown (looked after children, temporary accommodation) • Domestic violence	Young people are adjudicated sex offenders deemed at risk of residential treatment. They have an average age of 13 years 7 months and 54% have been identified as special education students. The most common diagnoses are conduct or oppositional-defiant disorder (61%), attention deficit hyperactivity disorder (45%), depressive disorders (39%), and learning disorders (25%). Additional youth risk factors identified at intake include drug and alcohol abuse (26%), runaway behaviour (24%), and previous psychiatric hospitalisation (23%). Youth have often endured harsh life conditions. Many reside in impoverished and high-crime neighbourhoods. 44% of families have an annual gross income of less than US$15,000, for an additional 31% of families gross income was less than US$25,000. Additional family risk factors identified at intake include substance-abusing caretaker (41%), abandonment by parent (38%), parental incarceration (32%), domestic violence (29%), neglect (17%), and parental severe mental illness (15%). (p182)
Jones et al. (2006) Addressing antisocial behaviour: an independent evaluation of Shelter Inclusion Project	74 households containing 98 adults and 132 children/dependent teenagers One adult was from a Black or Minority Ethnic (BME) group; the others were of White British origin.	• Unemployment • Anti-social behaviour • Exclusion/non-attendance at school • Criminal convictions • Poor health outcomes • Substance misuse • Mental health problems • Family breakdown (looked after children, temporary accommodation) • Socio-economic deprivation • Domestic violence	"In 70 per cent of cases, the antisocial behaviour in a household was being committed solely by an adult or adults." In 12% of cases, children and young people were the sole perpetrators of antisocial behaviour, with the adult or adults in the household not being involved. In 18% of households, both adults and children or young people in the same household were involved in antisocial behaviour. Around 12% of adults and 8% of children were involved in criminal activity (including serious crime such as arson, violence, theft and drug dealing). >50% of households contained an adult with self-reported depression, >25% contained an adult with a limiting illness or disability, and 25% of households contained an adult who self-reported drug and/or alcohol dependency. 24% (N=18) of households were recorded as having high and/or complex support needs…"In particular, these households were likely to have a risk of violence (11 cases)…In two cases, at least one household member had a learning disability." 8% of children were reported by a parent as having either a disability or a long-term limiting illness. 18% of children were described by a parent as having behavioural problems (including mental health problems). Just under 25% of children (for whom data were available at referral) were experiencing severe problems at school or were absent from school. Child protection concerns (15 households) "included neglect or failure to protect, physical abuse, non-accidental injury, emotional abuse and, in a few cases, inappropriate sexual behaviour or abuse. In some cases, the household was typified by abusive relationships and included not only parental abuse (mother and father) but also abuse between siblings (as well as by children against parents)." (p16–20)

Nelson et al. (2000) Applying a family-ecosystemic model to reunite a family separated due to child abuse: a case study	*1 family (mother and 5 children)* *African American*	• Unemployment • Child abuse/neglect • Poor health outcomes *mother was HIV+* • Substance misuse • Family breakdown (looked after children, temporary accommodation) (one child in foster care) • Socio-economic deprivation	Mother: African American, had successfully completed residential drug treatment, was HIV+ but her health was good and she did not suffer from any physical symptoms. She received social security benefits, did not work, and lived in a two-bedroomed government subsidised apartment. She had a long history of parenting difficulties due to substance abuse, and had often lived apart from her children. She, herself, had an unstable childhood (she had been raised by her father after her mother walked out on the family; she had smoked crack cocaine at age 14, and had her first child at age 16). Children (N=5): 12 year old daughter 22 year old son other adult son (in prison) eldest daughter (conflictual relationship with mother) The fifth child, a daughter, had been state custody for 5 years. She was aged 17, but acted like a 12 year old because of her developmental disability. She had problem behaviours such as running away frequently and sexual promiscuity. She was removed from the home because of abuse and neglect (she had three concurrent sexually transmitted diseases).
Nixon et al. (2006) Interim evaluation of rehabilitation projects for families at risk of losing their homes as a result of anti-social behaviour	99 families containing 131 adults and 259 children 94% white British (others black Caribbean, mixed, 'other')	• Unemployment • Anti-social behaviour • Exclusion/non-attendance at school • Criminal Convictions • Child abuse/neglect • Poor health outcomes • Substance misuse • Mental health problems • Family breakdown (looked after children, temporary accommodation) • Socio-economic deprivation • Poor quality of physical environment • Domestic violence	"Service users were characterised as having multiple and inter-related support needs that had been manifest over a long period of time. • Problems connected with children's schooling affected just under half (46%) of all families and in a quarter (25%) of families one or more child was reported as having special educational needs such as ADHD, dyslexia or dyspraxia. • Ill health represented a further set of difficulties faced by many families. In 39% of families one or more member of the household were identified as having mental health problems, most commonly depression related illnesses. Substance abuse fuelled neighbour problems in 27% of families where there were reported to be drug or alcohol related problems. Further, members of more than one in five families were affected by chronic physical ill health such as asthma. • High levels of family violence were noted, with violence in the home affecting over a quarter of families (28%). Violence was not always perpetrated by adult family members and in a number of cases it was reported that teenage children had assaulted their mothers." (p 6)

Pritchard (2001) A family-teacher-social work alliance to reduce truancy and delinquency – the Dorset Healthy Alliance project	14–16 year olds and their families Intervention group (young people: N=272 Year 1; N=356 Year 3) control group (young people: N=365 Year 1; N=503 Year 3) Ethnicity not stated/ unclear	• Unemployment • Anti-social behaviour • Exclusion/non-attendance at school • Criminal convictions • Child abuse/neglect • Poor health outcomes • Substance misuse • Mental health problems • Family breakdown (looked after children, temporary accommodation) • Socio-economic deprivation • Other (young women had high age-related pregnancy rates)	"In the first year, Lords Park families had a much higher contact with statutory services than the other schools (12%)… The nature of the Lords' families' contact with Social Services was illustrated by a detailed analysis of 36 current or recent case-records. Two-fifths of the presenting problems were child protection cases, with over 10 per cent involving child sexual abuse. More than one in 10 of parents had predominantly mental health problems, one in five had medical and chronic health disorders, while seven per cent had a physical disability. Their difficulties were compounded by the fact that the majority of fathers involved with statutory services were unemployed (75 per cent plus); more than a quarter had a long-standing mental health problem; and a third had spent some time in temporary housing, reflecting their chronic housing difficulties. …Overall (and especially in Lords Park) children in all four schools were more disadvantaged than their age peers elsewhere in the county, with a significant minority having inter-generation difficulties." (p 17) Children's problematic behaviours included truancy, bullying, smoking, drinking alcohol, fighting, vandalism, and theft.
Sen and Goldbart (2005) Partnership in action	*21 families containing 22 children with disabilities (and other children)* *Implicit: 67% spoke Bengali and 33% Hindi; 67% were Muslim and 33% Hindu*	• Poor health outcomes • Socio-economic deprivation • Poor quality of physical environment *(families lived in slum housing)* • Other *(literacy levels were low)*	Families lived in slum housing, with most homes (76%) consisting of only one room. "Of the 21 families identified, 15 fathers (71%) and 13 mothers (62%) had no formal education. The majority of fathers (71%) worked as labourers…the monthly income in 15 families (71%) was very low." 22 children with disabilities (11 boys and 11 girls) were identified, with ages ranging from 2 to 21 years. "Eleven of the children had multiple disabilities with a primary diagnosis of cerebral palsy; seven children had an intellectual disability and four had a motor impairment resulting from a range of conditions (post-polio paralysis, congenital deformity of the leg, osteogenesis imperfecta). Five children also experienced epilepsy." (p 285–7)
Tischler et al. (2004) A family support service for homeless children and parents: users' perspectives and characteristics	49 families Ethnic status of the main carer: • 71% white British/Irish • 14% Asian • 8% Black American • 2% Middle Eastern	• Exclusion/non-attendance at school • Poor health outcomes • Mental health problems • Family breakdown (looked after children, temporary accommodation) • Socio-economic deprivation • Poor quality of physical environment	"Half of the families (N=24, 49%) had been homeless in the past. Their reasons for becoming homeless were: domestic violence (N=6, 12%); relationship breakdown (N=15, 31%) – on further questioning most of these mothers were also found to be victims of domestic violence; neighbour harassment (N=13, 27%); eviction (N=7, 14%); refugee status (N=3, 6%); overcrowding (N=3, 6%); natural disaster (N=1, 2%); and release from prison (N=1, 2%)." The children's ages ranged from 2 to 17 years. The most frequently reported difficulties were "aggressive and disruptive behaviour (N=8, 21%); overactivity and attention deficit (N=9, 24%); scholastic or language skills problems (N=9, 24%); emotional problems (N=8, 21%); peer relationships (N=9, 24%); school non-attendance (N=5, 13%); family life problems (N=7, 19%); and lack of information about appropriate services (N=6, 17%)…" (p 330–1)

Table 2 Services delivered and study results

What country was the study conducted in? What is the formal name, if any, of the programme of intervention?	Who provides the services?	What is the specific support provided?	Results
De Paul and Arruabarrena (2003) Evaluation of a treatment program for abusive and high-risk families in Spain Spain The Gipuzkoa Program	• Counsellor/therapist see p 422 for description of different therapies used • Social worker home visitors included social workers, psychologists and teachers • Teacher/education support staff • Psychologist • Unspecified/not clear unclear who ran the parent training groups	• Parent training • Psychological therapy (play therapy and psicomotricidad (a method developed in France) was used with children; problem-focused psychotherapy was used with adults; and for family and marital therapy, the systemic model was used, using its different orientations) • Personal/social/family support • Assessment • Other ("Families received other community services in addition to the treatment program, when these services were appropriate for the treatment process. Direct intervention of the judicial system was very infrequent.") (. 423)	"The analysis obtained the lowest rates of success for neglectful and abusive-neglectful families. Dropout and non-dropout families differed in two paternal characteristics: alcohol problems and childhood experience of out-of-home care. Rehabilitated and non-rehabilitated families differed in several variables, including time elapsed between case detection and referral to the treatment program. Scores on measures showed significant changes during treatment." (p 413) Of the 110 families who finished the treatment program, case co-ordinators indicated that "the treatment was successful in 53.6% of the cases and unsuccessful in 46.4% of the cases. Within the group rated as partially but not sufficiently improved (31.8%), workers thought some families, with treatment and supportive services longer than 24 months, were likely to reach a sufficient level of competence in their functioning and in the parental role performance." Researchers "obtained the treatment results for the high-risk, physical-abuse, and emotional-abuse/neglect groups, but the data about the physical-abuse, and emotional-abuse/neglect groups are questionable because of the small number of cases. They obtained the lowest rates of rehabilitation for the physical abuse and neglect as well as the neglect groups (see table 4). "No personal or psychosocial characteristics of parents and families were significantly related to treatment results, except for the extent of economic dependence on social welfare. Fewer economically dependent families were rehabilitated"; chi-square = 4.25, $p<0.05$. (p 427) "…families who reached rehabilitation provided better care for children's needs at the beginning of treatment…Children from families who reached rehabilitation showed fewer behaviour problems at school at the beginning of treatment than children from families who did not reach rehabilitation." (p 432)

Dillane et al. (2001) Evaluation of the Dundee Families Project Scotland Dundee Families Project	• Criminal Justice System staff (probation officer, court welfare officer, prison staff etc.) • Community/outreach worker • Social worker • Teacher/education support staff • Health care worker • Family support workers	• Criminal justice (prison, community sentence, probation, ASBO, youth justice) • Counselling (non-specific) • Support with service and resource access (including benefits) • Specific education intervention • Parent training • Personal/social/family support • Health services (not psychology/ counselling) • Assessment • Other (please specify) *The Project offers both individual and family support and counselling and group activities. Group activities include: after school clubs anger management groups and tenancy workshops.*	"Overall, the research data showed that the Project has been very successful in terms of its image, collaborative relationships and production of change in families… "The case record analysis, the in depth survey of 20 families and stakeholder feedback indicated that the great majority of families who engaged with the Project made progress… "The evidence about the comparative success of the three main service types offered by the Project (core, dispersed, outreach) was inconclusive, partly because numbers were small, especially of core and dispersed cases. A few respondents in the study identified individual components of the Project's programme as being particularly useful (e.g. couple counselling, tenancy workshops). The majority, though, stated that the whole package was most important, rather than any particular ingredient. They believed that the crucial attribute of the Project was the availability of a range of methods, allowing for both multiple intervention and adapting method choice to the needs of individual families. In their views, another key asset was the intensity… "Since the Project was established, the number of evictions in Dundee has dropped markedly. While this is has been much influenced by changes in housing department policy and the introduction of Anti-Social Behaviour Orders, some stakeholders believed that the presence of the Project contributed to the downward trend." (p 116–8)

Harrell et al. (1999) Evaluation of the Children at Risk Program: results one year after the end of the program USA Children at Risk (CAR) drug and delinquency prevention program	• Criminal justice system staff (probation officer, court welfare officer, prison staff etc.) • Community/outreach worker • Teacher/education support staff • Health care worker • Family support workers • Employment advisor/ case worker	• Advocacy • Criminal justice (prison, community sentence, probation, ASBO, youth justice) • Support with service and resource access (including benefits) • Specific education intervention tutoring and homework assistance • (e.g. reward schemes) • Parent training • Skill development • Personal/social/family support Assessment Other (please specify) *recreational after-school and summer activities; the provision of transport (e.g. for appointments); mentoring; work preparation opportunities; community policing*	Compared to both the comparison and the random control group, CAR youths: • participated in higher rates of positive activities (e.g. sports, clubs etc.) • were more likely to attend drug and alcohol programs Compared to the random control group, CAR households • used more services (although most families reported not receiving all the core services) Compared to the random control group, CAR youths were significantly more likely to: • receive more positive peer support • be associated less often with delinquent peers • feel less pressured • be less frequently urged by peers to behave in antisocial ways • be 'promoted in school' ('which may lead to higher graduation rates') Compared to the random control group, CAR youths were significantly less likely to: • have used 'strong' drugs (psychedelics, crack, cocaine, heroin, etc.) at the end of the program ($p<0.05$) • have used 'gateway' drugs (cannabis, alcohol, solvents, cigarettes) at the end of the program ($p<0.001$) and a year after the program ($p<0.01$) • have sold drugs ever ($p<0.05$) and in the past month ($p<0.01$) • have committed violent crimes in the year following the program ($p<0.05$) The process evaluation documented substantial problems in engaging these multi-problem families in services.
Hunter et al. (2004) Strengthening community-based programming for juvenile sexual offenders: key concepts and paradigm shifts USA Wraparound Milwaukee Program	• Criminal justice system staff (probation officer, court welfare officer, prison staff etc.) • Counsellor/therapist • Social worker • Psychologist	• Support with service and resource access (including benefits)	**Program outcomes: system changes** To ensure appropriate supervision and structure for adjudicated juvenile sexual offenders managed in the community, community and home-based services were more frequently prescribed…These included crisis one-to-one stabilization (up 72%), parent assistance (up 54%), and treatment foster care (up 38%). Offence-specific doctoral-level individual therapy (up 22%) and in-home family therapy (up 49%) were also increased. Access to community-based psycho-educational groups has also improved and now includes a parent-education and support-group component." (p 183) **Program outcomes: recidivism** To date, adjudicated sexual recidivism during Wraparound Milwaukee enrolment (N=202) is 8%; nonsexual recidivism is 27%. The average length of enrolment for adjudicated juvenile sexual offenders in Wraparound Milwaukee is 16.5 months. Youth, 1 year following discharge from Wraparound Milwaukee (N=100), have reoffended at a 2% sexual offence rate and at 23% for nonsexual offending." (p 183)

Jones et al. (2006) Addressing antisocial behaviour: an independent evaluation of Shelter Inclusion Project England Shelter Inclusion Project	• Family support workers • Management/ administrator (project manager, administrator, office assistant, child and youth worker team leader) • Other (young persons workers)	• Advice/feedback • Counselling (non specific) • Support with service and resource access (including benefits) • Parent training • Skill development *financial skill development* • Personal/social/family support • Assessment	"…Overall, inter-agency relationships were good and had improved over the course of the pilot. "…The project showed significant success in ending antisocial behaviour and promoting tenancy sustainment among the households with whom it had worked. "…Among the 45 households which had completed their time with the project, 60 per cent were reported as no longer exhibiting any antisocial behaviour. A further 11 per cent of these 'closed cases' were reported as showing improvements in respect of their antisocial behaviour. Overall, 71 per cent of closed cases had either ceased their antisocial behaviour or shown improvement. Tracking service users' behaviour before, during and after the project, however, showed that it sometimes took a long time to address more severe antisocial behaviour and that it was not always possible to do so. "… small number of adults experienced an improvement in their economic status while with the project. "…Thirty-four children and young people received direct support from the project with their education. In 91 per cent of these cases, improvements in school attendance were recorded by the project workers. "…Agency representatives reported that the project had been successful in helping service users address problems in their lives…The project was felt to have played a part, alongside other initiatives, in addressing wider social exclusion at a local level." (p 5–7)
Nelson et al. (2000) Applying a family-ecosystemic model to reunite a family separated due to child abuse: a case study USA SET (Structural Ecosystems Therapy)	• Criminal justice system staff (probation officer, court welfare officer, prison staff etc.) • Counsellor/therapist • Social worker • Health care worker	• Advocacy • Advice/feedback • Criminal justice (prison, community sentence, probation, ASBO, youth justice) • Counselling (non-specific) • Support with service and resource access (including benefits) • Parent training • Psychological therapy • Personal/social/family support • Assessment	The SET therapist and the mother were able to work together to create an effective plan of action. The intervention was successful in mediating and building alliances between the family and other agencies where relationships had been difficult, particularly child welfare services. Collaborations were built among the agencies involved in overseeing the child's welfare. The SET therapist was successful in improving family functioning and relationships through parent training, family support and through involving other agencies in family support (e.g. social housing providers, advocates). Successful reintegration of an adolescent into her family after a five-year separation (following a court-order) too place.

Nixon et al. (January 2006) Interim evaluation of rehabilitation projects for families at risk of losing their homes as a result of anti-social behaviour England	• Community/outreach worker • Residential care worker • Family support workers	• Advocacy • Counselling (non specific) • Support with service and resource access (including benefits) • Parent training • Skill development Psychological therapy (cognitive-behavioural anger management) • Personal/social/family support • Health services (not psychology/ counselling) • Assessment	**Impact on user outcomes:** (incomplete data) • threat to home 'stabilised' for 80% of families (N=45/56 families) • improvement in school attendance for 84% (N=31/38) • maintained tenancy or had a 'planned move' for 95% (N=73/77) • stabilisation of complaints for 15% (N=9/62) • reduction in level of complaints for 82% (N=50/62) **Referral agencies perceptions of the impact of the intervention:** "The large majority of referrers viewed the projects in a positive light for a variety of reasons…Despite the very positive views expressed, some referrers also had reservations about making a judgement on how successful the projects were in dealing with all types of families. "…Some referrers thought that the project didn't really offer anything new or different and that similar types of provision is already available, albeit targeted slightly differently, such as Sure Start and work administered by YOT teams or YISPs. …Reservations were also expressed as to how successful any one project could be at addressing long-standing, deep-seated problems that may be at the root of a family's behaviour. …Notwithstanding these reservations, most referral agencies assessed the projects as being successful at helping to reduce the risk of eviction in the long term… (and) confirmed that there had been positive outcomes such as reduced complaints of anti-social behaviour, a stabilisation of the family's tenancy, improvement in the condition of a property or improvement in the welfare of the children." **Families views on the service:** Overwhelmingly, these assessments were positive…Many families felt like they had been given a new start, given stability and a general feeling of being more in control and better-able to make decisions and choices. Some also described changes in their family relationships and the way they communicate with each other.

Pritchard (2001) A family-teacher-social work alliance to reduce truancy and delinquency – the Dorset Healthy Alliance project England The Dorset Healthy Alliance Project	• Criminal justice system staff (probation officer, court welfare officer, prison staff etc.) • Counsellor/therapist (teacher-counsellors in addition to class teachers) • Social worker (educational social worker) • Teacher/education support staff • Health care worker including child protection team	• Advocacy • Advice/feedback • Criminal justice (prison, community sentence, probation, ASBO, youth justice) • Counselling (non-specific) • Support with service and resource access (including benefits) • Specific education intervention • Personal/social/family support • Health services (not psychology/ counselling) • Assessment • Other (consultative service to teachers)	"Analysis of 198 case records showed over 90 per cent of the child/family problems were either resolved or improved. …A parent and child consumer study of the PSW's work found very high positive scores, no negative ratings, and appraisals which were significantly better than the 'standard' service…. **Primary** After three years, there were major improvements in Lords Park – virtually no truancy, lowest ever repair costs, theft rate had halved, improved attitudes to school – equalling the earlier comparison school results, and in some areas surpassing them… **Secondary** Earls Park adolescents' (14 to 16 years) truancy went from 28 per cent to 16 per cent; they had better behaviour and attitudes than the comparison school – especially lower theft from school, reductions in vandalism, less under-age drinking, lowered solvent abuse and use of hard drugs. They had marked improvements in identification with the school, and better aspirations for the future. These results were confirmed by an independent coterminous county-wide survey… Factors identified which were least associated with delinquency found the second best feature was having two parents, and having an employed father; but the strongest statistical association with reduced delinquency was in teenagers who enjoyed school, despite the fact that 27 per cent had an unemployed father, and 31 per cent belonged to a single parent family, suggesting that a positive school ethos can be a protection or a barrier against delinquency." (p viii-x)

Sen and Goldbart (2005) Partnership in action: introducing family-based intervention for children with disability in urban slums of Kolkata, India	• Community /outreach worker	• Advice/feedback • Support with service and resource access (including benefits) • Specific education intervention • Parent training • Personal/Social/Family support • Health services (Not psychology/ counselling) • Assessment	"Most children and adults benefited through the intervention…Four children attended school for the first time. All families were informed of entitlements to government facilities and concessions. Family needs in relation to young adults could not be met directly through the project… …Because the fieldworkers and supervisors were equipped with basic knowledge of early identification of disability and the need for immediate referrals, there is likelihood that they will be able to identify children with disabilities early in life so that the effects of the disability may be decreased and there is increased potential for improvement in the quality of the child's life. Nine community meetings…although small in terms of scale, brought disability out of the family in to the public arena, thereby initiating processes of attitudinal change and greater awareness… At the child level, positive changes were noted in most of the "before" (i.e., pre-intervention) and "after" (i.e., post-intervention) profiles compiled... The impact of the project on the community volunteers was encouraging... At the level of the partner organisations, the project co-ordinators and field workers felt that the project had been feasible ….. It is not clear, however, whether the impact reached the entire governance of the partner organisations… All the partners expressed the need for further training of field workers. The collaborative teamwork in the sites was effective in reaching out to community members…"(p 294)

Tischler et al. (2004) A family support service for homeless children and parents: users' perspectives and characteristics	• Social worker • Teacher/education support staff (educational welfare or Sure Start) • Health care worker • Family support workers. • Other	• Support with service and resource access (including benefits) • Parent training • Personal/social/family support • Assessment • Other *(organisation of activities; ensuring school placement and attendance; liaising with and maximising the involvement of specialist agencies)*	**Impacts of service user outcomes** "The majority of comments regarding the FSW were positive… Her advice on practical issues, parenting, and schooling, were also positively received… Referrals were made to other agencies, and contact was enabled with community psychiatric nurses from the adult service, social workers, health visitors and general practitioners… The majority of the residents felt that the FSW had made a positive difference, with a small number unsure, or reporting no change. (p 332–333) **Perceptions of the service** "The expectations of the intervention were variable, and there were fewer responses to this question. Residents wanted information on services, help with schooling or letters of support for re-housing. Some residents wanted someone to talk to, while others were unsure of what was being offered. Six residents stated they did not want help. The assessment interviews with the FSW appeared to cover a wide range of issues. The residents felt that the support and counselling provided was an important part of the intervention." (p 328)

Table 3 Methods and weight of evidence

Studies Method	Validity of data collection tools/ methods	Reliability of data collection tools/ methods	Study timing	Maryland scale score	WoE A	WoE B	WoE C	WoE D
De Paul & Arrubuena. (2003) One group pre-post test	Clinical Judgment of Case Co-ordinator scale Beck Depression Inventory not mention about validity of Spanish translation of BDI version CAP yes TRF Yes. However, the authors did not state about validity of a Spanish translation of TRF version CWB	Clinical Judgment of Case Co-ordinator scale Yes Beck depression inventory- Yes CAP yes TRF yes CWBS Not stated	Prospective	Level 2	Medium	Low	Medium	Low
Dillane et al. (2001) One group pre-post test Views studies	Small number of interviews – high interview failure rate – part of evidence from project records which were not externally verified	Yes. Both staff and client families interviewed twice where possible. Some mention of consistency of staff answers in interviews (e.g. p 28). Interviews tape-recorded (p 7)	Prospective	Level 2	Medium	Low	High	Low
Harrell et al. (1999) Randomised controlled trial Non-randomised controlled trial	Supplemented self-reported data with official criminal records/data on school performance.	Not reported	Prospective	Level 5	High	High	High	High
Hunter et al (2004) One group post-test only	No	No	Not stated	Level 1	Low	Low	Low	Low
Jones et al. (2006) Surveys Referral Views studies Document study	Not stated	Limited. the author stated about information from the Legal and Enforcement Team was much more reliable, so it was decided to concentrate on the Legal and Enforcement records (p 54)	Cross-sectional Prospective	Level 1	Medium	Low	High	Low

Nelson et al. (2000) Case study N=1 family	First hand account of events.	No	Retrospective	Level 1	Low	Low	Low	Low
Nixon et al. (2006) One group post-test only Views studies	No	Concerns re. reliability of record keeping	Cross-sectional	Level 1	Low	Low	Medium	Low
Pritchard (2001) Non-randomized controlled trial	self-reported questionnaires used for outcomes no verification	All the questionnaire-type surveys were subjected to independent inter-rater reliability tests	Prospective	Level 3	High	Medium	High	Medium
Sen and Goldbart (2005) One group pre/post-test Action research	Needs assessment questionnaire was developed in consultation with field workers, piloted with a sample of six families and altered based on their feedback. (p 284)	"As far as possible, the project team always included two team members so that information obtained from the needs assessment could be cross-checked for accuracy of interpretation. However, no further methods of verification by families were used." (p 284)	Prospective	Level 2	High	Low	Medium	Low
Tischler et al. (2004) Surveys Views studies The focus of this data extraction.	Interview schedule developed based on previous research. Interviews conducted in hostel. Participants were assured of confidentiality. Independent researcher	Semi-structured interview with clear interview schedule. Independent researcher	Cross-sectional	Level 1	Medium	Low	Medium	Low

Table 4 Characteristics of the co-ordination/integration intervention and overall study results

	Interventions							
Item WOE Method	Who are the instigators?	Who provides the services?	Which agencies/ individuals are responsible for the operational aspects? How are strategic management issues dealt with? What incentives and/or sanctions are used to encourage/ support the co-operation/ integration effort	In 'brokerage' interventions who is the case worker? All studies contained a case worker who acted as a broker	How is co-ordination/ integration funded?	What actions were required to improve the co-ordination?	Services provided/how they work (a) How were families identified by the service providers as HCHHHU? (b) What entry 'entry criteria' exist for the services? (c How were service recipients 'recruited' to and 'maintained' in service? (d) Where were services located? Please give exact location	Outcomes and perceptions +: positive outcome -: negative outcome N: No difference perceptions

De Paul & Arruabarrena (2003) Evaluation of a treatment program for abusive and high-risk families in Spain WOE: Low One group pre/ post-test	The Child Protection Services (CPS) were involved in the creation of the program.	1. Counsellor/ therapist 2. Social worker - home visitors included socia l workers, psychologists and teachers 3. Teacher/ education support staff 4. Psychologist 5. Unspecified/ not clear - unclear who ran the parent training groups	Case co-ordinators - direct and co-ordinate the treatment for each family. They also write reports for CPS. Home visitors - include para-professionals and professionals (social workers, psychologists, teachers) Case co-ordinators individually match families and home visitors. They write reports for the CPS. They supervise and provide technical support to home visitors.	The home visitor had the most contact with the families. But not a lot of brokerage activity is described, if any.	Not stated	The action/ activity was the creation of a new program to introduce co-ordination within Child Protection Services (CPS).	(a) Workers could refer families to the treatment program. (b) "worker only made referrals to the program when CPS (Child protection services) substantiated the maltreatment or the high-risk situation and parents agreed to participate in the treatment. In some cases, parental rights had been temporarily suspended, and children were in out-of-home care." (p 419) "The researchers excluded cases of interfamilial child sexual parents with severe drug problems or severe psychiatric disorders, and families in which there was no parental figure with at least minimal intellectual skills." (p 419) (c) Parents had to agree to the treatment to participate in the treatment. "Worker offered participation in the treatment to some of these parents as a way to achieve family reunification" (p 148) (d) Gipuzkoa county, Spain	**+ Antisocial behaviours** + Behaviour problems **+ Family / peer outcomes** + Child abuse + Parenting/ child role, family/child capacity **+ Mental health and wellbeing** + Loneliness + Depression --- No perception outcomes

Dillane et al. (2001) Evaluation of the Dundee Families Project WOE: Low One group pre-post test	Programme funding to assist families who are homeless or at severe risk of homelessness as a result of 'antisocial behaviour'. Previous ways of tackling this problem were seen as expensive and ineffective. The Project is run by NCH Action for Children Scotland in partnership with Dundee Council Housing and Social Work Departments. (p v)	1. Criminal justice system staff (probation officer, court welfare officer, prison staff etc.) 2. Community/ outreach worker 3. Social worker 4. Teacher/ education support staff 5. Health care worker 6. Family support workers	Presumably manager of project team --- The Project is run by NCH Action for Children Scotland in partnership with Dundee Council Housing and Social Work Departments --- Not stated	The staff members came from diverse backgrounds (e.g. housing, field social work, community work, residential care), but they reported a significant level of cohesiveness within the staff group. This could be due to the fact that the most of the current staff had been working at the Project since its inception. This enabled the group to work through any initial difficulties, to develop a positive group identity and to become well grounded in their practice.	The Dundee Family Project was established with Urban Programme funding	- Admissions meetings between representatives of NCH, Social Services and Housing (p 19) - regular case conferences (p 24) - NCH offer specific training for staff (p 27) Relationships with specific services: Housing – regular contact at senior management level, and with Homeless Persons Officers, area managers and housing officers (p 84) Social work: Regular contact at senior management level, and with area social work staff (p. 85). Police: Staff trained & advised by community police officer & formal contacts in case of offences (pp. 85-6). Health services: ad hoc contacts (p. 87)	(a) "The panel may accept referrals from a range of sources, although in practice, the vast majority of referrals come from the Housing Department and the Social Work Department." (p 19) Self-referral was also possible, but rare. (b) families had to have exhibited a range of anti-social behaviours with the likelihood that they would be evicted or were living in unsatisfactory tenancy arrangements. Some families lived in a core residential block. "Initially, this was confined to families who had been evicted for anti-social behaviour, but as the number of the evictions reduced this was broadened to 'families who really cannot function in mainstream society and normal council housing' - regardless of their eviction status." (p 19) (c) "Stakeholders suggested that very few referred families explicitly refused to work with the project. One of the interviewees suggested that this was due to a combination or 'persuasion and coercion'. An example of this carrot and stick approach was noted by another person." (d) Dundee, Scotland	No statistical outcomes --- **Perception outcomes** + Economic wellbeing + Education outcomes + Antisocial behaviours + Family/peer outcomes + Mental health and well being
The Dundee Family Project was established with Urban								

Harrell et al. (1999) Evaluation of the Children at Risk (CAR) program: results one year after the end of the program WOE: High Non-randomised controlled trial	CAR was developed, funded and monitored by the National Center on Addiction and Substance Abuse (CASA) at Columbia University.	1. Criminal Justice System staff (Probation officer, Court Welfare Officer, Prison staff etc.) 2. Community/ outreach worker 3. Teacher/ education support staff 4. Health care worker 5. Family support workers 6. Employment advisor/case worker	CAR case managers --- CAR case managers presumably manage their own workload but no details re: STRATEGIC management --- None reported	CAR case manager - work with 15–18 families. Responsib-ilities/tasks include: -recruitment of young people/ families -assessment -treatment -planning -'linkage' -monitoring.	CAR was funded by the National Centre on Addiction and Substance Abuse (CASA) at Columbia University with financial support from the National Institute of Justice, the Bureau of Justice Assistance, and the Office of Juvenile Justice and Delinquency Prevention in the U.S. Department of Justice's Office of Justice Programs. Additional support was provided by the Annie E. Casey Foundation, the Ford Foundation, the Prudential Foundation, the Rockefeller Foundation, the American Express Foundation, the Pew Charitable Trusts, Ronald McDonald Children's Charities, and United Technologies.	Not reported	(a) "The youths chosen for intensive interventions lived in severely distressed neighbourhoods and were selected because they already had exhibited problems associated with predictors of drug activity in later life. The programs targeted small geographical areas with the highest rates of crime, drug use, and poverty on each city...." (p 2) (b) "Staff from the schools, courts, and CAR programs, following clearly defined guidelines, identified eligible 11 to 13 year old youths who attended the sixth or seventh grade, lived in the target neighbourhood, and exhibited risk in one of three domains: school, family, or personal factors..." (c) recruitment: information not given. how participants were 'maintained': Youths and families were encouraged to remain in the program by offering the following: • reminding families about and providing transportation to appointments • providing food at events that families were expected to attend • offering youths stipends for participating in work preparation programs (such as working in a library or attending a summer camp offering science and technology training) • offering youths and family members small rewards (e.g. $10) for good behaviour and for cooperating with CAR program activities and objectives. For example, monetary awards were given to youths for attending after school activities and writing in their journals. Non-monetary rewards included trips to sporting events and vouchers for pizza, sports shops and the cinema. • involving participants in decisions about incentives. (d) Where were services located 1. Austin, Texas 2. Bridgeport, Connecticut 3. Memphis, Tennessee 4. Savannah, Georgia 5. Seattle, Washington	**Education outcomes** + Peer support + Drop out + Peer pressure + Potential gain in the area of educational risk N School performance N Educational and job expectation N School attendance --- **Antisocial behaviours** + Substance misuse (drug uses, sold drug) + Criminal offences (violence crime) + Criminal offences (property crimes, any crimes) + Gang membership N Severe personal problem **Family / peer outcomes** N risk of family conflict + Early pregnancy or parenthood + Runaway **Mental health and well being** N Self esteem, alienation, risk taking No perception outcomes

Hunter et al. (2004) Strengthening community-based programming for juvenile sexual offenders: Key concepts and paradigm shifts WOE: Low One group post-test only	Milwaukee Child and Adolescent Health Services US Dept. of Justice (provided additional funding)	1. Criminal justice system staff (probation officer, court welfare officer, prison staff etc.) 2. Counsellor/ therapist 3. Social worker 4. Psychologist	Wraparound Milwaukee Not reported Not reported	'Care co-ordinator' - 'bachelor's level workers who are intensively trained and certified' 'Care co-ordinator' manage caseload of no more than 8 young people and facilitate the 'collaborative child and family team process'. Care Co-ordinators 'broker' services.	National and state funding.	"Wraparound Milwaukee has developed a fee-for-service provider network that includes more than 200 agencies and individuals offering a broad range of services and supports". Wraparound Milwaukee also operates a "mobile urgent treatment team", which brings together psychologists and social workers.	(a) families are identified through their children who have who have been convicted of a sex offence and, therefore, referred to Wraparound Milwaukee (b) entry criteria are that young people have complex emotional and/or behavioural needs – approx. 65–70 out of every 560 young people who enter the service are sex offenders (c) Mandatory participation (based on reviewers assessment of the authors description) (d) Milwaukee	No statistical outcomes No perception outcomes

Jones et al. (2006) Addressing antisocial behaviour: An independent evaluation of Shelter Inclusion Project WOE: Low Surveys Views studies Document studies	Shelter Inclusion Project represents a new approach to tackling antisocial behaviour and social exclusion. The scheme was launched in 2002 in partnership with Rochdale Metropolitan Borough Council. The project was designed to provide an Alternative model to present enforcement policies and residential schemes by offering a specialist floating support service to help households identify and deal with the causes of their behaviour and learn how to resolve their situations.	1. Family support workers - 4 - support staff (2 full time, 2 half time) 2. Management/ administrator - 1 - Project manager - 1 - administrator - 1 - office assistant - 1 - child and youth worker team leader 3. Other (please specify) - a children and youth worker team leader and young persons workers	Child and young persons workers and support workers --- The manager does not carry a caseload, the project manager line manages the support workers, team leader and the administrator, while team leader supervises the work of the children and young persons workers and the office assistants --- Not stated	Child and young persons workers and support workers dealt directly with the users and co-ordinated the services	- Local Authority (LA) Grants - LA Supporting People - LA Neighbourhood Renewal - Children's Fund - Homelessness Directorate	Develop a good relationship with other agency represent-atives, increase numbers of staff, information exchange, project staff continued to be involved with the Anti-Social behaviour Case conference panel and the case intervention group Staff stressed theimportance of agencies having clear delineation from each other in their work so that service users could understand as far as possible which agency could help with which issues as well as avoiding duplication of services. (p 27)	(a) The majority of households were referred by Rochdale Borough wide Housing (b) During the period of the pilot, Shelter Inclusion Project operated a broad referral policy. The main criteria for referral were that: -households were homeless or faced homelessness in the near future -households had a history of antisocial behaviour - households were willing to engage with the service. (d) Rochdale Metropolitan Borough Council	**+ Economic well being** + Housing (at risk of losing housing) **Antisocial behaviours** + (based on project workers) - (based on case records) --- **Perception outcomes** + Economic wellbeing + Family outcomes + Mental health and well being

Nelson et al. (2000) Applying a family-ecosystemic model to reunite a family separated due to child abuse: a case study WOE: Low Case study N=1 family	Research driven intervention: Funding provided by Center for Mental Health Research on Aids, National Institute of Mental Health. 'Structural Ecosystems Therapy (SET) appears to be in response to difficulties in re-uniting families because of tensions between families and child welfare/ legal services and it aims to mediate between families and these agencies, as well as providing additional family support.'	1. Criminal justice system staff (probation officer, court welfare officer, prison staff etc.) 2. Counsellor/ therapist 3. Social worker 4. Health care worker	The participant's assigned therapist Not reported Negotiations/ persuasion by the therapist	The SET therapist appears to be the main broker for the users	Study grant? (Study funded by Centre for Mental Health Research on AIDS.)	SET therapists liaise and mediate between different agencies, such as child welfare services, the court, health services etc. In this case, improvement needed in relation between individuals from different agencies	(a) Not reported, although likely to be referred by health or social services agencies rather than self-referral. Stated that this mother was randomly assigned to SET as part of a bigger study of the service. (b) targets HIV+ African American mothers (c) Facilitators to maintaining women in the intervention: • Participant involvement in decisions • Participant develops their own individualized treatment goals • Intensive intervension • peer/family support • 'The majority of the sessions take place in the woman's home' (p 127) (d) Not reported (USA only)	No statistical outcomes **Perceptions outcomes** Improve relationships between the family

Nixon et al. (2006) Interim evaluation of rehabilitation projects for families at risk of losing their homes as a result of anti-social behaviour WOE: Low One group post-test only Views studies	This intervention is based on the Home-Office endorsed Dundee Families Project. This intervention replicates this new model of support for families at risk of homelessness as a result of anti-social behaviour. "A variety of funding sources have been used to support the development of the projects with the lion's share of revenue funding provided by the Supporting People Programme.	1. Community/ outreach worker 2. Residential Care worker 3. Family support workers	5 of the 6 projects were managed by a leading voluntary sector providers of children's services (NCH) - in partnership with the local city councils. The 6th project was managed by the city council only (Sheffield). Unclear This was a formal partnership.	Family Worker (no further details re qualifications etc reported).	A variety of funding sources have been used to support the development of the projects with the lion's share of revenue funding provided by the Supporting People Programme.	Family workers made support plans/ advocated for families	(a) Families were identified as HCHH as the result of the likelihood of homelessness (or actual homelessness) resulting from anti-social behaviour. Families were referred by housing dept. and/or social services. (b) Contact with agencies, such as youth offending team, social services, housing dept, because of anti-social or offending behaviour and had a 'direct' or 'indirect' threat to their home. (They had to have been evicted - and so living in temporary/unstable etc. housing, or under threat of eviction). (c) Not all families 'engaged' with the project. Accepting a referral was formally the decision of the family, but a majority of referrers suggested that the families' choice was constrained, and pressure often appears to have been put on the families to agree to the referral (the social workers etc emphasising that there was a lack of options, or even none at all, open to the family). (d) Darwen (Blackburn), Bolton, Manchester, Oldham, Salford and Sheffield.	**+ Economic wellbeing** + Housing (maintained tenancies) + Housing (threat of possession action) **+ Education outcomes** + School attendance **+ Antisocial behaviours** **Perception outcomes** + Economic wellbeing + Mental health and wellbeing

Pritchard (2001) A family-teacher-social work alliance to reduce truancy and delinquency – the Dorset Healthy Alliance project WOE: Medium Non-randomised controlled trial	"In January 1992 Dorset's Chief Officers of Education, Health, Probation and Social Services initiated the Dorset Healthy Alliance Project (DHAP)."	1. Criminal Justice System staff Probation officer 2. Court Welfare Officer, Prison staff etc. 3. Counsellor/ therapist - teacher-counsellors in addition to class teachers 4. Social worker - Educational social worker 5. Teacher/ education support staff 6. Health care worker - including Child Protection team	The project team was led by an experienced and well qualified senior educational social worker, who operated as the full-time co-ordinator and was the project social worker (PSW) in both primary and secondary project schools From its inception DHAP was inter-disciplinary and multi-agency in concept, which led to the establishment of a steering committee of the Chief Officers of the four agencies: Education, Health, Probation and Social Service departments. This inter-disciplinary collaboration greatly facilitated the work of the project, and was invaluable at resolving any inter-departmental communication problems Project was fundamentally based around partnerships, therefore cooperation etc was expected.	The project team was led by an experienced and well qualified senior educational social worker, who operated as the full-time co-ordinator and was the project social worker (PSW) in both primary and secondary project schools. ... he had the task of ensuring effective inter-agency collaboration.	The Home Office Programme Development Unit (PDU)	(a) the PSW maintained a desk in the area EWO office (b) the PSW sought admission into the 'staff room' by invitation and was able to 'informally' consult and be consulted by teachers about various children and families. (c) the PSW, along with the PST and SST, were able to provide a speedy and appropriate feedback to the referring teacher, thus further enhancing trust, and avoiding any derogation of the teacher's responsibilities. This tended to create a sense of partnership (d) the team offered direct and indirect support to the teachers in their professional and pastoral work with children. A crucial element in the team's success was the total acceptance of the educational and social objectives of the school. The project's introduction into the schools early established the team's credentials, whilst also providing them with a structure of work, thus giving a framework for direct intervention.	(a) Referral to the project came from both within and without the school (i.e. school staff (not only class teacher) and parents). The team made an initial invitation for each school to refer their ten most time-demanding children. "The majority of referrals were from the school, 10 per cent were extra-school, but nine per cent and 22 per cent were child and parental self-referrals." (p 18 - this may only refer to part of the service). Referrals reviewed by project team leader (p 7) - not entirely clear on what criteria. (b)"troubled children within the school situation" were eligible for the services. No formal entry criteria stated. (c) "To reach the potential caseload the team adopted two simple but effective tactics. In the first few weeks the PSW would stand outside the gates of the school and introduce himself, and inform parents of the team's availability to respond to any problems. The second was to visit the estate in the early evening, informing parents who seldom or never came to school of a forthcoming event and asking whether they needed any assistance in attending. Initially, when seeing someone from the school, parents usually expected problems, but on finding that it was a general invitation, this was greatly appreciated and encouraged the school-community link. Indeed, so successful was the school in reaching out to families that in the last year of the project, every parent in both schools had attended school at least once for a non-disciplinary meeting. This was unprecedented." (p 11) Also apparently some pro-active contact with families for maintenance of service use. (d) Dorset	**+ Education outcomes** + School performance + School attendance + School exclusion + Peer support **Antisocial behaviours** + Antisocial behaviour: vandalism (primary school) - Antisocial behaviour: Vandalism (Middle school) + Antisocial behaviour: Vandalism (Senior school) + Criminal offences (primary school) - Criminal offences (middle school) + Criminal offences (senior school) + Substance misuse: alcohol (Senior school) No perception outcomes

Sen & Goldbart (2005). Partnership in action: introducing family-based intervention for children with disability in urban slums of Kolkata, India WOE: Low One group pre-post test	"The organisation that initiated the project, Indian Institute of Cerebral Palsy (IICP), had professionally qualified, experienced staff and extensive experience of working with families with a child with disability in urban, semi-rural, and rural areas	1. Advice/ feedback 2. Support with service and resource access (including benefits) 3. Specific education intervention 4. Parent training 5. Personal/ social/family support 6. Health services (not psychology/ counselling) 7. Assessment	The Indian Institute of Cerebral Palsy team and the three NGOs (in partnership). --- "An initial meeting with each organisation was followed by a written 'agreement' on mutual roles and responsibilities. It highlighted the participatory nature of the 'partnership' and emphasised continuous consultation, sharing, and dialogue." --- "Agreement" between IICP and partner organisations presumably involved some form of enforcement, although this is not stated.	Field workers employed by partner NGOs and community volunteers, some already known to the partners and some recruited specially.	Not clear - possibly by IICP, but may just use existing resources available to them & to partner organisations	Training workshops for field workers at IICP home base, tour of IICP premises, extensive feedback from field workers. Each of the partners requested an initial orientation so that the field workers and a "key named" person co-ordinating the project within the organisation could be familiarised with the rationale and basic aims of the project	(a) "The families were identified in one of two ways. In the case of a family with a disability already known to the field worker or via other slum dwellers (b) Initially, the entry criteria for the services = urban families who were vulnerable and economically disadvantaged and had a child (aged 0 to 15 years) with disability. However, this original plan was modified so that young adults were also included. (c) Recruitment through home visits as under (a) and through community meetings: Other measures that may have helped maintain their participation included: • team efforts to be accommodating, respectful, and nonintrusive • the needs assessment using language suitable for those with low literacy levels • the involvement of families "in identifying their own perspectives and needs so that there was potential for the boundaries between the "researchers and those researched" to be less marked. (d) Kolkata, West Bengal, India	No statistical outcomes --- Perception outcomes + Education outcomes + Family outcomes

Tischler et al. (2004) A family support service for homeless children and parents: users' perspectives and characteristics WOE: Low Views studies	Housing dept. and health authority funding for the FSW intervention	1) Support with service and resource access (including benefits) 2) Parent training 3) Personal / Social / Family support 4) Assessment 5) Other (please specify) - organise activities; ensure school placement and attendance; liase with and maximise the involvement of specialist agencies	The FSW co-ordinated the overall care plan.	Family Support Worker (FSW) assess families needs, co-ordinates services	Joint funding from the housing department and health authority (in Leicester).	The appointment of the FSW	(a)families were recruited to a new family support service following consecutive referrals to the FSW. Only after families were recruited were quantitative measures used to establish parenting difficulties, and mental health problems among parents and children. (b) Entry criteria = eligible participants had to live at the main local authority hostel for homeless families in Leicester and be referred several (consecutive) times to the FSW over the period of one year (April 2001 to April 2002). (c) "Families were recruited from consecutive referrals to the FSW over a period of one year (between April 2001 and April 2002)." (p 328) Mechanisms to encourage the continuing participation of families included: 1. conducting interviews at the hostel; 2. "the clients' expectations of the intervention were explored after discussing previous help received and the help they felt they required. Their experiences of the intervention and the difference it made were documented. The help the clients require in future was also explored" (p 329) (d)Leicester, England	No statistical outcomes Perception outcomes + Family outcomes + Mental health and well being

Key Services provided/how they work
(a) How were families identified by the service providers as HCHHHU, that is as potential beneficiaries of the integrated service provision (i.e. how those that provide the services decide that these particular families needed these services)? This may include self-referral, but if families are referred by other agencies or identified by the service provider(s) want to know on what basis or how diagnosis of need was made. Please note if this information is not given.
(b) What entry 'entry criteria' exist for the services?
Please describe in full. Please note if none or if not given state not given.
(c) How were service recipients 'recruited' to and 'maintained' in service? – i.e. How were families 'persuaded' to participate in service and to continue participating in service. This may include incentives, sanctions, compulsion, through mechanisms such as proactive contact on the part of service staff, use of techniques such as participant involvement in management organisation of services, peer support etc. Please give as much detail as possible.
(d) Where were services located?
Please give exact location of services (i.e. country and town)

Table 5 Summary of economic analysis

Item	What inputs and or outcomes are measured in financial terms?	What are the sources of data for the financial estimates?	How are the financial values given for inputs and outputs derived?	Economic analysis results	Quality of economic analysis
Dillane et al. (2001)	**The operating costs of the DFP.** **Potential cost savings** (The broad costs of providing a range of services): • Average costs pertaining to the eviction process (e.g. costs to landlords re defending cases; costs to other agencies including the Scottish Legal Aid Board and the Sheriff Court. Housing officer costs are also subsumed within the average costs of an eviction.) • The average cost, incurred by the Dundee Homeless Persons Unit, of processing a homeless application • The average cost of placing a child in foster care, a residential school or a children's unit. **Potential cost-effectiveness of the DFP** (illustrative examples were used to indicate the potential cost-effectiveness of the DFP, by assuming likely outcomes if the project were not there).	Budget data (i.e. financial accounts) indicated the operating costs of the project. (The operating costs of the DFP are met by Dundee District Council (inclusive of stakeholder contributions) and the Social Inclusion Partnership.) Potential cost savings: Stakeholder interviews and previous research provided estimates of the broad costs of providing a range of services: "None of the agencies surveyed in this research exercise had quantified the financial costs and savings accrued in any given instance (or case) as a result of a successful intervention being made by the DFP. However, the case record analysis was able to determine the number of successful cases managed by the DFP, while stakeholders were able to provide broad costs of providing a range of services. In addition, previous research (Atkinson, et al 2000) can be utilised to quantify other relevant direct and societal costs." (p110)	Data drawn from the stakeholder interviews and vignette data analysis are merged with case record and cost data derived from the DFP and other agencies to assess the cost-effectiveness of the DFP	The operating costs of the DFP "can be calculated as being about £345,000 per annum. This figure approximates to the amount for 1999-2000, which was the year when our other financial data were collected. The rental income received by the DFP has not been calculated." (p 110) Illustrative calculations of the potential cost-effectiveness of the DFP: "The stakeholder interviews indicated that the 'routine' staff time costs involved in input to the families were on the whole neither increased nor decreased by DFP involvement, so the estimates include only the additional costs that would have been incurred if the Project had not been used." The calculations were based on the assumption that 2 successful core cases and 9 successful dispersed/outreach cases were achieved per annum between November 1997 and October 2000 (and a number of other assumptions about the number of families that would be evicted, children who would be placed in care, etc). For the 2 core cases, the costs were expressed as follow: Eviction process: £21,400 Homeless presentations: £3,800 Residential school: £156,000 Foster care: £52,000 Total Illustrative Cost for these 2 core cases = £233,200 For the 9 'dispersed/outreach' cases, the costs were expressed as follows: Eviction process: £ 53,500 Homeless presentations: £ 9,500 Residential school: £104,000 Foster care: £ 62,400 Total Illustrative Cost for these 9 dispersed/outreach cases = £229,400 "Adding the cost implications of the absence of the DFP for both types of case (11 families) yields an estimated annual expenditure of £462,600, which compares with the average operating cost of the DFP of £345,000. **This represents an immediate financial saving of around £117,600 per annum."** (p 111-2) **"The illustrative examples presented above should be treated with some caution, as they are based on a set of assumptions, rather than actual data.** .However...the analyses were based upon family problems persisting for one year only and excluded a set of broader societal costs...." (p 112-3)	Low WOE D Low

Jones et al 2006	Total cost of Shelter Inclusion Project **Two main unit costs were calculated:** 1. The cost per household month for 2003/04 and for 2004/05; 2. The average total cost per household leaving the project, for households whose cases were closed in 2003/04 and 2004/05. Other costs which were calculated included: (a) The average total cost per person per year; (b) The average cost per household per year (see p 42) **Short-term cost savings:** (re tenancy sustainment, anti-social behaviour, foster and residential care for children and 'other' potential cost consequences) **Long-term cost savings:** (re social exclusion) **Potential cost savings by Shelter Inclusion Project:** A case study is used to illustrate the potential savings from supporting a family where the mother is facing mental health problems and may not be able to sustain her tenancy and household without support.	**Costs (total and unit) of the Project:** Data provided by Shelter Inclusion Project Short-term **cost savings: re tenancy sustainment:** Pawson et al. (2005); The Audit Commission (1998); Shelter; Crisis; a Housing Association in the north west of England; Rochdale Borough Council **re foster and residential care for children:** Curtis and Netten (2004); Rochdale Borough Council **re 'other potential cost consequences':** Matrix Research and Consultancy (2004) **Long-term cost savings: re social exclusion** Scott et al. (2002); NEET at 16-18; Godfrey et al. (2002) **Potential cost savings by Shelter Inclusion Project:** Rochdale Borough Council; Pawson et al. (2005); a Housing Association in north west England; the Audit Commission (2004)	Shelter Inclusion Project provided the research team with details on income and expenditure for the pilot periods, in the form of monthly accounts. **Calculation of unit costs:** 1. The cost per household month for 2003/04 and for 2004/05 was calculated by dividing the expenditure in the year by the total number of months of contact with each household provided by the project during the year. (For full details see Appendix A, p 55) 2. The average cost per discharged household was calculated (for those leaving the project in 2003/04) "by multiplying the total number of contact months with these households in 2002/03 and 2003/04 by the average cost per household month for 2003/04. It is assumed that the cost per household month in 2003/04 also applied to 2002/03. The resulting total cost is then divided by the number of households discharged during 2003/04 to give the average total cost per closed case for that year. No households left the project during 2002/03. (For those leaving the project in 2004/5, see p 55.) **Calculation of potential cost savings by Shelter Inclusion Project:** it is estimated that if the family in the case study were evicted, the following costs could be incurred (court related costs + other eviction-related costs for landlord + custodial sentence in a secure unit for the older boy + specialist children's home for the younger boy + foster care for the girl)	(See key findings - p 40) Total costs: -The total income and expenditure for the project per year was approximately £300,000. The main income sources were Supporting People and the Neighbourhood Renewal Fund. Unit costs: -The average duration of contact with the project was 9.3 months for those households leaving the project in 2003/04, and 16.4 months for leaving in 2004/05. -The average total cost for each household leaving the project in 2003/04 was £6,280, compared with an average cost of about £11,900 for those leaving the project in 2004/05. It is estimated that the average total cost per household whose case closed in 2005/06 was £9,254. -The average total cost per individual member of each household whose case was closed during 2003/04 was £2,700, and £3,380 in 2004/05. **Cost savings (long term):** -Longer term cost consequences of not preventing antisocial behaviour include those associated with social exclusion, educational underachievement and unemployment **Cost savings (short term):** -In the short term, costs of up to £9,500 per household could be saved by households not losing tenancies because of antisocial behaviour. It is estimated that antisocial behaviour costs £3.4 billion a year across England and Wales. The figure £9,500 is taken from the Pawson et al. study and covers landlord costs of an eviction only. Jones et al. also provides a case study of a more extreme situation in which children are removed from the care of the parent. **Potential cost savings by Shelter Inclusion Project:** "...the potential savings from supporting a family where the mother is facing mental health problems and may not be able to sustain her tenancy and household without support....could amount to about £150,000 over a six month period." (p 47) The Jones study does not claim that this case study is representative. However, neither does it make a systematic attempt to calculate likely savings.	Low WOE D Low

Pritchard, Colin (2001) A family-teacher-social work alliance to reduce truancy and delinquency – the Dorset Healthy Alliance project	1. Educational budget costs (i.e. cost of the project p.a.) 2. Educational cost savings of the project 3. Costs to the Criminal Justice System (of exclusion) 4. Cost savings of the project to the Criminal Justice System 5. Overall cost benefit of the Dorset Healthy Alliance project	1. not reported 2. re cost of an exclusion unit (Educational Behavioural Disturbed Unit [EBDU]): Blythe and Milner (1998) 3. costs to the Criminal Justice System: Cooper and Lybrand (1994); Pritchard and Butler (2000); Pritchard and Cox (1997) 4, Home Office costings of an offence: Cooper and Lybrand (1994) 5. Cooper and Lybrand (1994); Blythe and Milner (1998)	1. not reported **2. education budget cost savings:** "These were based upon the known costs of an 'exclusion unit' place, and projected on the number of 'net' savings of young people who were successfully 'transferred in' to the project schools when under threat of permanent exclusion." (p. 59) (It was assumed that young people would only be in school for average of 6 months a year). **3. costs to the Criminal Justice System:** A different study by Pritchard is used (Pritchard and Butler (2000) is used to derive estimates for these costs, and other secondary research **4. Criminal Justice System cost savings:** "We estimate the potential cost savings by the number of students in the project schools who did not commit crime, assuming that in the absence of the project they would have offended at the same rate as the comparator schools." **5. Overall cost benefit of the Dorset Healthy Alliance project** "A cost-benefit analysis estimated the 'value added' (Morgan and Murgatroyd 1994) input of the project. This was based upon Home Office costings of an offence (Cooper and Lybrand 1994), and fee-estimated 'Education' costs for 'home tuition' and/or admission into an Exclusion Unit (Blythe and Milner 1998) at the end of year three. As no hard data was available for possible costs related to SSD or Health, they were not included in the cost-benefit analysis, so the 'savings' are an under-estimate. This cost-benefit approach has the merit of being simple, yet based upon authoritative sources, and typically is biased towards under-estimating costs and savings (Goldblat and Lewis 1998)" (434413, p 28).	1. Cost of the project: £59,000 pa **2. education budget cost savings:** 2 different results are reported in the main and linked reports **£395,000 p.a.** (p. 50 main report) "Consider the direct net 'savings' of the 56 'included' pupils in the project secondary school: the cost of an Exclusion Unit place in the county during the period of the research was £39,000 per annum. Let us assume that these youngsters would not have stayed in school for the usual year, but only for an average of six months. This would represent a net annual cost to education of at least £395,000 in the first year of exclusion." **An overall saving of £87,200 p.a.** (Linked report ITT434413, p.38) It was calculated that for the third year of the project alone, the minimal estimated saving to the project primary school (Atlee) would be £56,700, and to the project secondary school (Bevan) £30,500. **3. costs to the Criminal Justice System** "Based only upon court appearances, costs of weeks in prison, and the cost of their time in the Exclusion Units (excluding other likely social service costs mentioned above) the 149 young adults had already cost the public purse £4.2 million." (p.50; data from Pritchard and Butler, 2000) **4. cost savings of the project to the Criminal Justice System** Minimally £37,800, possibly over £400,000. A 'saving' of 14 offenders yielded a notional saving of £37,800 (14 offenders was thought to be the number most at risk of a criminal career. The much higher figure of £400,000 was based on an overall potential of 92 offenders). (see linked report ITT434413, p 38). **5. Overall cost benefit of the Dorset Healthy Alliance project** Minimally 111 percent return on the investment, possibly as much as 250 per cent. "Taking the education and criminal justice system known costs, and contrasting these with possible 'savings' on the likely exclusion places alone, yields an estimated 'saving' above the cost of the project, of at least 250 per cent." (p 51 main report) "Continuing on the side of caution, and including only the minimal savings of criminal justice of £37,800, and the £87,200 education 'savings', after deducting the annual cost of the project, we are looking at an estimated gross saving in excess of £65,700, or an 111 per cent return on the 'investment'..." (linked report ITT 434413, p 38) "This estimate does not include the potential savings from the substantial fall in child protection referrals and likely health gains." (p xi)	Low WOE Medium

The SREA is divided into four parts

BRIEFING SUMMARY	A 1 page summary that has key findings from the review
EXECUTIVE SUMMARY	A 3 page summary that has a summary of the methods used in the review and the key findings
REPORT	A report which details the main findings of the SREA
TECHNICAL REPORT	**A Technical Report which provides details of the methods used in the SREA and a detailed summary of the studies included in the SREA**

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