Evidence from systematic reviews of research relevant to implementing the “wider public health” agenda

Prepared by:
Contributors to the Cochrane Collaboration and the Campbell Collaboration and the NHS Centre for Reviews and Dissemination,
with support from the NHS Research and Development Programme

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Foreword

Background to this report

In February 1998, Tessa Jowell, then Minister for Public Health, asked for a report summarising the findings of systematic reviews of research evidence relevant to proposals in the then recently published Green Paper on Public Health, and to the forthcoming White Paper on Public Health. A paper entitled *'Evidence from systematic reviews of research relevant to the forthcoming White Paper on Public Health'* was subsequently prepared by the NHS Centre for Reviews and Dissemination and the UK Cochrane Centre, with input from other UK-based contributors to the Cochrane Collaboration. The paper was delivered to the Minister on 1 May 1998 and was well received by her and by others within the Department of Health. The Department's Research and Development Division subsequently distributed about 100 copies of the paper within the National Health Service and beyond. During the winter of 1998/1999 the paper was reportedly helpful to those responsible for preparing the White Paper.

As the Green Paper had done, the White Paper (published last year) – *Saving Lives: Our Healthier Nation* – focuses on what it refers to as "the main killers: cancer, coronary heart disease and stroke, accidents and mental illness." The White Paper ranges over a broader canvas than the Green Paper, however, highlighting determinants and dimensions of health which are less specific than many of those that are directly relevant to preventing and treating the four "main killers". After noting that people can improve their own health (through physical activity, better diet and quitting smoking), the White Paper stresses the importance of material factors such as poverty, low wages, unemployment, poor education, sub-standard housing, crime and disorder, and a polluted environment. The impact of these factors is reflected in health inequalities, the most disadvantaged suffering most from poor health. The White Paper thus reflects the government's efforts to address the determinants of poor health with a range of initiatives, many of which are mentioned in the document.*****

During the summer of 1999, Professor Richard Lilford, director of Research and Development, NHS Executive West Midlands, convened a group to discuss the formulation of Health Improvement Plans, and thus trying to implement locally (some in designated Health Action Zones) policies outlined in the White Paper, and related policy documents. During these discussions, it became clear that an update of the 1998 paper prepared for Tessa Jowell would be helpful, because the White Paper had not referred explicitly to the relevant research evidence. Accordingly, in November 1999, Professor Lilford commissioned the current paper.

Content and organisation of this report

To reflect the broad scope of the White Paper, this report has been entitled *Evidence from systematic reviews of research relevant to implementing the 'wider public health' agenda*. The organisation of the material in the report follows the classification and listing of policies within each of the four main areas – cancer, coronary heart disease and stroke, accidents, and mental health - as laid out in Appendix 1 of the White Paper. Contributors to the Cochrane Collaboration (www.cochrane.org) based in the UK have prepared these sections.

As a starting point for informing the development of relevant strategies in areas of 'the wider public health' not specifically included as part of the White Paper, three further sections - on education, social care and social welfare, and crime, drugs and alcohol – are presented as additional resources. These have been prepared by contributors to the recently inaugurated international Campbell Collaboration, which has been established to prepare and maintain systematic reviews of research on the effects of social and educational interventions (http://campbell.gse.upenn.edu/).

As in the 1998 report, reference has also been made to new systematic reviews currently being prepared within the editorial structure of the Cochrane Collaboration. These have been singled out among systematic reviews in preparation because the information is public, because Cochrane reviews should be maintained (as new evidence emerges), and because both the published protocols and the complete reviews are now widely accessible within the NHS through *The Cochrane Library*.

In the four sections of this report dealing with cancer, coronary heart disease and stroke, accidents, and mental health, the evidence from systematic reviews is shown in relation to the specific policies listed in Appendix 1 of the White Paper. Accordingly, the first column restates each policy. In the second column, the relevant systematic reviews are summarized (or the absence of systematic reviews is noted). The third column contains references to the cited reviews. At least 400 of the total of 929 reviews relevant to these sections have been prepared with support from the NHS R&D Programme, and the references to these are shown in bold type.

The topic areas addressed in the three further sections - on education, social care and social welfare, and crime, drugs and alcohol – are shown in the Contents pages. The first column presents the full citation; the second column summarises the materials and methods of the review; and the final column summarises the findings. Because these have been contributed by different teams, and were originally collated for other purposes, these last three sections, of necessity, have different styles and levels of detail.

The search strategies used to identify these reviews, and references to all the reviews cited in this report, are contained in two appendices.

Ways in which we hope this document will be helpful

The report is principally a source document containing brief summaries of and references to the results of reviews of research relevant to the wider public health agenda. It does not tell you what should be done. Rather, we hope it will be helpful in addressing each of the following three questions:

Which policies might be prioritised because research evidence suggests that they are likely to succeed in achieving specific public health goals?
First, the report allows you to identify areas where there is substantial research indicating that specific strategies have been effective. You may therefore wish to focus your public health investment in these areas.

Having prioritised policy areas for public health investment, how might your goals be best achieved?
Second, the report allows readers to identify detailed research evidence relevant to the policy areas in which public health agencies have decided to invest. This may allow you to identify specific, effective interventions, and ways of delivering them, in order to achieve these goals. We encourage

readers who wish to know more about these interventions and the context in which they were applied, to consult the source reviews and, where relevant, the full reports of the research covered by the reviews.

What additional research might help to identify further strategies for improving the public health?
Finally, the report allows you to identify areas where the findings from existing research need to be synthesised in systematic reviews, and also where reviews indicate that the existing research is inadequate to inform policy, and that therefore new studies are required.

Arrangements for updating and amending the material in this report

There will continue to be a flow of new and updated systematic reviews of research evidence relevant to supporting the further development and implementation of the wider public health agenda, and to other government initiatives relevant to promoting the public's health, such as the National Service Frameworks. The people and organisations tasked with implementing policies relevant to promoting the wider public health need to have ready access to this updated information. Accordingly, the NHS Research and Development Programme has been approached to make arrangements for this report to be updated regularly under the aegis of the NHS Centre for Reviews and Dissemination (http://www.york.ac.uk/inst/crd). We encourage readers to contribute their comments on this document to the website, and draw attention to the errors that will inevitably have been made in a project with this scope.

Iain Chalmers, UK Cochrane Centre, NHS R&D Programme
Trevor Sheldon, Department of Health Studies, University of York
Catherine Rounding, UK Cochrane Centre

July 2000

***** Government initiatives mentioned in the White paper include (in alphabetical order):

A Better Quality of Life - a Strategy for Sustainable Development in the UK; Active Schools Programme; Anti-drugs Co-ordinator Action Plan; Better Government for Older People; Cooking for Kids Programme; Developing Emergency Services in the Community; Excellence in Schools; Health Action Zones; Health Improvement Programme Performance Scheme; Healthy Living Centres; Healthy Schools Programme; Healthy Workplace Initiative; Independent Inquiry into Inequalities in Health; Information for Health; Keep Warm, Keep Well Campaign; Modernising Mental Health Services; Modernising Social Services; National Air Quality Strategy; New Deal for Communities Initiative; New Deal for Transport; New Insurance Contract for Pensions; National Service Framework for Coronary Heart Disease; National Service Framework for Mental Health; National Service Framework for Older People; Paediatric Intensive Care: a Framework for the Future; Road Safety Strategy; Rough Sleepers Initiative; Safer Travel to School Initiative; Smoking Kills; Social Exclusion Unit Report on Teenage Pregnancy; Sports Strategy; Strategy for Tackling Communicable Disease; Strategy to Tackle Alcohol Misuse; Supporting Families; Sure Start; Sustainable Development: Towards better practice; Tackling Drugs to Build a Better Britain; Tackling Racial Harassment in the New NHS; Task Force on Genetics and Disease Prevention; The New NHS; and Welfare to Work.

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Julie Glanville, Kate Misso

Appendix 2
References to all systematic reviews cited in this report, ordered alphabetically

Materials and Methods

Project organisation

Staff at the UK Cochrane Centre commissioned the component elements of the project, which was co-supervised by Iain Chalmers and Trevor Sheldon, and co-ordinated by Catherine Rounding and Elizabeth Holmes.

UK contributors to the Cochrane Collaboration prepared the sections of the report relating to the four 'main killers' identified in the White Paper. The Cochrane Cancer Network and Cochrane Injuries Group prepared the sections on Cancer and Accidents, respectively. The Cochrane Heart Group and Cochrane Stroke Group collaborated in preparing the section on Heart Disease and Stroke. The Cochrane Schizophrenia Group and the Cochrane Depression Anxiety and Neurosis Group had overall responsibility for preparing the section on Mental Health, with inputs from the Cochrane Developmental, Psychosocial and Learning Problems Group, and the Education and Crime and Justice Groups of the Campbell Collaboration.

The sections on Education, Social Care and Social Welfare, and Crime, Drugs and Alcohol were prepared by the Campbell Education Group, the Campbell Social Welfare and Social Work Group, and the Campbell Crime and Justice Group, respectively.

Identification of potentially eligible reviews

The authors of the various sections of the current report were responsible for identifying and assessing the quality of the reviews relevant to their respective areas of responsibility, drawing on the variety of sources which, as topic specialists, they deemed likely to be worth searching. In addition, section authors were supplied with references to reviews which were identified by staff at the NHS Centre for Reviews and Dissemination and the UK Cochrane Centre. The NHS Centre for Reviews and Dissemination also helped by obtaining and passing on to section authors hard copies of some relevant reports. The wide ranging search strategies used to identify systematic reviews of potential relevance were coordinated by Julie Glanville and Kate Misso at the NHS Centre for Reviews and Dissemination. These are presented in detail in Appendix 1.

The best single source of information about systematic reviews is *The Cochrane Library*. Within it, *The Cochrane Database of Systematic Reviews* contains complete reviews and protocols of reviews in preparation, prepared to the standard required by the Cochrane Collaboration. *The Database of Abstracts of Reviews of Effectiveness* contains references to systematic reviews identified by staff at the NHS Centre for Reviews and Dissemination, using regular searches of Current Contents - Clinical Medicine (weekly); MEDLINE (monthly); CINAHL (monthly); ERIC (annually); BIOSIS (annually); Allied and Alternative Medicine (annually); and PsycINFO (annually).

Some of the systematic reviews which have not met the criteria for inclusion in *The Database of Abstracts of Reviews of Effectiveness* have been rejected, not because they were methodologically inadequate, but because they were of insufficient relevance to the NHS (for example, because no health outcomes were recorded). Accordingly, the titles about 20,000 records were scanned by staff at the UK Cochrane Centre to identify any systematic reviews which may have been rejected on those grounds, but which were nevertheless potentially relevant to the wider aspects of public health, such as reviews of educational interventions.

Although *The Cochrane Database of Systematic Reviews* and *The Database of Abstracts of Reviews of Effectiveness* were important starting points for identifying systematic reviews relevant to the wider public health, searches of additional sources were necessary. These presented a number of challenges. First, few of the additional databases searched (see below) support subject indexing that captures the concept of systematic review, and the abstracts of reviews tend to have very little description of the methodology used. Second, there are relatively few systematic reviews outside of the fields of medicine, psychology, education and criminology. Third, a large number of disparate interventions seem likely to be relevant to the wider public health.

By combining text words taken from the White Paper and the sensitive strategies for identifying systematic reviews which had been developed by the NHS Centre for Reviews and Dissemination, staff there identified and searched other databases likely to contain systematic reviews of potential relevance to public health (see Appendix 1 for details of search strategies).

- Applied Social Sciences Index and Abstracts (ASSIA)
- Canadian Preventive Taskforce Guidelines
- Econlit
- Health Management Information Consortium (UK health management databases)
- Health Technology Assessment Database (CRD)
- Health Services Technology Assessment Text (HSTAT) (US web site providing access to Agency of Health Care Policy and Research (AHCPR) publications and other US review and guideline material)
- National Co-ordinating Centre for Health Technology Assessment (NCCHTA) web site
- National Research Register
- Turning Research Into Practice (TRIP) index (index to reviews, guidelines and evidence summaries)
- US Preventive Taskforce Guidelines
- Sociological Abstracts

Staff at the UK Cochrane Centre also searched the Social, Psychological, Educational and Criminological Trials Register (SPECTR) for additional, potentially relevant material.

A National Contract on Cancer

Cochrane Cancer Network
Allison Hirst, Sally Hunt, Mark Lodge and Chris Williams

A National Contract on Coronary Heart Disease and Stroke

Cochrane Heart Group
Karen Rees, Debbie A Lawlor and Shah Ebrahim
and
Cochrane Stroke Group
Jonathan Mant

A National Contract on Accidents

Cochrane Injuries Group
Frances Bunn, Ian Roberts and Carolyn DiGuiseppi

A National Contract on Mental Health

Cochrane Schizophrenia Group
Clive Adams and Simon Gilbody
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Education

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Social Care and Social Welfare

Cochrane Psychosocial, Developmental and Learning Problems Group
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Crime, drugs and alcohol

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A NATIONAL CONTRACT ON CANCER

General Note: **Nearly all studies of the impact of interventions designed to reduce exposure to carcinogens or to reduce the effect of these carcinogens have used surrogate short-term measures such as smoking rates and consumption of fruit and vegetables, rather than examining their impact on cancer prevalence or mortality. Given the long-term nature of the effect of such interventions on cancer rates, it seems unlikely that anything but surrogate end-points will be available in the immediate future.**

CANCER: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
C1	Increase tax on cigarettes by 5 per cent in real terms each year	Tobacco consumption is associated with lung cancer,[a] laryngeal cancer,[b] oral cancer,[c] oesophageal and gastric cancer[d] and may be associated with cervical cancer[e] and some types of leukaemia.[f] A reduction in population levels of smoking may contribute to a lower incidence of lung, laryngeal and oral cancer. Taxation and similar fiscal and legislative measures can be used alongside interventions aimed at individuals to reduce cigarette consumption. Higher cigarette prices reduce cigarette consumption.[g] However, the effect of increasing prices differs across demographic groups, a more marked reduction in consumption is shown with increasing price amongst women and young people.[a] In the poorest groups, an increase in price produces significant hardship for those who do not curtail their consumption.[h] No systematic reviews have been identified examining the effect on cancer rates of increasing tax on cigarettes.	a. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** b. Cattaruzza MS, Maisonneuve P, Boyle P. Epidemiology of laryngeal cancer. European Journal of Cancer – B-Oral Oncology 1996;2B:293-305. c. La Vecchia C, Tavani A, Franceschi S, Levi F, Corrao G, Negri E. Epidemiology and prevention of oral cancer. Oral Oncology 1997;33:302-12. d. Trédaniel J, Boffetta P, Buiatti E, Saracci R, Hirsch A. Tobacco smoking and gastric cancer: review and meta-analysis. International Journal of Cancer 1997;72:565-73. e. Licciardone JC, Brownson RC, Chang JC, Wilkins JR 3rd. Uterine cervical cancer risk in cigarette smokers: a meta-analytic study. American Journal of Preventative Medicine 1990;6:274-81. f. Brownson RC, Novotny TE, Perry MC. Cigarette smoking and adult leukemia. A meta-analysis. Archives of Internal Medicine 1993;153:469-75. g. Chaloupka FJ, Wechsler H. Price, tobacco control policies and smoking among adults. Journal of Health Economics 1997;6:359-73. Choi BCK, Ferrence RG, Pack AWP. Evaluating the effects of price on the demand for tobacco products: review of methodologies and studies. Ontario Tobacco Research Unit, 1997. **NHS Executive. Guidance on commissioning cancer**

CANCER: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			services: improving outcomes in lung cancer. London: Department of Health, 1998. h. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** Townsend J. Price and consumption of tobacco. British Medical Bulletin 1996;52:132-42.
C2	End advertising and promotion of cigarettes	Control of advertising is an effective intervention to place alongside interventions aimed at individuals to help reduce cigarette consumption.[a] The ideal choice of policy for controlling advertising is to reduce the level of advertising and increase the level of counteradvertising. Research suggests that advertising bans lead to media substitution so a total ban on all forms of cigarette promotion is needed if bans are to be successful.[b] No systematic reviews have been identified examining the impact of changes in tobacco advertising on cancer rates.	a. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** Smee C. Tobacco advertising and smoking: a discussion document. London: Department of Health, 1993. Sone T. Effects of tobacco advertising regulations in various countries. Nippon Koshu Eisei Zasshi 1995;42:1017-28. b. Saffer H. Economic issues in cigarette and alcohol advertising. Journal of Drug Issues 1998;28:781-93.
C3	Prohibit sale of cigarettes to youngsters and ensure enforcement	Interventions aimed at retailers to enforce the legal age limit on selling cigarettes to young people reduces their access to cigarettes but no evidence has been found that shows this affects smoking behaviour.[a] Restricting access to cigarette vending machines limits access, but has not been shown to affect behaviour.[a] Stronger regional, national and international strategies are required if restriction of youth access is to contribute to a reduction in smoking prevalence in this age group. Targeting retailers with educational programmes alone is less effective than combined education and enforcement (warnings or visits by police or health officials), but sustained effects require enforcement at least 4-6 times a year.[b] No systematic reviews have been identified examining prohibition of tobacco sales to youngsters and subsequent cancer rates.	a. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998**. US Department of Health and Human Services. Preventing tobacco use among young people: a report of the Surgeon General. Atlanta, 1994. b. **Lancaster T, Stead LF. Interventions for preventing tobacco sales to minors [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
C4	Seek to ensure cheaper supplies of fruit and vegetables	Consumption of fresh fruit and vegetables is associated with a lower incidence of many cancers.[a] No systematic reviews have been identified examining reducing the cost of fruit and vegetables and subsequent cancer rates.	a. American Institute for Cancer Research. Food Nutrition and the prevention of cancer. World Cancer Research Fund, 1997. **Working Group on Diet and Cancer of the Committee on Medical Aspects of Food and Nutrition policy. Nutritional aspects of the development of cancer. Department of Health, 1998.**

CANCER: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C5	Tackle joblessness, social exclusion, low educational standards and other factors which will make it harder to live a healthy life	There are consistent social class gradients in the incidence and outcomes of most cancers.[a] No systematic reviews have been identified examining the effects of interventions to improve social circumstances on subsequent cancer rates.	a. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.**
	Local Players and Communities can:		
C6	Tackle social exclusion in the community to make it easier for people to make healthy decisions	Cancer is more common among the socially disadvantaged and there tends to be a stepwise relationship with socio-economic status.[a] Similarly risk factors are more common in more disadvantaged groups.[b] For cancers of the colon, rectum, breast and cervix, patients from higher socio-economic status groups have better survival.[c] No systematic reviews have been identified examining the effects of reducing social exclusion on cancer rates or survival.	a. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998**. b. Macintyre S. Socioeconomic variations in Scotland's health: a review. Health Bulletin 1994;52:456-71. c. Schrijvers CT, Mackenbach JP. Cancer patient survival by socioeconomic status in seven countries: a review for six common cancer sites. Journal of Epidemiology and Community Health 1994;48:441-6.
C7	Work with deprived communities and with businesses to ensure a more varied and affordable choice of food (including fruit and vegetables)	Consumption of fresh fruit and vegetables is associated with a lower incidence of many cancers. However, there is little direct evidence to suggest that available interventions are successful in promoting dietary change in this context.[a] A systematic review of 15 studies of community intervention programmes in school children, adolescents and adults found the most successful interventions for increasing fruit and vegetable consumption were those that were part of a multi-component programme. Successful interventions also included education directed at behavioural change, were over a longer time period with multiple contacts made with participants, and where the message was specifically targeted to fruit and vegetables rather than nutrition in general.[b] No systematic reviews have assessed the effect of increasing fruit and vegetable intake on cancer rates. There is no convincing evidence that specific anti-oxidant micronutrients, such as selenium and Vitamins C and E, or any other specific nutrients, are protective against cancer. Some supplementation, such as the addition of beta carotene to the diet, may be harmful.[c]	a. American Institute for Cancer Research. Food Nutrition and the prevention of cancer. World Cancer Research Fund, 1997. **Working Group on Diet and Cancer of the Committee on Medical Aspects of Food and Nutrition policy. Nutritional aspects of the development of cancer. Department of Health, 1998.** b. Ciliska D, Miles E, O'Brien M, Turl C, Tomasik H, Donovan U, Beyers J. The effectiveness of community interventions to increase fruit and vegetable consumption in people four years of age and older. Ontario Public Health Research Education and Development Programme. Effective Public Health Practice Project. March 1999. c. American Institute for Cancer Research. Food Nutrition and the prevention of cancer. World Cancer Research Fund, 1997. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998**. **Working Group on Diet and Cancer of the Committee on Medical Aspects of Food and Nutrition policy. Nutritional aspects of the development of cancer. Department of Health, 1998.**

CANCER: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	People can:		
C8	Participate in social networks and provide social support to others to reduce stress, and to give them help to give up smoking	There is some evidence that community interventions help prevent smoking in young people.[a] A systematic review of community interventions for reducing smoking in adults is underway.[b] There are no systematic reviews of the effects of community interventions on the prevalence of cancer.	a. **Sowden A, Arblaster L. Community interventions for preventing smoking in young people [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. **Secker-Walker R. Community interventions for reducing smoking among adults [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
C9	Take opportunities to better their lives and their families' lives through education, training and employment	No systematic reviews have been identified on the effects of "bettering peoples lives" on subsequent cancer rates.	

CANCER: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
C10	Encourage employers and others to provide a smoke-free environment for non-smokers	Environmental tobacco smoke is associated with an increased incidence of lung cancer and respiratory problems.[a] The evidence for a direct causal link between non-residential smoking and a broad range of cancers, remains equivocal.[b] Controlling non-residential environmental tobacco smoke is likely to have a modest effect on cancer rates.[c] Work place tobacco policies can reduce tobacco consumption at work and worksite environmental tobacco smoke exposure.[d] No systematic reviews have been identified which examine the effects of reducing environmental tobacco smoke on cancer rates.	a. Hackshaw AK, Law MR, Wald MJ. The accumulated evidence on lung cancer and environmental tobacco smoke. BMJ 1997;315:980-8. b. Copas JB, Shi JQ. Reanalysis of epidemiological evidence on lung cancer and passive smoking. BMJ 2000;320:417-8. c. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** d. Erikson MP, Gottlieb NH. A review of the health impact of smoking control at the workplace. American Journal of Health Promotion 1998;13:83-104. Fielding JE. Smoking control in the workplace. Annual Review of Public Health 1991;12:209-34.
C11	Encourage local action to tackle radon in the home and to eliminate risk factors in the workplace (eg enforcing regulations on asbestos and encouraging provision of non-smoking areas) and the environment (eg air pollutants)	Exposure to radon gas is associated with increased mortality from lung cancer in high-risk groups, such as some miners, and there is an association between exposure to naturally occurring radiation from radon gas and lung cancer.[a] Measures which can reduce risk of exposure to indoor radon include informing people of known associations between radon and cancer and encouraging residents in areas with high radon levels to have radon concentrations measured in their homes. If levels are high, owners of affected homes can be encouraged to have remedial work undertaken and local authority grants can be provided for this work.[b] The potential risks from radon in the home continue to be estimated indirectly through studies on miners, so the risk from domestic radon should be interpreted with caution until further studies are completed.[c] No systematic reviews have been identified examining the effect of reducing radon in the home on the risk of developing lung cancer.	a. Lubin JH, Tomasek L Edling C Hornung RW, Howe G, Kunz E, Kusiak RA, Morrison HI, Radford EP, Samet JM, Timarche M, Woodward A, Yao SX. Estimating lung cancer mortality from residential radon using data for low exposures of miners. Radiation Research 1997;147:126-34. Stidley CA, Samet JM. A review of ecologic studies of lung cancer and indoor radon. Health Physiology 1993;65:234-510. Darby SC, Whitley E, Howe GR, Hutchings SJ, Kusiak RA, Lubin JH, Morrisson HI, Tirmarche M, Tomasek L, Radford EP. Radon and cancers other than lung cancer in underground miners: a collaborative analysis of 11 studies. Journal of the National Cancer Institute 1995;87:378-84. b. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** c. Lubin JH, Boice JD Jr. Lung cancer risk from residential radon: meta-analysis of eight epidemiologic studies. Journal of the National Cancer Institute 1997;89:49-57.

CANCER: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C12	Continue to press for international action to restore the ozone layer	The incidence of skin cancer has been increasing in the UK in recent years. The majority of skin cancers occur as a result of overexposure to ultraviolet light from the sun or an artificial source such as a sunbed, and are therefore preventable. Preventative measures, such as sunscreens, are effective in avoiding overexposure of the skin to sunlight and may reduce the incidence of skin cancer. However, while health education programmes enhance knowledge of skin cancer, evidence that they change behaviour is very weak.[a] No systematic reviews have been identified which examine the effect of reducing skin exposure to ultraviolet light on subsequent rates of skin cancer.	a. Harvey I. Prevention of skin cancer: a review of available strategies. University of Bristol Health Care Evaluation Unit, 1995.
	Local Players and Communities can:		
C13	Through local employers, make a smoke free environment the norm, with adequate separate provision for smokers and availability of smoke extractors where possible	Environmental tobacco smoke is associated with an increased incidence of lung cancer and respiratory problems.[a] The evidence of a direct causal link between non-residential smoking and a broad range of cancers however, remains equivocal.[b] Controlling non-residential environmental tobacco smoke is likely to have a modest effect on cancer rates.[c] No systematic reviews have been identified which examine the effects of reducing environmental tobacco smoke on cancer rates. Whilst daily consumption of cigarettes at work can be reduced by employers encouraging a smoke-free work environment, there is evidence that smokers compensate by smoking more during non-working hours.[d] A total ban on cigarettes in the workplace coupled with monetary incentives to quit has been shown to improve cessation rates substantially.[d] No systematic reviews have been identified which examine the effect of introducing these policies on the incidence of lung or other cancers.	a. Hackshaw AK, Law MR, Wald MJ. The accumulated evidence on lung cancer and environmental tobacco smoke. BMJ 1997;315:980-8. b. Copas JB, Shi JQ. Reanalysis of epidemiological evidence on lung cancer and passive smoking. BMJ 2000;320:417-8. c. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** d. Chapman S, Borland R, Scollo M, Brownson RC, Dominello A, Woodward S. The impact of smoke-free workplaces on declining cigarette consumption in Australia and the United States. American Journal of Public Health 1999;89:1018-23. Fielding JE. Smoking control at the workplace. Annual Review of Public Health 1991;12:209-34. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998**.
C14	Tackle radon in the home (eg through direct advice from local authorities to affected householders) *(cont)*	Exposure to radon gas is associated with increased mortality from lung cancer in high-risk groups, such as some miners, and there is an association between exposure to naturally occurring radiation from radon gas and lung cancer.[a] Measures which can reduce risk of exposure to indoor radon include informing people of known associations between radon and cancer and encouraging	a. Lubin JH, Tomasek L Edling C Hornung RW, Howe G, Kunz E, Kusiak RA, Morrison HI, Radford EP, Samet JM, Timarche M, Woodward A, Yao SX. Estimating lung cancer mortality from residential radon using data for low exposures of miners. Radiation Research 1997;147:126-34. Stidley CA, Samet JM. A review of ecologic studies of

CANCER: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C14	*(cont)* Tackle radon in the home (eg through direct advice from local authorities to affected householders)	residents in areas with high radon levels to have radon concentrations measured in their homes. If levels are high, owners of affected homes can be encouraged to have remedial work undertaken and local authority grants can be provided for this work..[b] The potential risks from radon in the home continue to be estimated indirectly through studies on miners so the risk from domestic radon should be interpreted with caution until further studies are completed.[c] No systematic reviews have been identified examining the effect of reducing radon in the home on the risk of developing lung cancer.	lung cancer and indoor radon. Health Physiology 1993;65:234-510. Darby SC, Whitley E, Howe GR, Hutchings SJ, Kusiak RA, Lubin JH, Morrisson HI, Tirmarche M, Tomasek L, Radford EP. Radon and cancers other than lung cancer in underground miners: a collaborative analysis of 11 studies. Journal of the National Cancer Institute 1995;87:378-84. b. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** c. Lubin JH, Boice JD Jr. Lung cancer risk from residential radon: meta-analysis of eight epidemiologic studies. Journal of the National Cancer Institute 1997;89:49-57.
	People can:		
C15	Protect others from second hand smoke and children from sunburn	<u>Passive smoking:</u> A reduction in exposure to passive smoking in the home may be effective in protecting the health of children.[a] A systematic review on family/carer smoking control programmes for reducing children's exposure to environmental tobacco smoke is in preparation.[b] Pre-natal counselling, which incorporates smoking cessation advice in the form of written materials and continued health professional contact maintained throughout pregnancy, can reduce the reduce the incidence of low birthweight.[c] <u>Sunburn:</u> The incidence of skin cancer has been increasing in the UK in recent years. The majority of skin cancers occur as a result of overexposure to ultraviolet light from the sun or an artificial source such as a sunbed, and are therefore preventable. There is evidence that preventive measures, such as sunscreens, are effective in avoiding overexposure of the skin to sunlight and may reduce the incidence of skin cancer. However, while health education programmes enhance knowledge of skin cancer, evidence that they change behaviour is very weak.[d]	a. Hackshaw AK, Law MR, Wald MJ. The accumulated evidence on lung cancer and environmental tobacco smoke. BMJ 1997;315:980-8. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998**. Uberla K. Lung cancer from passive smoking: hypothesis or convincing evidence? International Archives of Occupational and Environmental Health 1987;59:421-37. b. **Waters E, Campbell R, Webster P, Spencer N. Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software** c. **Agency for Health Care Policy and Research. Smoking Cessation. Clinical Practice Guideline, 1996.** **Lumley J, Oliver S, Waters E. Interventions for promoting smoking cessation during pregnancy [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. Harvey I. Prevention of skin cancer: a review of available strategies. University of Bristol Health Care Evaluation Unit, 1995.

CANCER: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
C16	Develop healthy living centres	Despite suggested benefits of community wellness programmes, current evidence is inconclusive.[a] Studies of community action for health promotion have not been methodologically sound.[b] No systematic reviews were found examining the impact of such centres on cancer rates.	a. Watt D, Verma S, Flynn L. Wellness programs: a review of the evidence. Canadian Medical Association Journal 1998;158:224-30. b. Hancock L, Sanson-Fisher R W, Redman S, Burton R, Burton L, Butler J, Girgis A, Gibberd R, Hensley M, McClintock A, Reid A, Schofield M, Tripodi T, Walsh R. Community action for health promotion: a review of methods and outcomes 1990-1995. American Journal of Preventive Medicine 1997;13:229-39.
C17	Fund health education campaigns to provide reliable and objective information on the health risks of smoking, poor diet and too much sun *(cont)*	Simple provision of information/education about the health risks of smoking, poor diet and too much sun improves knowledge but has little effect on changing health-related behaviour. Health education campaigns which provide information but no additional interventions are only effective in altering the behaviour of higher status socio-economic groups. Programmes providing information together with personal support can be used to change behaviour across all socio-economic groups.[a] <u>Alcohol intake:</u> Alcohol consumption at presently recommended levels has not been shown to be associated with increased risk of cancer,[b] however, consumption at higher levels is associated with cancers of the mouth, larynx and oesophagus.[c] There is also a link with breast cancer and a possible link with colorectal cancer.[d] No systematic reviews have been identified assessing the effects of reducing alcohol consumption on cancer rates. <u>Fruit and vegetables/fibre and whole-grain intake:</u> Greater fruit and vegetable consumption is associated with a lower incidence of cancers of the stomach, oesophagus, lung, oral cavity and pharynx, endometrium, pancreas and colon. Raw vegetables appear to offer the most protection.[e] There is also some evidence to suggest that a high intake of dietary fibre is associated with a reduced risk of colon cancer.[f] Evidence supports the hypothesis that whole-grain intake protects against various cancers.[g] Community intervention programmes in school children, adolescents and	a. Gepkens A, Gunning-Schepers LJ. Interventions to reduce socioeconomic health differences: A review of the international literature. European Journal of Public Health 1996;6:218-26. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998** b. Chhabra SK, Souliotis VL, Kyrtopoulos SA, Anerson LM. Nitrosamines, alcohol and gastrointestinal tract cancer: recent epidemiology and experimentation. In Vivo 1996;10:265-84. Hiatt RA. Alcohol consumption and breast cancer. Medical Oncology and Tumour Pharmacotherapy 1990;7:143-51. Holman CD, English DR, Milne E, Winter MG. Meta-analysis of alcohol and all-cause mortality: A validation of NHMRC recommendations. Medical Journal of Australia 1996;164:141-5. Longnecker MP, Orza MJ, Adams ME, Vioque J, Chalmers TC. A meta-analysis of alcoholic beverage consumption in relatioin to risk of colorectal cancer. Cancer Causes and Control 1990;1:59-68. Longnecker MP. Alcoholic beverage consumption in relation to risk of breast cancer: Meta-analysis and review. Cancer Causes and Control 1994;5:73-82. c. Holman CD, English DR, Milne E, Winter MG. Meta-analysis of alcohol and all-cause mortality: A validation of NHMRC recommendations. Medical Journal of Australia 1996;164:141-5. d. Longnecker MP. Alcoholic beverage consumption in relation to risk of breast cancer: Meta-analysis and

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POLICY

C17 *(cont)*Fund health education campaigns to provide reliable and objective information on the health risks of smoking, poor diet and too much sun *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

adults found the most successful interventions for increasing fruit and vegetable consumption were those that were part of a multi-component programme. Successful interventions included education directed at behavioural change, were over a longer time period with multiple contacts made with participants, and used a message specifically targeted to fruit and vegetables rather than nutrition in general.[h]

Body mass/Physical activity/Dietary fat intake:

There is a modest inverse association between body mass index and the risk of breast cancer[i] and also some evidence that exercise is associated with a reduced risk of early onset breast cancer.[j] Research has shown that women are much less physically active than men.[k]

Dietary fat reduction can result in a lowering of serum oestradiol levels and may offer an approach to breast cancer prevention.[l]

A review on low fat diets for reducing obesity is underway.[m]

No systematic reviews have been identified relating interventions to reduce dietary fats/obesity/increase physical activity and cancer rates.

Other dietary factors:

No association has been detected between artificial sweetener consumption and bladder cancer in humans even though saccharin has been found to be carcinogenic in rats.[n]

No association between a high intake of linoleic acid and breast, colorectal or prostate cancer has been found in humans, despite animal experiments indicating that linoleic acid is required to promote growth of artificially induced tumors in rodents.[o]

There is no support for the hypothesis that calcium protects against colorectal cancer[p] or that a high coffee consumption protects against colorectal cancer.[q]

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POLICY

C17 *(cont)*Fund health education campaigns to provide reliable and objective information on the health risks of smoking, poor diet and too much sun

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

Sunlight exposure:

Skin cancer prevention campaigns are more likely to be effective if they aim to alter attitudes and beliefs not simply to provide information.[r]

Smoking:

National media campaigns targeted at smokers can result in small reductions in the prevalence of smoking.[s] Mass-media campaigns may be effective in preventing uptake of smoking among young people, but the intensity and duration of campaigns are important in determining their effects.[t]

Interventions to reduce health-risk behaviours:

Didactic knowledge-based school-based intervention programmes have not been shown to be effective in reducing risky behaviours in adolescents (smoking/alcohol/drug abuse, sexual risk). Interactive programmes are more effective at changing behaviour than non-interactive ones. Interactive programmes based on social learning theory were most effective. While some programmes worked for some subgroups of youth, the effective programmes had modest effects overall.[u]

Community-based interventions to promote public awareness of environmental health risks and adoption of risk reduction measures can be effective, particularly for outcomes related to knowledge and attitude. The greatest positive behavioural shifts were associated with intensive interventions in which there were multiple events or means of delivery in various settings. However the limited variety of hazards that have been examined (primarily exposure to ultraviolet light or environmental tobacco smoke) and generally short follow-up times, limit the strength of this conclusion.[v]

No systematic reviews of the impact of such interventions on cancer rates have been found.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			v. Campbell M, Buckeridge D, Dwyer J, Fong S et al. Effectiveness of environmental awareness interventions. Ontario Public Health Research Education and Development Programme. Effective Public Health Practice Project, March 1999.
C18	Encourage research into ways to modify high-risk behaviours	No systematic reviews have been identified that assess the effects of behaviour modification on cancer rates.	
	Local Players and Communities can:		
C19	Target health information on groups and areas where people are most at risk	No systematic reviews have been identified that examine targeting health information on at-risk groups on cancer rates.	
C20	Encourage the development of healthy workplaces and healthy schools *(cont)*	<u>Smoking:</u> Multi-component workplace smoking cessation programmes are effective.[a] Smoking cessation group programmes are more effective than minimal treatment schemes.[b] Workplace tobacco policies can reduce cigarette consumption at work.[b] School-based programmes that use social reinforcement techniques (and not simply education or information) have been shown to prevent the uptake of smoking among children.[b] A review assessing school based programmes for preventing smoking is in progress.[c] No systematic reviews have examined the effects on cancer rates of programmes to discourage smoking at school/work. <u>Potential occupational carcinogens:</u> <u>Agricultural occupations:</u> Farmers are at increased risk of various cancers.[d] Findings suggest a slight increase of risk of developing Hodgkin's disease in male farmers from exposure to infectious micro-organisms, herbicides and insecticides.[e] Similar exposure to micro-organisms or pesticides might be a risk factor for non-Hodgkin's lymphoma among farmers.[f] Although one review of 37 studies of	a. Agency for Health Care Policy and Research. Smoking Cessation. Clinical Practice Guideline, 1996. b. Agency for Health Care Policy and Research. Smoking Cessation. Clinical Practice Guideline, 1996. Erikson MP, Gottlieb NH. A review of the health impact of smoking control at the workplace. American Journal of Health Promotion 1998;13:83-104. **NHS Centre for Reviews and Dissemination. Preventing the uptake of smoking in young people. Effective Health Care 1999:5(5)**. c. **Thomas R, Busby K. School based programmes for preventing smoking [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. Blair A, Zahm SH. Agricultural exposures and cancer. Environmental Health Perspectives 1995;103:205-8. Keller-Byrne JE, Khuder SA, Schaub EA. Meta-analyses of prostate cancer and farming. American Journal of Industrial Medicine 1997;31:580-6. Khuder SA, Mutgi B. Meta -analyses of multiple myeloma and farming. American Journal of Industrial Medicine 1997;32:510-6. e. Khuder SA, Mutgi AB, Schaub EA, Tano BD. Meta-analysis of Hodgkin's disease among farmers. Scandinavian Journal of Work, Environment and Health 1999;25:436-41.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*
C20	*(cont)* Encourage the development of healthy workplaces and healthy schools *(cont)*	farmers found an increase in lip cancer but not other cancers.[g] There is debate over the relationship between formaldehyde exposure and nasopharyngeal cancer.[h] <u>Industrial occupations:</u> National surveillance programmes have reported high rates of respiratory cancer in asbestos workers,[i] although there is wide variability of the association between occupational asbestos and lung cancer. Mesothelioma deaths showed a dose-response effect and an association with laryngeal cancer has been found.[j] Interventions now to reduce asbestos exposure may reduce the incidence of lung cancers over the long term.[k] There is an association between substantial exposure to diesel exhaust and lung cancer.[l] There is evidence that those working in wood-related industries are at an increased risk of nasopharyngeal cancer, multiple myeloma and sinonasal cancer.[m] There is an increased risk of cancer of larynx, rectum, pancreas, skin, scrotum and bladder in workers exposed to metal working fluids in industrial machining and grinding operations.[n] Workers with stainless steel are at increased risk of lung cancer.[o] There is an association between silicosis and lung cancer.[p] There is weak evidence of a link between working as a painter and risk of cancer.[q] There is weak evidence of increased risk for asphalt workers and roofers of a number of cancers.[r] There is an association between lung cancer among shipyard, mild steel and stainless steel welders and exposure to hexavalent chromium and nickel, but this may be explained by asbestos exposure and smoking.[s]

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Demers PA, Boffetta P, Kogevinas M, Blair A, Miller, B., Robinson CF, Roscoe RJ, Wionter PD, Colin D, Matos E. Pooled re-analysis of cancer mortality among five cohorts

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C20	*(cont)* Encourage the development of healthy workplaces and healthy schools	There is some association between heavy exposure to lead and stomach and lung cancer but this association may also be explained by smoking and poor dietary habits.[t] No association was found between working with acrylonitrile and cancer.[u]	of workers in wood-related industries. Scandinavian Journal of Work Environment and Health 1995;21:179-90. Fielding JE. Smoking control at the workplace. Annual Review of Public Health 1991;12:209-34. n. Calvert GM, Ward E, Schnorr TM, Fine LJ. Cancer risks among workers exposed to metalworking fluids: a systematic review. American Journal of Industrial Medicine 1998;33:282-92. o. Moulin JJ. A meta-analysis of epidemiologic studies of lung cancer in welders. Scandinavian Journal of Work Environment and Health 1997;23:104-13. p. Smith AH, Lopipero PA, Barroga VR. Meta-analysis of studies of lung cancer among silicotics. Epidemiology 1995;6:617-24. q. Chen R, Seaton A. A meta-analysis of painting exposure and cancer mortality. Cancer Detection and Prevention 1998;22:533-9. r. Partanen T, Boffetta P. Cancer risk in asphalt workers and roofers: review and meta-analysis of epidemiologic studies. American Journal of Industrial Medicine 1994;26:721-40. s. Sjogren B, Hansen KS, Kjuus H, Persson PG. Exposure to stainless steel welding fumes and lung cancer: a meta-analysis. Occupational and Environmental Medicine 1994;51:335-6. t. Fu H, Boffetta P. Cancer and occupational exposure to inorganic lead compounds: a meta-analysis of published data. Occupational and Environmental Medicine 1995;52:73-81. u. Collins JJ, Acquavella JF. Review and meta-analysis of acrylonitrile workers. Scandinavian Journal of Work Environment and Health 1998;24:71-80.
	People can:		
C21	Stop smoking, increase consumption of fruit, vegetables, and dietary fibre each day, avoid high consumption of red and processed meat, keep	A number of interventions are effective in promoting smoking cessation.[a] These include nicotine replacement therapy (inhalers and patches appear to be slightly more effective than chewing gum);[b] behaviour modification, combined with advice and social skills training;[c] and encouragement and brief advice given by well trained GPs or other health professionals during routine	a. Law M, Tang JL An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine 1995;155:1933-41. b. Henningfield JE. Nicotine medications for smoking cessation. New England Journal of Medicine 1995;333:1196-203. **Silagy C, Mant D, Fowler G, Lancaster T. Nicotine**

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POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
physically active, maintain a healthy body weight that does not increase during adult life *(cont)*	consultations (which is particularly effective with more motivated patients).[d] There is no evidence that silver acetate,[e] aversion treatments,[f] lobeline,[g] acupuncture,[h] anxiolytics or antidepressants[i] result in smoking cessation. Community intervention programmes in school children, adolescents and adults found the most successful interventions for increasing fruit and vegetable consumption were those that were part of a multi-component programme. Successful interventions also included education directed at behavioural change, were over a longer time period with multiple contacts made with participants, and used a message specifically targeted to fruit and vegetables rather than nutrition in general.[j] Public health campaigns on diet, exercise and smoking are likely to be more effective if they take into account variations across cultural groups.[k]	**replacement therapy for smoking cessation. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. **NHS Centre for Reviews and Dissemination. Smoking cessation: What can the Health Service do? Effectiveness Matters 1998:3(1).** d. Law M, Tang JL An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine 1995;155:1933-41. **NHS Centre for Reviews and Dissemination. Smoking cessation: What can the Health Service do? Effectiveness Matters 1998:3(1)**. **Silagy C, Fowler G, Spiers I. Training health professionals to provide smoking cessation. interventions. [Cochrane Review] In: The Cochrane Library, Issue 1,2000. Oxford: Update Software.** **Silagy C, Ketteridge S. Physician advice for smoking cessation. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** e. **Lancaster T, Stead L. Silver acetate for smoking cessation. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** f. **Hajek P, Stead LF. The effect of aversive smoking on smoking cessation. [Cochrane Review] In: The Cochrane Library, Issue 1 2000. Oxford: Update Software.** g. **Stead LF, Hughes JR. Lobeline for smoking cessation. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** h. **White AR, Rampes H. Acupuncture in smoking cessation. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** i. **Hughes JR, Stead LF, Lancaster TR. Anxiolytics and antidepressants in smoking cessation. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** j American Institute for Cancer Research. Food Nutrition and the prevention of cancer. World Cancer Research Fund, 1997. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C21	*(cont)* Stop smoking, increase consumption of fruit, vegetables, and dietary fibre each day, avoid high consumption of red and processed meat, keep physically active, maintain a healthy body weight that does not increase during adult life		**Working Group on Diet and Cancer of the Committee on Medical Aspects of Food and Nutrition policy. Nutritional aspects of the development of cancer. Department of Health, 1998.** Ontario Public Health Research Education and Development Programme. Effective Public Health Practice Project. The effectiveness of community interventions to increase fruit and vegetable consumption in people four years of age and older. March 1999. k. **NHS Centre for Reviews and Dissemination.: Ethnicity and health: Reviews of literature and guidance for purchasers in the areas of cardiovascular disease, mental health and haemoglobinopathies. University of York: NHS Centre for Reviews and Dissemination, Report 5, 1996.**
C22	Cover up in the sun.	The incidence of skin cancer has been increasing in the UK in recent years. The majority of skin cancers occur as a result of overexposure to ultraviolet light from the sun or an artificial source such as a sunbed, and are therefore preventable. There is evidence that preventive measures, such as sunscreens, are effective in avoiding overexposure of the skin to sunlight and may reduce the incidence of skin cancer. However, while health education programmes enhance knowledge of skin cancer, evidence of changed behaviour is very weak.[a] It is not clear which interventions may be effective in reducing the risk of skin cancer from ionizing radiation. No systematic reviews have been identified assessing the effects of reducing skin exposure on rates of skin cancer.	a. Harvey I. Prevention of skin cancer: a review of available strategies. University of Bristol Health Care Evaluation Unit, 1995.
C23	Practice safer sex *(cont)* *(cont)* Practice safer sex	Several risk factors are known to be associated with the development of cervical cancer. The most significant is contact with the human papillomavirus (HPV). Condom use is likely to reduce the risk of HPV-related illness and also cervical cancer. When encouraging safer sexual behaviours; education on disease transmission, when combined with skill development, achieved a short-term increase in condom use. There is no evidence on whether the interventions produce lasting effects.[a]	a. **Shepherd J, Weston R, Peersman G, Napuli IZ. Interventions for encouraging sexual lifestyles and behaviours intended to prevent cervical cancer [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

CANCER: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C23		No systematic reviews have been identified that examine the effects of interventions to encourage safer sex on cancer rates.	
C24	Follow sensible drinking advice	There is no indication that alcohol consumption at presently recommended levels is associated with any increased risk of cancer,[a] however, consumption at higher levels is associated with cancers of the mouth, larynx and oesophagus,[b] and possibly link with breast cancer[c] and colorectal cancer.[d] There is no reliable evidence that any specific intervention programmes for alcohol misuse prevention in young people is effective in the long term.[e] No systematic reviews have been identified assessing the effects of reducing alcohol consumption on cancer rates.	a. Chhabra SK, Souliotis VL, Kyrtopoulos SA, Anerson LM. Nitrosamines, alcohol and gastrointestinal tract cancer: recent epidemiology and experimentation. In Vivo 1996;10:265-84. Hiatt RA. Alcohol consumption and breast cancer. Medical Oncology and Tumour Pharmacotherapy 1990;7:143-51. Holman CD, English DR, Milne E, Winter MG. Meta-analysis of alcohol and all-cause mortality: A validation of NHMRC recommendations. Medical Journal of Australia 1996;164:141-5. Longnecker MP, Orza MJ, Adams ME, VioqueJ, Chalmers TC. A meta-analysis of alcoholic beverage consumption in relatioin to risk of colorectal cancer. Cancer Causes and Control 1990;1:59-68. Longnecker MP. Alcoholic beverage consumption in relation to risk of breast cancer: Meta-analysis and review. Cancer Causes and Control 1994;5:73-82. b. Holman CD, English DR, Milne E, Winter MG. Meta-analysis of alcohol and all-cause mortality: A validation of NHMRC recommendations. Medical Journal of Australia 1996;164:141-5. c. Longnecker MP. Alcoholic beverage consumption in relation to risk of breast cancer: Meta-analysis and review. Cancer Causes and Control 1994;5:73-82. d. Longnecker MP, Orza MJ, Adams ME, VioqueJ, Chalmers TC. A meta-analysis of alcoholic beverage consumption in relatioin to risk of colorectal cancer. Cancer Causes and Control 1990;1:59-68. e. Foxcroft DR, Lister-Sharp D, Lowe G. Alcohol misuse prevention for young people: a systematic review reveals methodological concerns and lack of reliable evidence of effectiveness. Addiction 1997; 92:531-7.

CANCER: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
C25	Encourage doctors, dentists, nurses and other health professionals to give advice on prevention *(cont)*	Patient education and counselling contribute to behaviour change for primary prevention of disease, some techniques, particularly self-monitoring, and using several communication channels, eg media plus personal communication, having the greatest effect.[a] <u>Advice on alcohol intake:</u> Brief interventions in primary care, including assessment of alcohol intake and provision of information and advice, may be used to reduce alcohol consumption in those with consumption levels above recommended levels. Evidence suggests alcohol consumption can be reduced by up to 20% in people with raised alcohol consumption. Brief interventions are as effective as more expensive specialist treatment in this context.[b] <u>Advice on smoking cessation:</u> Advice given by GPs can be effective in reducing smoking.[c] Training health professionals increases the degree to which they offer anti-smoking interventions, and their effectiveness in doing so.[d] <u>Advice on weight reduction:</u> There is evidence that health professionals can improve the organisation of care for obese people, and weight reduction may reduce the risk of breast and endometrial cancer as well as many other diseases.[e] <u>Advice on prevention and cancer rates:</u> A review of methods to implement prevention in primary care is underway.[f] Other reviews are examining the use of physician reminders in prevention.[g] However no reviews have been identified that assess the effects of advice on prevention on cancer rates. <u>Other areas of advice related to prevention:</u> There is evidence of a small increase in the risk of breast cancer in women taking the oral contraceptive pill and for ten years after they cease to take it. This factor should be taken into account when making decisions about using	a. Mullen PD, Simons-Morton DG, Ramirez G, Frankowski RF, Green LW, Mains DA. A meta-analysis of trials evaluating patient education and counseling for three groups of preventive health behaviors. Patient Education and Counseling 1997;32:157-73. b. Kahan M, Wilson C, Becker L. Effectiveness of physician-based interventions with problem drinkers: a review. Canadian Medical Association Journal 1995;152:851-9. **NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. Effective Health Care 1993:1(7).** c. **Silagy C, Ketteridge S. Physician advice for smoking cessation. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. **Lancaster T, Silagy C, Fowler G, Spiers I. Training health professionals to provide smoking cessation interventions. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** e. **Harvey EL, Glenny A, Kirk SFL, Summerbell CD. Improving health professionals' management and the organisation of care for overweight and obese people [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** f. **Hulscher MEJL, Wensing M, Van der Weijden T, Grol R, Van Weel C. Interventions to implement prevention in primary care [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** g. **Rowe R, Wyatt J, Grimshaw J, Gordon R, Hicks N, Altman D, Durieux P, Haaijer F, Denig P, Gill P. Manual paper reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Gordon RB, Grimshaw JM, Eccles M, Rowe RE, Wyatt JC. On-screen computer reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C25	*(cont)* Encourage doctors, dentists, nurses and other health professionals to give advice on prevention	oral contraceptives.[h] Long term post-menopausal unopposed oestrogen therapy increases the risk of breast and endometrial cancer. There is no indication that short term therapy is harmful.[i] While the risk of breast cancer is increased in women using hormone replacement therapy (HRT) and increases with the duration of use, its effects decline after cessation of use and have largely disappeared after 5 years.[j] HRT use may also increase risk of ovarian cancer[k] but may reduce risk of colorectal cancer.[l] No systematic reviews have been identified assessing the effects of health professional advice on cancer when prescribing hormones to women.	**Gorman PN, Redfern C, Liaw T, Mahon S, Wyatt JC, Rowe RE, Grimshaw JM. Computer-generated paper reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** h. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormonal contraceptives: collaborative reanalysis of individual data on 53 297 women with breast cancer and 100 239 women without breast cancer from 54 epidemiological studies. Lancet 1996;347:1713-27. i. Grady D, Gebretsadik T, Kerlikowske K, Ernster V, Petitti D. Hormone replacement therapy and endometrial cancer risk: a meta-analysis. Obstetrics and Gynecology 1995;85:304-13. j. Collaborative Group on Hormonal Factors in Breast Cancer. Breast cancer and hormone replacement therapy: collaborative reanalysis of data from 51 epidemiological studies of 52,705 women with breast cancer and 108,411 women without breast cancer. Lancet 1997;350:1047-59. k. Garg PP, Kerlikowske K, Subak L, Grady D. Hormone replacement therapy and the risk of epithelial ovarian carcinoma: a meta-analysis. Obstetrics and Gynaecology 1998;92:472-9. l. Grodstein F, Newcomb PA, Stampfer MJ. Postmenopausal hormone therapy and the risk of colorectal cancer: a review and meta-analysis. American Journal of Medicine 1999;106:574-82.
C26	Ensure that healthy schools work with pupils and parents to improve health	Evidence suggests that school health promotion initiatives can have a positive impact on children's health and behaviour, but do not do so consistently. Most are able to increase knowledge but changing children's attitudes and behaviour is harder to achieve.[a] No reviews have been identified assessing the effects of school health promotion initiatives on cancer rates.	a. **NHS Centre for Reviews and Dissemination/University of Oxford Health Services Research Unit. Health Technology Assessment 1999;3(22).**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*
C27	Ensure smokers have access to high-quality smoking cessation services, particularly in health action zones	Free telephone quit lines, as part of an anti-smoking campaign, can improve quit rates.[a] A number of reviews of anti-smoking interventions in a variety of healthcare settings is helping to identify the best ways to help people stop smoking.[b]

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Rice VH, Stead LF. Nursing interventions for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
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C28	Maintain effective, appropriate and high quality existing cancer screening programmes and consider possible extensions of these *(cont)*	<u>Cervical cancer</u>: Screening for cervical cancer is likely to be most effective if women are screened every 2 years starting at age 18 (or within a year of first sexual intercourse) and ending at age 70, with a systematic approach to monitoring the screening programme.[a] Extended tip spatulas appear to be better for collecting endocervical cells than the commonly used Ayres spatula.[b] Human papilloma virus (HPV) testing is more sensitive than cytology for high grade cervical intraepithelial neoplasia (CIN), but has lower specificity, especially in young women, and is currently recommended.[c] <u>Breast cancer</u>: If carried out to a high standard, screening for breast cancer results in reduced mortality amongst women 50 years of age and older,[d] however, concern has been expressed about the quality of the evidence upon which this conclusion has been based.[e] Film screen mammography is the most effective form of primary screening and it is particularly effective if the films are read	a. Braggett D, Lea A, Carter RC, Hailey D, Ludowyk P. Issues in cervical cancer screening and treatment: new technologies and costs of alternative management strategies. Canberra: Australian Institute of Health and Welfare, 1993. Ibbotson T, Wyke S. A review of cervical cancer and cervical screening: implications for nursing practice. Journal of Advances in Nursing 1995;22:745-52. Noorani HZ, Arratoon C, Hall A. Assessment of techniques for cervical cancer screening. Ottawa: Canadian Coordinating Office for Health Technology Assessment/Office Canadien de Coordination de l'évaluation des Technologues de la Santé, 1997. b. Buntinx F, Brouwers M. Relation between sampling device and detection of abnormality in cervical smears: a meta-analysis of randomised and quasi-randomised studies. BMJ 1996;313:1285-90. **Martin-Hirsch P, Jarvis G, Kitchener H, Lilford R. Collection devices for obtaining cervical cytology samples [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. **Cuzick J, Sasieni P, Davies P, Adams J, Normand C, Frater A, Van Ballegooijen M, Van den Akker E. A systematic review of the role of human papillomavirus**

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POLICY	SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE	REFERENCES
C28 *(cont)* Maintain effective, appropriate and high quality existing cancer screening programmes and consider possible extensions of these *(cont)*	independently by two readers, one of whom is a radiologist.[d] There is continuing uncertainty about the effects of breast cancer screening in women under 50.[f] There is however, no evidence that breast self-examination is effective.[g] <u>Colorectal cancer</u>: Colorectal cancer screening using faecal occult blood tests can reduce mortality from colorectal cancer. Annual screening is more effective than biennial screening.[h] Colonoscopic surveillance should be offered to patients with long standing ulcerative colitis.[i] A review of screening for colorectal cancer in people with all types of inflammatory bowel disease is underway.[j] <u>Prostate cancer</u>: Evidence suggests that screening for prostate cancer is not presently justified as the screening tests are not sufficiently accurate, available treatments have not been adequately evaluated and, given the slow growing nature of prostate tumours, outcome may be as good as without active intervention.[k] <u>Ovarian cancer</u>: Evidence suggests that routine screening for ovarian cancer is not presently justified in women, with or without a family history of ovarian cancer, since the available tests are insensitive and can raise anxiety without any evidence that they reduce mortality or morbidity.[l] <u>Lung cancer</u>: Screening for lung cancer is not presently justified as there is little evidence that it reduces mortality or morbidity rates and there is some evidence that it causes harm.[m] A further review on the effectiveness of screening for lung cancer is underway.[n]	**testing within a cervical screening programme. Health Technology Assessment. 1999;3(14).** d. Kerlikowske K, Grady D, Rubin SM, Sandrock C, Ernster VL. Efficacy of screening mammography : A meta-analysis. JAMA 1995;273:149-54. **NHS Centre for Reviews and Dissemination. The management of primary breast cancer. Effective Health Care 1996:2(6).** Mushlin AI, Kouides RW, Shapiro DE. Estimating the accuracy of screening mammography: a meta-analysis. American Journal of Preventive Medicine 1998;14:143-53. e. **Gøtzsche PC, Olsen O. Mammographic screening for detection of breast cancer. [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Gøtzsche PC, Olsen O. Is screening for breast cancer with mammography justifiable? Lancet 2000;355:129-34. f. Hendrick RE, Smith RA, Rutledge JH 3rd, Smart CR. Benefit of screening mammography in women aged 40-49: a new meta-analysis of randomised controlled trials. Journal of the National Cancer Institute Monograph 1997;87-92. Glasziou PP, Woodward AJ, Mahon CM. Mammographic screening trials for women aged under 50: a quality assessment and meta-analysis. Medical Journal of Australia 1995;162:625-9. g. Austoker J. Screening and self examination for breast cancer. BMJ 1994;309:168-74. **NHS Centre for Reviews and Dissemination. The management of primary breast cancer. Effective Health Care 1996:2(6).** h. Agency for Health Care Policy and Research. Colorectal cancer screening. Rockville, MD:Agency for Health Care Policy and Research, 1997. **Towler BP, Irwig L, Glasziou P, Weller D, Kewenter J. Screening for colorectal cancer using the faecal occult blood test, Hemoccult [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C28	*(cont)* Maintain effective, appropriate and high quality existing cancer screening programmes and consider possible extensions of these	Clinical surveillance for second cancers is recommended for patients successfully treated for cancers of the head and neck and lungs.[o] <u>General issues in screening:</u> A review to examine the ways of communicating risk in health screening programs is underway.[p]	i. Griffiths A M, Sherman P M Colonoscopic surveillance for cancer in ulcerative colitis: a critical Review. Journal of Pediatric Gastroenterology and Nutrition 1997;24:202-10. j. **Watson A, Robinson A, Lashner B, Irvine E, Katchatouian M. Strategies for detecting colon cancer and/or dysplasia in patients with inflammatory bowel disease [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** k. Coley CM, Barry MJ, Fleming C, Mulley AG. Early detection of prostate cancer. Part 1: Prior probability and effectiveness of tests. Annals of Internal Medicine 1997;126:394-406. **Chamberlain J, Melia J, Moss S, Brown J. The diagnosis, management, treatment and costs of prostate cancer in England and Wales. Health Technology Assessment 1997;1(3**). **NHS Centre for Reviews and Dissemination. Screening for prostate cancer. Effectiveness Matters 1997:2(2).** **Selley S, Donovan J, Faulkner A, Coast J, Gillat D. Diagnosis, management and screening of early localised prostate cancer: A systematic review. Health Technology Assessment 1997;1(2).** Coley CM, Barry M J, Fleming, C, Fahs MC, Mulley AG. Early detection of prostate cancer. Part II: Estimating the risks, benefits, and costs. American College of Physicians. Annals of Internal Medicine. 1997;126:468-79. l. **Bell R, Petticrew M, Luengo S, Sheldon TA, Screening for ovarian cancer: a systematic review. Health Technology Assessment 1998;2:1-84.** Carlson KJ, Skates SJ, Singer DE. Screening for ovarian Cancer. Annals of Internal Medicine 1994;121:124-32. m. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** n. **Manser R, Ansari MZ, Irving L, Abramson M, Hart W, Campbell DC. Screening for lung cancer [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
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C29	Ensure all patients with suspected cancer are seen by a specialist within 2 weeks of urgent referral by a GP	Evidence suggests that one third of women with breast cancer symptoms delay seeking help for 3 or more months[a] and that delays in diagnosing breast cancer of 3-6 months are associated with lower survival.[b] No systematic reviews have been identified on the effect of interventions to reduce delay in diagnosis on survival rates.	a. Facione NC. Delay versus help seeking for breast cancer symptoms: a critical review of the literature on patient and provider delay. Social Science and Medicine 1993;36:1521-34. b. Richards MA, Westcombe AM, Love SB, Littlejohns P, Ramirez AJ. Influence of delay on survival in patients with breast cancer: a systematic review. Lancet 1999; 353:1119-26.
C30	Ensure equal access to high-quality treatment and care, through implementation of the expert report on the organisation and management of NHS cancer services *(cont)*	Outcomes in cancer treatment can be improved by concentrating care in the hands of specialists, although there is wide variability in outcome across the UK.[a] Treatment within randomised controlled trials may also result in better outcomes.[b] Centralisation of cancer services can make access for people in rural areas more difficult. There is some weak evidence that shared outreach is safe and can make specialist care more accessible to outlying patients.[c] After primary treatment is complete, routine intensive hospital follow up after cancer treatment has not been shown to improve outcome.[d] GP-led follow-up with access to specialist care appears to be effective and acceptable to both patients and GPs.[e] Effective palliative care by home care teams allows patients to stay at home longer, which is preferred by most patients and is the least expensive option for the NHS.[d] Systematic reviews of the effects of strategies for dealing with common problems in palliative care are being prepared[f] and will inform the guidelines in the management of palliation.[g]	a. **NHS Centre for Reviews and Dissemination. The management of colorectal cancer. Effective Health Care. 1997:3(6).** **NHS Executive. Improving outcomes in colorectal cancer. London: Department of Health, 1997.** Grilli R, Minozzi S, Tinazzi A, Labianca R, Sheldon TA, Liberati A. Do specialists do it better? The impact of specialization on the processes and outcomes of care for cancer patients. Annals of Oncology 1998;9:365-74. b. Howard GC, Clarke K, Elia MH, Hutcheon AW, Kaye SB, Windsor PM. A Scottish national audit of current patterns of management for patients with testicular non-seminomatous germ-cell tumours. The Scottish Radiological Society and the Scottish Committee of the Royal College of Radiologists. British Journal of Cancer 1995;72:1303-6. Howard GC, Clarke K, Elia MH, Hutcheon AW, Kaye SB, Windsor PM, Yosef HM, Sharp L. A Scottish national mortality study assessing cause of death, quality of and variation in management of patients with testicular non-seminomatous germ-cell tumours. The Scottish Radiological Society and the Scottish Standing Committee of the Royal College of Radiologists. British Journal of Cancer 1995;72:1307-11. c. Campbell NC, Ritchie LD, Thain J, Deans HG, Rawles

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C30	*(cont)* Ensure equal access to high-quality treatment and care, through implementation of the expert report on the organisation and management of NHS cancer services	Mass media channels of communication can influence use of healthcare.[h]	JM, Squair JL. Secondary prevention in coronary heart disease: a randomised trial of nurse led clinics in primary care. Heart 1998;80:447-52. d. **NHS Executive. Improving outcomes in breast cancer. London: Department of Health, 1997.** **NHS Executive. Improving outcomes in colorectal cancer. London: Department of Health, 1997.** **NHS Executive. Improving outcomes in gynaecological cancer. London: Department of Health, 1999.** **NHS Executive. Improving outcomes in lung cancer. London: Department of Health, 1998.** e. **NHS Executive. Improving outcomes in breast cancer. London: Department of Health, 1997.** f. **McQuay HJ, Collins SL, Carroll D, Moore RA. Radiotherapy for the palliation of painful bone metastases [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Hearn J, Higginson IJ. Do specialist palliative care teams improve outcomes for cancer patients - a systematic literature review. Palliative Medicine 1998;12:317-32. g. **NHS Executive. Palliative Care. London: Department of Health, 1998.** **McQuay HJ, Moore RA, Eccleston C, Morley S, de C Williams AC. Systematic review of outpatient services for chronic pain control. Health Technology Assessment 1997;1:137.** h. **Grilli R, Freemantle N, Minozzi S, Domenighetti G, Finer D. Mass media interventions: effects on health services utilisation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford:Update Software.**
	Local Players and Communities can:		
C31	Provide effective help in stopping smoking to people who want to stop especially for disadvantaged groups *(cont)*	Free telephone quit lines as part of an anti-smoking campaign can improve quit rates.[a] Reviews of anti-smoking interventions in a variety of healthcare settings are helping to identify the best ways to help people stop smoking.[b]	a. **Health Education Authority. Tobacco control in England: Communication strategies of the Health Education Authority London: Health Education Authority 1997.** b. **Abbot NC, Stead LF, White AR, Barnes J, Ernst E. Hypnotherapy for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000.**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C31	*(cont)* Provide effective help in stopping smoking to people who want to stop especially for disadvantaged groups		**Oxford: Update Software.** Mullen PD, Simons-Morton DG, Ramirez G, Frankowski RF, Green LW, Mains DA. A meta-analysis of trials evaluating patient education and counseling for three groups of preventive health behaviors. Patient Education and Counseling 1997;32:157-73. **Gourlay SG, Stead LF, Benowitz NL. Clonidine for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Health Education Authority. Tobacco control in England: Communication strategies of the Health Education Authority. London: Health Education Authority 1997.** **Lancaster T, Stead LF. Individual behavioural counselling for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Lancaster T, Stead LF. Mecamylamine (a nicotine antagonist) for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Lancaster T, Stead LF. Self-help interventions for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Lumley J, Oliver S, Waters E. Interventions for promoting smoking cessation during pregnancy [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Rice VH, Stead LF. Nursing interventions for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Rigotti NA, Munafo M. Interventions for smoking cessation in hospitalised patients [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Silagy C, Mant D, Fowler G, Lancaster T. Nicotine replacement therapy for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Stead LF, Lancaster T. Group behaviour therapy**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
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C32	Ensure that vulnerable groups have equitable access to screening services	Interventions which appear helpful in promoting the uptake of screening are invitation appointments, letters (less effective for mammography) and telephone calls, telephone counselling, reduction of financial barriers (such as postage costs) and chart reminders for physicians. Most educational materials have limited effectiveness, but educational home visits may increase uptake.[a] A review of different strategies for inviting women for breast cancer screening is underway.[b] A review on ways of minimising anxiety and improving people's understanding and experience of screening is underway.[c] No evidence has been identified on strategies to improve access to screening specifically for vulnerable groups.	a. **NHS Centre for Reviews and Dissemination. Systematic review of the determinants of screening uptake and interventions for increasing uptake. 2000.** b. **Bonfill X, Marzo M, Emparanza JI, Pladevall M. Strategies for inviting women to participate in breast cancer screening [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. **Bastian H, Keirse MJNC, Searle J. Influencing people's experiences of screening [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
C33	Work with voluntary organisations to provide clear and consistent messages about early detection and uptake of screening	No systematic reviews have been identified examining the effects of messages provided by voluntary groups on the uptake of screening.	
C34	Ensure rapid specialist treatment for cancers when they are diagnosed *(cont)*	**Diagnosis and staging:** Careful evaluation of patients with suspected and diagnosed cancer is necessary to inform treatment decisions.[a] Cervical cancer: Computed tomography and magnetic resonance imaging provide more detailed information for clinical evaluation of invasive cervical cancer,[b] but no reviews were identified assessing the impact of diagnostic methods on treatment or outcomes.	a. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998.** **NHS Executive. Guidelines on improving outcomes in colorectal cancer. London: Department of Health, 1997.** b. Scheidler J, Hricak H, Yu KK, Subak L, Segal MR. Radiological evaluation of lymph node metastases in patients with cervical cancer: a meta-analysis. JAMA 1997;278:1098-101. c. Merritt M, Williams MF, James TH, Porubsky ES. Detection of cervical metastasis: a meta-analysis comparing computed tomography with physical

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C34	*(cont)* Ensure rapid specialist treatment for cancers when they are diagnosed *(cont)*	Head and neck cancer: Computed tomography examination is superior to physical examination in the detection of lymph nodes in the neck.[c] However, no reviews have been identified on the impact of diagnostic methods on treatment or outcomes. Lung cancer: Computed tomography and radionuclide imaging have a high negative predictive value,[d] but no reviews have been identified on the influence of diagnostic tests on survival. Melanoma: Both the ABCD and 7-point checklists appear to be sensitive diagnostic tests that can help physicians differentiate between benign and malignant moles.[e] Urological cancer: There is evidence that macroscopic haematuria is a risk marker for urological cancer.[f] However no reviews have been identified that examined the impact of diagnostic tests on survival or other outcomes. Breast cancer: The speed and cost-effectiveness of definitive diagnosis for suspected breast cancer can be substantially improved by the routine and consistent use of the "Triple assessment" (a combination of clinical examination, mammography and fine-needle aspiration cytology).[g]	examination. Archives of Otolaryngology Head and Neck Surgery 1997;123:149-52. d. Silvestri GA, Littenberg B, Colice GL. The clinical evaluation for detecting metastatic lung cancer. A meta-analysis. Am J Respir Crit Care Med. 1995;152:225-30. e. Whited JD, Grichnik JM. Does this patient have a mole or a melanoma? JAMA 1998;279:696-701. f. Buntinx F, Wauters H. The diagnostic value of macroscopic haematuria in diagnosing urological cancers: a meta-analysis. Family Practice 1997;14:63-8. g. **NHS Centre for Reviews and Dissemination. The management of primary breast cancer. Effective Health Care 1996:2(6).** **NHS Executive. Guidelines on improving outcomes in breast cancer. London: Department of Health, 1997.**
		Treatment: Prostate cancer: In the management of early prostate cancer one review concluded that radiotherapy is superior to radical prostatectomy,[a] but other evidence found that survival with any of watchful waiting, radiotherapy or radical prostatectomy is relatively high with no significant difference in mortality between the three treatments.[b]	a. Robinson JW, Dufour MS, Fung TS. Erectile functioning of men treated for prostate carcinoma. Cancer 1997;3:538-44. b. **NHS Centre for Reviews and Dissemination, The University of York. Screening for Prostate Cancer. Effectiveness Matters 1997;2(2).** c. Selley S, Donovan J, Faulkner A, Coast J, Gillat D. Diagnosis, management and screening of early localised prostate cancer. Health Technology Assessment. National Coordinating Centre for Health Technology Assessment (NCCHTA). 1997;1:96.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C34	*(cont)* Ensure rapid specialist treatment for cancers when they are diagnosed. *(cont)*	Conservative management is a reasonable treatment option for men with localised disease.[c] No one radiotherapy technique is has been found to be superior.[d] Evidence suggests that maximal androgen blockade (MAB) for advanced prostate cancer produces a modest overall and cancer-specific survival at 5 years (from 0-5%) but is associated with increased adverse events and reduced quality of life.[e]	d. Vicini FA, Horwitz EM, Kini VR, Stromberg JS, Martinez AA. Radiotherapy options for localized prostate cancer based upon pretreatment serum prostate-specific antigen levels and biochemical control: a comprehensive review of the literature. International Journal of Radiation Oncology, Biology, Physics. 1998;40:1101-10. e. **Schmitt B, Bennett C, Seidenfeld J, Samson D, Wilt T. Maximal androgen blockade for advanced prostate cancer [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software**. Caubet JF, Tosteson TD, Dong EW, Naylon EM, Whiting GW, Ernstoff MS, Ross SD. Maximum androgen blockade in advanced prostate cancer: a meta-analysis of published randomized controlled trials using nonsteroidal antiandrogens. Urology 1997;49:71-8. Prostate Cancer Trialists' Collaborative Group. Maximum androgen blockade in advanced prostate cancer: an overview of the randomised trials. Lancet 2000;355:1491-8.
		<u>Lung cancer:</u> Multiple drug chemotherapy in advanced and disseminated non-small cell lung cancer reduces mortality at six months and improves quality of life.[a] Cisplatin-based chemotherapy combinations improve survival rates, but has unpleasant side effects.[b] Prophylactic granulocyte colony-stimulating factor (G-CSF) does not affect mortality, but does significantly reduce the incidence of neutropenic fever in patients receiving chemotherapy for small cell lung cancer.[c] A review on chemotherapy for extensive small cell lung cancer is underway.[d] A review of maintenance chemotherapy for small cell lung cancer found that trials showing poor outcomes were of poor methodological quality. The authors thus concluded that maintenance therapy may be associated with some survival advantage, particularly in patients with limited disease and those responding completely to cyclophosphamide and in cases of objective response to multi-drug regimens.[e]	a. Marino P, Preatoni A, Cantoni A. Randomized trials of radiotherapy alone versus combined chemotherapy and radiotherapy in stages IIIa and IIIb non-small cell lung cancer: a meta-analysis. Cancer 1995;76:593-601. b. Marino P, Preatoni A, Cantoni A. Randomized trials of radiotherapy alone versus combined chemotherapy and radiotherapy in stages IIIa and IIIb non-small cell lung cancer: a meta-analysis. Cancer 1995;76:593-601. Non-small Cell Lung Cancer Collaborative Group. Chemotherapy in non-small cell lung cancer: a meta-analysis using updated data on individual patients from 52 randomised trials. BMJ 1995;311:899-909. Souquet PJ, Chauvin F, Boissel JP, Bernard JP. Meta-analysis of randomised trials of systemic chemotherapy versus supportive treatment in non-resectable non-small cell lung cancer. Lung Cancer 1995;12:147-54. c. Messori A, Trippoli S, Tendi E. G-CSF for the prophylaxis of neutropenic fever in patients with small cell lung cancer receiving myelosuppressive antineoplastic chemotherapy : meta-analysis and pharmacoeconomic evaluation. Journal of Clinical Pharmacy and Therapeutics 1996;21:57-63.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C34	*(cont)* Ensure rapid specialist treatment for cancers when they are diagnosed *(cont)*	Prophylactic cranial irradiation reduces the risk of central nervous system (CNS) relapse in patients with small cell lung cancer who attain a complete remission with chemotherapy. It also improves survival but by a smaller amount.[f] Thoracic radiotherapy reduces mortality in patients with limited small cell lung cancer.[g] Post-operative radiotherapy for non-small cell lung cancer decreases survival.[h] The role of radical radiotherapy for stage I and II non-small-cell lung cancer patients unable to undergo surgery is the subject of a review in progress.[i] Evidence suggests that CHART (Continuous Hyper-fractionated Accelerated Radiotherapy) should be offered to suitable patients with non small-cell lung cancer.[j]	d. **Agra Y, Pelayo M, Sacristan A, Urrutia G, Bonfill X. Chemotherapy for extensive small cell lung cancer [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000 Oxford: Update Software.** e. **Sculier JP, Berghmans T, Castaigne C, Luce S, Sotiriou C, Vermylen P, Paesmans M. Maintenance chemotherapy for small cell lung cancer: a critical review of the literature. Lung Cancer 1998;19:141-51.** f. Auperin A, Arriagada R, Pignon JP, Le Pechoux C, Gregor A, Stephens RJ, Kristjansen PE, Johnson BE, Ueoka H, Wagner H, Aisner J. Prophylactic cranial irradiation for patients with small cell lung cancer in complete remission. New England Journal of Medicine 1999;341:476-84. g. Arriagada R, Pignon JP, Ihde DC, Johnson DH, Perry MC, Souhami RL, Brodin O, Joss RA, Kies MS, Lebeau B, Onoshi T, Osterlind K, Tattersall MH, Wagner H. Effect of thoracic radiotherapy on mortality in limited small cell lung cancer. A meta-analysis of 13 randomized trials among 2,140 patients. Anticancer Research 1994;14:333-5. **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998**. h. PORT Meta-analysis Trialists Group. Postoperative radiotherapy in non-small-cell lung cancer: systematic review and meta-analysis of individual patient data from nine randomised controlled trials. Lancet 1998;352:257-63. i. **Rowell NP, Williams CJ. Radical radiotherapy for stage 1/11 non-small cell lung cancer in patients not sufficiently fit for or declining surgery [Protocol for a Cochrane Review]. In: The Cochrane Library. Issue 1, 2000. Update Software.** j. **NHS Centre for Reviews and Dissemination. Management of lung cancer. Effective Health Care 1998;4:12.**
		<u>Gynaecological cancers:</u> <u>Cervical cancer:</u> Radiotherapy improves survival in cervical cancer. Simultaneous treatment with cisplatin and radiotherapy increases survival rates in women with high-	a. Swedish Council on Technology Assessment in Health Care. Cervical cancer (cervix uteri). Acta Oncologica 1996;2:75-80. **NHS Centre for Reviews and Dissemination. The management of gynaecological cancers. Effective**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*
C34	*(cont)* Ensure rapid specialist treatment for cancers when they are diagnosed *(cont)*	risk cervical cancer.[a] A review on neoadjuvant chemotherapy[b] is underway. A review of the effectiveness of concomitant chemotherapy and radiation therapy with standard radiotherapy in the treatment of locally advanced carcinoma of the cervix is underway.[c] There is no evidence to support the use of induction chemotherapy followed by radiotherapy for advanced cervical cancer.[d] There is no one superior surgical technique for treatment of cervical intraepithelial neoplasia (CIN).[e] A review comparing immediate versus delayed treatment for cervical intraepithelial neoplasia is underway.[f] <u>Endometrial cancer:</u> Adjuvant progestagen therapy in the primary treatment of endometrial cancer has not been shown to be benefiical.[g] Radiotherapy improves the outcome of women with endometrial cancer.[h] <u>Ovarian cancer:</u> There is no evidence supporting the use of adjuvant radiotherapy in the treatment of early ovarian cancer.[i] Patients with recurrent ovarian cancer, particularly after a prolonged clinical remission, can have increased survival benefit from optimal secondary de-bulking surgery.[j] A review using individual patient data from randomised trials of chemotherapy in advanced ovarian cancer suggests that platinum-based chemotherapy is better than non-platinum therapy. There was some evidence that combination therapy improves survival compared with platinum alone. No difference in effect was found between cisplatin and carboplatin.[k]

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b. **Cervix cancer meta-analysis collaboration. Neoadjuvant chemotherapy for locally advanced cervix cancer [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

c. **Green J, Fresco L, Kirwan J, Symonds P, Tierney J, Williams C. Concomitant chemotherapy and radiation therapy for cancer of the uterine cervix [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 3, 2000. Oxford: Update Software.**

d. Shueng PW, Hsu WL, Jen YM, Wu CJ, Liu HS. Neoadjuvant chemotherapy followed by radiotherapy should not be a standard approach for locally advanced cervical cancer. International Journal of Radiation Oncology, Biology, Physics 1998;40:889-96.

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g. **Martin-Hirsch PL, Jarvis G, Kitchener H, Lilford R. Progestagens for endometial cancer. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

h. Swedish Council on Technology Assessment in Health Care. Uterine cancer (corpus uteri). Acta Oncologica 1996;2:81-5.

i. Swedish Council on Technology Assessment in Health Care. Ovarian cancer. Acta Oncologica 1996;2:86-92.

j. Bristow RE, Lagasse LD, Karlan BY. Secondary surgical cytoreduction for advanced epithelial ovarian cancer: patient selection and review of the literature. Cancer 1996;78:2049-62.

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	POLICY	SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE	REFERENCES
C34	*(cont)* Ensure rapid specialist treatment for cancers when they are diagnosed *(cont)*	Vulval cancer: Evidence from a review of surgical treatments for early squamous cell carcinoma of the vulva concludes that radical local excision, ipsilateral lymph node dissection in lateral tumors and triple incision technique are safe treatment options for early vulvar cancer. However, superficial groin node dissection results in an excess of groin recurrences compared to a full femoro-inguinal groin node dissection.[l]	l. **Ansink A, Van der Velden J. Surgical interventions for treating early squamous vulval cancer. [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software**.
		Breast cancer: When managing ductal carcinoma in situ of the breast, lumpectomy followed by radiotherapy is an appropriate alternative for most patients. The use of lumpectomy alone in selected patients remains controversial.[a] A review on post-operative radiotherapy for ductal carcinoma in situ is in preparation.[b] Sentinel lymph node biopsy reflects the status of the axilla in 97% of cases and has a false negative rate of 5%.[c] Patients treated with breast conserving surgery have comparable survival rates to patients allocated to mastectomy. Mastectomy without adjuvant radiation appears to be inferior to breast conserving therapy for node positive patients.[d] It is important to select treatment on an individual basis taking into account factors such as the risk of local recurrence and the likely impact of disfigurement.[e] Evidence suggests that women who had breast conservation had a more favourable image of themselves, but the evidence on other parameters is inconclusive and the quality of the relevant evidence is poor.[f] Evidence suggests that in early breast cancer, radiotherapy produces a two-thirds reduction in local recurrence of the disease, and would be expected to produce an absolute increase in 20-year survival of about 2-4% were it not for the long-term hazards associated with the therapy. The average hazard reduces this 20-year survival benefit in young women and reverses it in older women.[g] This review is ongoing.[h] A review on immunotherapy for early breast cancer is in preparation,[i] but the evidence from a previous review is that immunotherapy does not confer any	a. Fonseca R, Hartmann LC, Petersen IA, Donohue JH, Crotty TB, Gisvold JJ. Ductal carcinoma in situ of the breast. Annals of Internal Medicine 1997; 127:1013-22. b. **Ghersi D, Simes RJ, Lockwood S. Post operative radiotherapy for ductal carcinoma in situ of the breast. [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. Miltenburg DM, Miller C, Karamlou TB, Brunicardi FC. Meta-analysis of sentinel lymph node biopsy in breast cancer. Journal of Surgical Research 1999;84:138-42. d. Morris AD, Morris RD, Wilson JF, White J, Steinberg S, Okunieff P, Arriagada R, Le MG, Blichert Toft M, van Dongen JA. Breast-conserving therapy vs mastectomy in early-stage breast cancer: a meta-analysis of 10-year survival. Cancer Journal from Scientific American 1997;3:6-12. **NHS Executive. Guidelines on improving outcomes in breast cancer. London: Department of Health, 1997.** e. **NHS Centre for Reviews and Dissemination. The management of primary breast cancer. Effective Health Care 1996:2(6).** f. Irwig L, Bennetts A. Quality of life after breast conservation or mastectomy: a systematic review. Australian and New Zealand Journal of Surgery 1997;67:750-4. g. Early Breast Cancer Trialists' Collaborative Group. Favourable and unfavourable effects on long-term survival of radiotherapy for early breast cancer: an overview of the randomised trials. Lancet 2000;355:1757-70. h. **Early Breast Cancer Trialists' Collaborative Group. Radiotherapy for early breast cancer. [Protocol for a**

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POLICY

C34 *(cont)* Ensure rapid specialist treatment for cancers when they are diagnosed *(cont)*

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survival benefit.[j]

Adjuvant systemic therapy in breast cancer using tamoxifen, ovarian ablation, or chemotherapy, improves survival and reduces recurrence rates in many women and is cost-effective.[k]

Evidence strongly favours some years of adjuvant tamoxifen for a wide range of women with early breast cancer, at least in terms of recurrence and survival, and the balance of the known long-term benefits and risks.[l] This review is ongoing.[m]

There is evidence that ablation of functioning ovaries in early breast cancer in women aged under 50 significantly improves long-term survival, at least in the absence of chemotherapy. Further randomised evidence is needed on the additional effects of ovarian ablation in the presence of other adjuvant treatments, and to assess the relevance of hormone-receptor measurements.[n]

Some months of adjuvant polychemotherapy typically produces an absolute improvement of about 7-11% in 10-year survival for women aged under 50 at presentation with early breast cancer, and of about 2-3% for those aged 50-69 (unless their prognosis is likely to be extremely good even without such treatment). Treatment decisions involve consideration not only of improvements in cancer recurrence and survival but also of adverse side-effects of treatment, no recommendations are offered as to who should or should not be treated.[o] This review is ongoing.[p]

Evidence suggests that combined cytotoxic and endocrine adjuvant therapies might be the most effective use of available treatments for most, if not all, patients with operable breast cancer.[q]

A review on follow-up strategies for women treated for early breast cancer is in preparation.[r] Evidence from a consensus statement suggests that mammography at one or two-year intervals, depending on the type of primary surgery and age of the patient, is the most effective follow-up after primary treatment. Evidence does not call for the routine use of any other instrumental test.[s]

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k. **Early Breast Cancer Trialists' Collaborative Group. Ovarian ablation in early breast cancer: overview of the randomised trials. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**.

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Early Breast Cancer Trialists' Collaborative Group Polychemotherapy for early breast cancer: an overview of the randomised trials. Lancet 1998;352:930-42.

Hall PD, Lesher BA, Hall RK. Adjuvant therapy of node-negative breast cancer. Annals of Pharmacotherapy 1995;29:289-98.

l. Early Breast Cancer Trialists' Collaborative Group. Tamoxifen for early breast cancer: an overview of the randomised trials. Lancet 1998;351:1451-67.

m. **Early Breast Cancer Trialists' Collaborative Group. Tamoxifen for early breast cancer. [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

n. Early Breast Cancer Trialists' Collaborative Group. Ovarian ablation in early breast cancer: overview of the randomised trials. Lancet 1996;348:1189-96.

o. Early Breast Cancer Trialists' Collaborative Group Polychemotherapy for early breast cancer: an overview of the randomised trials. Lancet 1998;352:930-42.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C34	*(cont)* Ensure rapid specialist treatment for cancers when they are diagnosed *(cont)*	Chemotherapy and hormonal therapy for women with metastatic breast cancer, offers a modest survival benefit but there is no evidence on the impact on quality of life.[t] The effectiveness of tamoxifen appears similar to ovarian ablation in premenopausal women with metastatic breast cancer.[u] Strong evidence supports the use of bisphosphonates to reduce both skeletal events (osteoporosis, osteolysis and pathologic fractures) and pain in multiple myeloma and in breast cancer patients with metastatic bone disease. Evidence also suggests bisphosphonates are useful as part of a pain management program for bone metastases from carcinoma of the breast, lung, and prostate, and for symptomatic myeloma. The bisphosphonates appear to be well tolerated.[v]	p **Early Breast Cancer Trialists' Collaborative Group. Multi-agent chemotherapy for early breast cancer. [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** q. Colleoni M, Coates A, Pagani O, Goldhirsch A. Combined chemo-endocrine adjuvant therapy for patients with operable breast cancer: still a question? Cancer Treatment Reviews 1998;24:15-26. r. **Fossati R, Confalonieri C, Liberati A. Follow-up strategies for women treated for early breast cancer [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** s Anonymous Consensus statement of the jury. Consensus Conference on 'Follow-up of Breast Cancer Patients'. Annals of Oncology 1995;6 (Suppl 2):69-70. t. Fossati R, Confalonieri C, Torri V, Ghislandi E, Penna A, Pistotti V, Tinazzi A, Liberati A. Cytotoxic and hormonal treatment for metastatic breast cancer: A systematic review of published randomized trials involving 31,510 women. Journal of Clinical Oncology 1998;16:3439-60. u. Crump M, Sawka CA, DeBoer G, Buchanan RB, Ingle JN, Forbes J, Meakin JW, Shelley W, Pritchard KI. An individual patient-based meta-analysis of tamoxifen versus ovarian ablation as first line endocrine therapy for premenopausal women with metastatic breast cancer. Breast Cancer Research and Treatment 1997;44:201-10. v. Bloomfield DJ. Should bisphosphonates be part of the standard therapy of patients with multiple myeloma or bone metastases from other cancers? An evidence-based review. Journal of Clinical Oncology 1998;16:1218-25.
		Colorectal Cancer: In early colorectal cancer surgery, care must be taken to remove tumour involvement at the circumferential margins, since such involvement is associated with high recurrence rates of colorectal cancer.[a] Routine pre-operative radiotherapy can improve outcome in patients with rectal cancer *except* in cases where there are low (<10%) local recurrence rates.[a]	a. **NHS Executive. Guidelines on improving outcomes in colorectal cancer. London: Department of Health, 1997.** b. MacRae HM, McLeod RS. Handsewn vs stapled anastomoses in colon and rectal surgery: a meta-analysis. Diseases of the Colon and Rectum 1998;41:180-9. c. **NHS Executive. Guidelines on improving outcomes in colorectal cancer. London: Department of Health, 1997.** **NHS Centre for Reviews and Dissemination. The management of colorectal cancer. Effective Health**
C34	*(cont)* Ensure rapid specialist	In surgery for colorectal cancer, intra-operative technical problems and	

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POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
treatment for cancers when they are diagnosed *(cont)*	postoperative strictures were more common with stapled anastomoses than hand sewn anastomoses, but there were no differences detected in other outcomes.[b] The use of prolonged (>3months) systemic chemotherapy, particularly if established early on, can improve survival in early operable colorectal cancer.[c] Evidence suggests that adjuvant 5-fluorouracil (5-FU) chemotherapy (with or without other cytotoxic drugs) delivered through the portal vein for about 1 week directly after surgery in patients with colorectal cancer may produce an absolute improvement in 5 year survival of around 5% percent. This evidence, however, is not strong.[d] Continuous infusion of 5-FU is superior to bolus 5-FU when used in advanced colorectal cancer.[e] Modulation of 5-FU by methotrexate doubles the response rate compared to 5-FU alone and yields a small improvement in survival.[f] Evidence shows the benefit of biomodulation of 5-fluorouracil by leucovorin.[g] Hepatic artery infusion chemotherapy increases survival over systemic chemotherapy in patients with colorectal cancer that has metastasized to the liver.[h] Intensive follow-up detects more recurrent cancers at a stage amenable to curative resection, resulting in an improvement in survival.[i]	**Care. 1997;3(6).** d. Gray R, Clarke M, Collins R, Peto R, Piedbois P, Buyse M. Portal vein chemotherapy for colorectal cancer: a meta-analysis of 4000 patients in 10 studies. Journal of the National Cancer Institute 1997;89:497-505. e. Meta-analysis Group in Cancer. Efficacy of intravenous continuous infusion of fluorouracil compared with bolus administration in advanced colorectal cancer. Journal of Clinical Oncology 1998;16:301-8. f. Advanced Colorectal Cancer Meta-Analysis Project. Meta-analysis of randomized trials testing the biochemical modulation of fluorouracil by methotrexate in metastatic colorectal cancer. Journal of Clinical Oncology 1994;12:960-9. g. Advanced Colorectal Cancer Meta-Analysis Project. Modulation of fluorouracil by leucovorin in patients with advanced colorectal cancer: evidence in terms of response rate. J Clin Oncol 1992;10:896-903. What can we learn from a meta-analysis of trials testing the modulation of 5-FU by leucovorin? Advanced Colorectal Meta-analysis Project. Piedbois P, Buyse M. Annals of Oncology 1993; 4:S15-9. h. Harmantas A, Rotstein LE, Langer B. Regional versus systemic chemotherapy in the treatment of colorectal carcinoma metastatic to the liver. Is there a survival difference? Meta-analysis of the published literature. Cancer 1996;78:1639-45. i. Rosen M, Chan L, Beart RW, Vukasin P, Anthone G. Follow-up of colorectal cancer: a meta-analysis. Diseases of the Colon and Rectum 1998;41:1116-26.
C34 *(cont)* Ensure rapid specialist	<u>Central Nervous System cancers:</u> There is a lack of data from high quality studies testing the utility of stereotactic radiotherapy for brain metastases.[a] Radiotherapy only produces modest survival benefits for gliomas but is more effective than chemotherapy.[b] The addition of chemotherapy to radiotherapy for malignant gliomas improves survival.[c]	a. Anderson D, Flynn K. Stereotactic radiosurgery for metastases to the brain: a systematic review of published studies of effectiveness. Technology Assessment Program 1997;7:1-16. b. Blomgren H for SBU, the Swedish Council on Technology Assessment in Health Care. Brain tumors. Acta Oncological 1996;35:16-21. c. Fine HA, Dear KB, Loeffler JS, Black PM, Canellos GP. Meta-analysis of radiation therapy with and without adjuvant chemotherapy for malignant gliomas in adults. Cancer 1993;71:2585-97. d. Huncharek M, Muscat J, Geschwind JF. Multi-drug

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POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
treatment for cancers when they are diagnosed *(cont)*	Single agent versus multiple agent drug chemotherapy does not show a benefit for combination chemotherapy regimens in patients with high grade astrocytoma.[d] The effects of emergency treatment of malignant extradural spinal cord compression are unclear.[e]	versus single agent chemotherapy for high grade astrocytoma; results of a meta analysis. Anticancer Research 1998;18:4693-7. e. Loblaw DA, Laperriere JJ. Emergency treatment of malignant extradural spinal cord compression: an evidence-based guideline. Journal of Clinical Oncology 1998;16:1613-24.
	<u>Testicular cancer:</u> A review on the role of bleomycin in the treatment of testicular cancer is in preparation.[a]	a. **Oliver RTD, Collette L, Stenning S, Fish RG, Mason M. Bleomycin for testicular cancer [Protocol for a Cochrane Review] Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	<u>Soft Tissue Sarcoma:</u> Doxorubicin-based adjuvant chemotherapy significantly improves recurrence-free survival in adults with resectable soft tissue sarcoma, but there is no clear evidence of an effect on overall survival.[a]	a. **Sarcoma Meta-analysis Collaboration (SMAC). Adjuvant chemotherapy for localised resectable soft tissue sarcoma in adults. [Cochrane Review]. Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	<u>Bladder cancer:</u> There is insufficient evidence to support the use of neo-adjuvant cisplatin-based chemotherapy for patients with locally advanced bladder cancer.[a] There is no evidence to support routine use of pre-operative radiation therapy in the treatment of muscle invasive bladder cancer.[b] Adjuvant intravesical chemotherapy for superficial bladder cancer prolongs disease-free interval but has no apparent long-term impact.[c] A review on the use of bacillus calmette-guerin (BCG) in high-risk superficial bladder cancer is underway.[d]	a. **Advanced Bladder Cancer Overview Collaboration. Neoadjuvant cisplatin for advanced bladder cancer [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. Huncharek M, Muscat J, Geschwind JF. Planned preoperative radiation therapy in muscle invasive bladder cancer; results of a meta analysis. Anticancer Research 1998;18:1931-4. c. Pawinski A, Sylvester R Kurth KH, Bouffioux C, van der Meijden A, Parmar MK. A combined analysis of European Organisation for Research and Treatment of Cancer, and Medical Research Council randomised clinical trials for the prophylactic treatment of stage TaT1 bladder cancer. EORTC Genitourinary Tract Cancer Co-operative Group and the Medical Research Council Working Party on Superficial Bladder Cancer. Journal of Urology 1996;156:1934-40. Discussion 1940-41. d. **Shelley MD, Fish RG, Kynaston H, Mason M,Wilt T.**
C34 *(cont)* Ensure rapid specialist		**Intravesical Bacillus Calmette-Guerin (BCG) for**

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POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
treatment for cancers when they are diagnosed *(cont)*		**high risk superficial bladder cancer [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	Hepatocellular cancer: There is no evidence to support routine use of tamoxifen in treating hepatocellular cancer.[a] A combination of 5-fluorouracil, adriamycin and transarterial chemotherapy for hepatocellular cancer is not associated with survival benefit at 1 year.[b] There is no evidence that current non-surgical treatments for hepatocellular carcinoma are effective, either alone,[c] or as adjuvant therapy.[d] Systematic review of chemotherapy for inoperable hepatocellular carcinoma is underway.[e]	a. **Findlay M, Vijuk G, Simes J, Stockler M. Tamoxifen for hepatocellular carcinoma [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. Mathurin P, Rixe O, Carbonell N, Bernard B, Cluzel P, Bellin MF, Khayat D, Opolon P, Poynard T. Overview of medical treatments in unresectable hepatocellular carcinoma – an impossible meta-analysis? Alimentary Pharmacology Therapy 1998;12:111-26. c. Simonetti RG, Liberati A, Angiolini C, Pagliaro L Treatment of hepatocellular carcinoma: a systematic review of randomised controlled trials. Annals of Oncology 1997;8:117-36. d. **Chan ESY, Chow PKH, Tai BC, Machin D, Soo KC. Neoadjuvant and adjuvant therapy for operable hepatocellular carcinoma. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** e. **Chow KH, Chan ESY, Tai BC, Soo KC, Machin D. Systemic chemotherapy for inoperable hepatocellular carcinoma [Protocol for a Cochrane Review] The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
(cont) Ensure rapid specialist	Bone neoplasms: Use of a high dose intensity of methotrexate is associated with significant improvement in outcome (disease free survival) in patients with localized high grade osteosarcoma.[a] Chemotherapy improves survival in craniofacial osteosarcoma.[b] Pain relief obtained using radiotherapy for bone metastases is generally poor. Higher dose, fractionated radiotherapy treatments produce a greater frequency, magnitude, and duration of response with better pain relief.[c] Strong evidence supports the use of bisphosphonates to reduce both skeletal events (osteoporosis, osteolysis and pathologic fractures) and pain in multiple myeloma and in breast cancer patients with metastatic bone disease. Evidence also suggests bisphosphonates are useful as part of a pain management	a. Delepine N, Delepine G, Bacci G Rosen G, Desbois JC. Influence of methotrexate dose intensity on outcome of patients with high grade osteogenic osteosarcoma. Analysis of the literature. Cancer. 1996;78:2127-35. b. Smeele LE, Kostense PJ, Van der Waal I, Snow GB. Effect of chemotherapy on survival of craniofacial osteosarcoma: A systematic review of 201 patients. Journal of Clinical Oncology 1997;15:363 –7. c. Ratanatharathorn V, Powers WE, Moss WT, Perez CA. Bone metastasis: Review and critical analysis of random allocation trials of local field treatment. International Journal of Radiation, Oncology, Biology, Physics. 1999;44:1-18. d. Bloomfield DJ. Should bisphosphonates be part of the standard therapy of patients with multiple myeloma or bone metastases from other cancers? An evidence-based

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C34	treatment for cancers when they are diagnosed *(cont)*	program for bone metastases from carcinoma of the breast, lung, and prostate, and for symptomatic myeloma. The bisphosphonates appear to be well tolerated.[d]	review. Journal of Clinical Oncology 1998;16:1218-25.
		Renal cancer: A review on immunotherapy for advanced renal cell cancer is underway.[a] The effect of interferon-alpha (IFN-alpha) as single agent or in combination in the treatment of metastatic malignant melanoma or of advanced renal cell carcinoma was evaluated in a recent meta-analysis. The reviewers found better response rates and prolonged survival were achieved for both diseases with regimens that included IFN-alpha.[b]	a. **Coppin C, Porzsolt F, Kumpf J, Coldman A. Immunotherapy for advanced renal cancer. [Protocol for a Cochrane Review] The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. Hernberg M, Pyrhönen S, Muhonen T. Regimens with or without interferon-alpha as treatment for metastatic melanoma and renal cell carcinoma: an overview of randomized trials. Journal of Immunotherapy 1999; 22:145-54.
		Skin cancer: There is no evidence that systemic treatments for metastatic cutaneous melanoma found are superior to best supportive care or placebo.[a]	a. **Crosby T, Fish R, Coles B, Mason MD. Systemic treatments for metastatic cutaneous melanoma. [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.**
		Head and neck cancer: Transpupillary thermotherapy improves local tumour control in posterior choroidal melanoma.[a] Survival following ruthenium plaque radiotherapy for uveal melanoma compares favourably with survival after enucleation for similarly sized tumours.[b] Simultaneous use of chemotherapy and definitive local therapy for squamous cell carcinoma of the head and neck, improved survival but increased morbidity.[c] Technical advances in radiotherapy offer the potential for better local tumour control in head and neck cancer, with less morbidity, but will require more sophisticated dose planning resources.[d] There is no reliable evidence that pre-operative radiotherapy of an improved rate of survival in patients with resectable oesophageal cancer.[e]	a. Gruterich M, Mueller AJ, Ulbig M, Kampik A. What is the value of transpupillary thermotherapy in treatment of flat posterior choroid melanomas? Klin Monatsbl Augenheilkd: 1999;215:147-51. b. Seregard S. Long term survival after ruthenium plaque radiotherapy for uveal melanoma. A meta-analysis of studies including 1066 patients. Acta Ophthalmologica Scandinavica 1999;77:414-7. c. El Sayed S, Nelson N. Adjuvant and adjunctive chemotherapy in the management of squamous cell carcinoma of the head and neck region. A meta-analysis of prospective and randomised trials. Journal of Clinical Oncology 1996;14:838-47. d. Moller T for SBU, the Swedish Council on Technology Assessment in Health Care. Head and Neck Cancer. Acta Oncologica 1996;35:22-45. e. Arnott SJ, Duncan W, Gignoux M, Girling DJ, Hansen HS, Launois B, Nygaard K, Parmar MK, Roussel A, Spiliopoulos G, Stewart LA, Tierney JF, Mei W, Rugang Z. (Oesophageal Cancer Collaborative Group). Pre-operative radiotherapy in esophageal carcinoma: a meta-analysis using individual patient data. International
	(cont) Ensure rapid specialist		

CANCER: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
C34	treatment for cancers when they are diagnosed		Journal of Radiation Oncology, Biology, Physics. 1998;41:579-83.
		Leukaemia: No cures based on systemic therapy have been found for patients with cutaneous T-cell lymphomas, although both single and combined chemotherapeutic agents produce high response rates. No evidence has been found to recommend one particular agent over another, but systemic therapy can be considered effective and palliative.[a] Conservative treatment strategies for chronic lymphatic leukaemia produce the best level of survival. This would be deferred chemotherapy for most patients with early-stage disease, and single-agent chlorambucil as the first line of treatment for most patients with advanced disease. No evidence of benefit from early inclusion of an anthracycline has been found.[b] For patients with Philadelphia chromosome positive chronic myeloid leukaemia, alpha-interferon increases survival compared with standard chemotherapy.[c] There is insufficient evidence of the effect in other types of chronic myeloid leukaemia.[c] A new review of alpha-interferon for chronic myeloid leukaemia is underway.[d] Intensive reinduction chemotherapy produces a small absolute improvement in long term survival in children with acute lymphoblastic leukaemia.[e] CNS radiotherapy appears to result in cognitive deficits in children treated for acute lymphoblastic leukaemia.[f] Evidence suggests that induction regimens based on idarubicin achieve better remission rates and better overall survival than those based on daunorubicin.[g]	a. Bunn PA, Hoffman SJ, Norris D. Systemic therapy of cutaneous T-cell lymphomas (mycosis fungoides and the Sezary syndrome). Annals of Internal Medicine 1994;121:592-602. b. CLL Trialists' Collaborative Group. Chemotherapeutic options in chronic lymphocytic leukemia: a meta-analysis of the randomised trials. Journal of the National Cancer Institute 1999;91:861-8. c. Chronic Myeloid Leukemia Trialists' Collaborative Group. Interferon alfa versus chemotherapy for chronic myeloid leukemia: a meta-analysis of seven randomised trials. J National Cancer Inst: 1997;89:1616-20. d. **Baillie K. Alpha-interferon for chronic myeloid leukaemia [Protocol for a Cochrane Review]. The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** e. Childhood ALL Collaborative Group. Duration and intensity of maintenance chemotherapy in acute lymphoblastic leukaemia: overview of 42 trials involving 12,000 randomised children. Lancet 1996;347:1783-8. f. Cousens P, Waters B, Said J, Stevens M. Cognitive effects of cranial irradiation in leukaemia: a survey and meta-analysis. Journal of Child Psychology and Psychiatry and Allied Disciplines 1988;29:839-52. g. AML Collaborative Group. A systematic collaborative overview of randomized trials comparing idarubicin with daunorubicin (or other anthracyclines) as induction therapy for acute myeloid leukaemia. British Journal of Haematology 1998;103:100-9.
C34	*(cont)* Ensure rapid specialist treatment for cancers when	Haematological cancer: Combined radiotherapy and chemotherapy for Hodgkin's disease has a significantly inferior survival compared to chemotherapy alone.[a] In early stage Hodgkin's Disease patients, less intensive primary treatment, particularly a reduction in radiotherapy fields, appears to achieve similar survival rates to more intensive treatment.[b] Early stage Hodgkin's disease in children is mostly curable but that there is not enough evidence to show which treatments are best in the long term.[c]	a. Loeffler M, Brosteanu O, Hasenclever D, Sextro M, Assouline D, Bartolucci AA, Cassileth PA, Crowther D, Diehl V, Fisher RI, Hoppe RT, Jacobs P, Pater JL, Pavlovsky S, Thompson E, Wienik P. Meta-analysis of chemotherapy versus combined modality treatment trials in Hodgkin's disease. Journal of Clinical Oncology 1998;16:818-29. b. Specht L, Gray RG, Clarke MJ, Peto R. Influence of more extensive radiotherapy and adjuvant chemotherapy on long-term outcome of early stage Hodgkin's disease:

POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
they are diagnosed *(cont)*	High-dose myeloablative therapy and progenitor cell transplantation (HDT/PCT) has not been found to be either superior or inferior in terms of survival when compared to conventional therapy for the treatment of various malignancies.[d] It is uncertain whether alpha interferon maintenance treatment for patients with multiple myeloma offers any survival advantage.[e] Strong evidence supports the use of bisphosphonates to reduce both skeletal events (osteoporosis, osteolysis and pathologic fractures) and pain in multiple myeloma and in breast cancer patients with metastatic bone disease. Evidence also suggests bisphosphonates are useful as part of a pain management program for bone metastases from carcinoma of the breast, lung, and prostate, and for symptomatic myeloma. The bisphosphonates appear to be well tolerated.[f] A review of clodronate vs pamidronate for hypercalcaemia in multiple myeloma is underway.[g]	a meta-analysis of 23 randomised trials involving 3,888 patients. Journal of Clinical Oncology 1998;16:830-43. c. **Louw G, Pinkerton CR. Interventions for early stage Hodgkin's disease in children [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.** d. **Johnson PWM, Simnett SJ, Sweetenham JW, Morgan GJ, Stewart LA. Bone marrow and peripheral blood stem cell transplantation for malignancy. Health Technology Assessment 1998; 2(8).** e. Trippoli S, Becagli P, Messori A, Tendi E. Maintenance treatment with interferon in multiple myeloma: a survival meta-analysis. Clinical Drug Investigation 1997; 14:392-9. f. Bloomfield DJ. Should bisphosphonates be part of the standard therapy of patients with multiple myeloma or bone metastases from other cancers? An evidence-based review. Journal of Clinical Oncology 1998;16:1218-25. g. **John A. Clodronate vs pamidronate for hypercalcaemia in multiple myeloma [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 3, 2000. Oxford: Update Software.**
	<u>General cancer:</u> Evidence published between 1970 and 1998 suggests that the prevalence of complementary and/or alternative therapy (CAM) use among patients with cancer ranges from 7-64%, with an average prevalence of 31.4%. The wide range of prevalence for CAM use was not explained by either regional variations or increasing popularity over time and was considered to be due to different understandings of "complementary/alternative medicine" on the part of both investigators and patients.[a] There is no evidence that mistletoe affects cancer outcome.[b] The literature on psychosocial interventions for children and adolescents with chronic medical illness is of such poor quality that no conclusions could be drawn about its effectiveness.[c] A review on short versus long duration infusions of paclitaxel for any	a. Ernst E, Cassileth BR. The prevalence of complementary/alternative medicine in cancer: a systematic review. Cancer 1998;83:777-82. b. Kleijnen J, Knipschild P. Misletoe treatment for cancer: review of controlled trials in humans. Phytomedicine 1994;1:255-60. c. Kibby MY, Tyc VL, Mulhern RK. Effectiveness of psychological intervention for children and adolescents with chronic medical illness; a meta-analysis. Clinical Psychology Review 1998;18:103-17. d. **Grafton C, Williams C. Short versus long duration infusions of paclitaxel for any advanced adenocarcinoma [Protocol for a Cochrane Review]. The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

CANCER: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
		advanced adenocarcinoma is underway.[d]	
	People can:		
C35	Attend cancer screenings when invited (ie for breast and cervical screening in women)	Cancer screening attendance increases with interventions targeting either the physician or the patient.[a] No systematic reviews have been identified on the impact of such strategies on cancer death rates.	a. Snell JL, Buck EL. Increasing cancer screening: a meta-analysis. Preventive Medicine 1996; 25:702-7.
C36	Participate in managing their own illness and treatment *(cont)*	Providing cancer patients with both written and verbal information about diagnosis and treatment options on a routine basis improves patient satisfaction and patient knowledge about their condition, and it has not been shown to increase anxiety.[a] The provision of recordings or summaries of key consultations may benefit most adults with cancer.[b] Psycho-educational care for adults with cancer decreases anxiety, relieves depression, improves mood, nausea, pain and vomiting and increases patients' knowledge about their condition.[c] Shared decision-making programmes are well received by patients and can be used with a wide variety of health problems.[d] A review on decision aids for people facing health treatment or screening decisions is underway.[e] Decision aids improve knowledge, reduce decisional conflict, and stimulate patients to be more active in decision making without increasing their anxiety. Decision aids have little effect on satisfaction and a variable effect on decisions. The effects on outcomes of decisions (persistence with choice, quality of life) remain uncertain.[f] The full benefits of medications cannot be realised at current levels of adherence. Current methods of improving adherence to follow prescriptions are complex and not very effective.[g]	a. **NHS Executive. Guidelines on improving outcomes in breast cancer. London: Department of Health, 1997.** **NHS Executive. Guidelines on improving outcomes in colorectal cancer. London: Department of Health, 1997.** **NHS Executive. Guidance on commissioning cancer services: improving outcomes in lung cancer. London: Department of Health, 1998**. b. **Scott JT, Entwistle VA, Sowden AJ, Watt I. Recordings or summaries of consultations for people with cancer [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. c. Devine EC. Effects of psycho-educational care for adults with cancer: a meta-analysis of 116 studies. Oncology Nursing Forum 1995;22:1319-81. d. Anderson D.. Shared decision-making programs: descriptive analysis of experience with shared decision making programs in VA. Technology Assessment Program 1997;6:1-12. e. **O'Connor AM, Fiset V, Rostom A, Tetroe JM, Entwistle V, Llewellyn-Thomas HA, Holmes-Rovner M, Barry M, Jones J. Decision aids for people facing health treatment or screening decisions [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** f. O'Connor A M, Rostom A, Fiset V, Tetroe J, Entwistle V, Llewellyn-Thomas H, Holmes-Rovner M, Barry M, Jones J. Decision aids for patients facing health treatment or screening decisions: systematic review. BMJ 1999; 319:731-4. g. **Haynes RB, Montague P, Oliver T, McKibbon KA, Brouwers MC, Kanani R. Interventions for helping**

CANCER: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			patients to follow prescriptions for medications [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.
C37	Seek medical advice promptly if they notice danger signs	Evidence suggests that one third of women with breast cancer symptoms delay seeking help for 3 or more months[a] and that delays in diagnosing breast cancer of 3-6 months are associated with lower survival.[b] No systematic reviews have been identified on the effect of interventions to reduce delay in diagnosis on survival rates.	a. Facione NC. Delay versus help seeking for breast cancer symptoms: a critical review of the literature on patient and provider delay. Social Science and Medicine 1993;36:1521-34. b. Richards MA, Westcombe AM, Love SB, Littlejohns P, Ramirez AJ. Influence of delay on survival in patients with breast cancer: a systematic review. Lancet 1999; 353:1119-26.

CANCER: Additional evidence

Drinking water

Chlorination by-products in drinking water are associated with an increased risk of bladder and rectal cancer.[a]

A systematic review is being carried out to assess effects of drinking water fluoridation.[b]

a. Morris RD, Audet AM, Angelillo IF, Chalmers TC, Mosteller F. Chlorination, chlorination by-products and cancer: A meta-analysis. American Journal of Public Health 1992;82:955-63.

b. **NHS Centre for Reviews and Dissemination. Fluoridation of drinking water: a systematic review of its efficacy and safety. NHS Centre for Reviews and Dissemination, The University of York. 2000 (in preparation).**

Treatment of side-effects associated with cancer treatments

Several reviews have examined effective treatment for side-effects in cancer patients.

Antifungal therapy is effective in cancer patients with neutropenia.[a] Fluoroquinolones plus other antibiotics significantly reduce the occurrence of gram negative and positive bacteremia without affecting the incidence of morbidity or mortality in patients receiving chemotherapy.[b] Quinolone prophylaxis substantially reduces the incidence of various infection-related outcomes but not deaths in cancer patients who are neutropenic following chemotherapy.[c]

P6 acupuncture seems to be an effective antiemetic technique.[d] 5-HT3 antiemetics have similar efficacy to high dose metoclopramide, with fewer side-effects.[e]

Reviews of the effects of non-surgical interventions for late radiation cystitis and proctitis in patients who have received radical radiotherapy to the pelvis are underway.[f]

There is some evidence that ice chips prevent mucositis in patients receiving chemotherapy. None of the other prophylactic agents in the review prevented mucositis although prophylactic antifungal agents reduced the incidence of oral candidiasis.[g] A review of treatment of oral mucositis in patients receiving chemotherapy is underway.[h] Another review is being prepared assessing the effects of treatment of oral candidiasis for cancer patients receiving chemotherapy and/or radiotherapy.[i]

The value of conservative management strategies for post prostatectomy incontinence remains uncertain.[j]

a. Cruciani M, Rampazzo R, Malena M, Lazzarini L, Todeschini G, Messori A, Concia E. Prophylaxis with fluoroquinolones for bacterial infections in neutropenic patients: a meta-analysis. Clinical Infectious Diseases 1996;23:795-805.

   Gøtzsche PC, Johansen HK. Routine versus selective antifungal administration for control of fungal infections in patients with cancer [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

b. Cruciani M, Rampazzo R, Malena M, Lazzarini L, Todeschini G, Messori A, Concia E. Prophylaxis with fluoroquinolones for bacterial infections in neutropenic patients: a meta-analysis. Clinical Infectious Diseases 1996;23:795-805.

c. Engels EA, Lau J, Barza M. Efficacy of quinolone prophylaxis in neutropenic cancer patients: a meta-analysis. Journal of Clinical Oncology 1998;16:1179-87.

d. Vickers AJ. Can acupuncture have specific effects on health?: a systematic review of acupuncture antiemesis trials. Journal of the Royal Society of Medicine 1996;89:303-11.

e. Jantunen IT, Kataja VV, Muhonen TT. An overview of randomised studies comparing 5-HT3 receptor antagonists to conventional anti-emetics in the prophylaxis of acute chemotherapy-induced vomiting. European Journal of Cancer 1997;33:66-74.

f. **Denton AS, Maher EJ. Non-surgical interventions for late radiation cystitis in patients who have received radical radiotherapy to the pelvis [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

   Denton AS, Maher EJ. Non-surgical interventions for late radiation proctitis in patients who have received radical radiotherapy to the pelvis [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

g. **Clarkson JE, Worthington HV, Eden OB. Prevention of oral mucositis or oral candidiasis for patients with cancer receiving chemotherapy (excluding head and neck cancer) [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

h. **Worthington HV, Clarkson JE, Eden OB. Treatment of oral mucositis or its associated pain for patients with cancer receiving chemotherapy and or radiotherapy [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

i. **Clarkson JE, Worthington HV, Eden OB. Treatment of oral candidiasis for patients with cancer receiving chemotherapy and or radiotherapy [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

j. **Moore KN, Cody DJ, Glazener CMA. Conservative management of post prostatectomy incontinence [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

A NATIONAL CONTRACT ON HEART DISEASE AND STROKE

HEART DISEASE AND STROKE: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
H1	Continue to make smoking cost more through taxation	Higher cigarette prices reduce cigarette consumption.[a] However, the effect of increasing prices differs across demographic groups; more marked reduction in consumption is shown with increasing price amongst women and young people.[b] In the poorest groups, an increase in price produces significant hardship for those who do not curtail their consumption.[b]	a. Chaloupka FJ, Wechsler H. Price, tobacco control policies and smoking among adults. Journal of Health Economics 1997;16:359-73. Choi BCK, Ferrence RG, Pack AWP. Evaluating the effects of price on the demand for tobacco products: review of methodologies and studies. Ontario Tobacco Research Unit, 1997. **Department of Health. Guidance on commissioning cancer services: improving outcomes in lung cancer. Leeds: Department of Health, 1998.** b. **Department of Health. Guidance on commissioning cancer services: improving outcomes in lung cancer. Leeds: Department of Health, 1998.**
H2	Tackle joblessness, social exclusion, low educational standards and other factors which make it harder to live a healthier life	Social instability, unemployment and job insecurity are associated with high blood pressure and raised mortality rates.[a] In particular, depression and lack of social support appear to be independently associated with increased risk of coronary heart disease.[b] The direct effects of income supplementation have been subjected to randomised controlled trials but reliable estimates of health outcomes have not been made.[c] Structural and legislative measures are the most effective interventions in reducing health inequalities.[d]	a. Schnall PL, Landsbergis PA. Job strain and cardiovascular disease. Annual Review of Public Health 1994;15:381-411. b. Hemingway H, Marmot M. Evidence based cardiology: psychosocial factors in the aetiology and prognosis of coronary heart disease. Systematic review of prospective cohort studies. BMJ 1999;318:1460-7. c. Connor J, Rodgers A, Priest P. Randomised studies of income supplementation: a lost opportunity to assess health outcomes. Journal of Epidemiology and Community Health 1999;53:725-30. d. Gepkens A, Gunning SL. Interventions to reduce socioeconomic health differences: A review of the international literature. European Journal of Public Health 1996;6:218-26.

HEART DISEASE AND STROKE: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Local Players and Communities can:		
H3	Tackle social exclusion in the community which makes it harder to have a healthy lifestyle	No systematic reviews were identified in this area.	
H4	Provide incentives to employees to cycle or walk to work, or leave their cars at home	Public health exercise promotion strategies aimed at modifying the environment, to encourage walking and cycling, are likely to reach a greater proportion of the inactive population than efforts that aim to increase the use of exercise facilities.[a]	a. Hillsdon M, Thorogood M. A systematic review of exercise promotion strategies. British Journal of Sports Medicine 1996;30:84-9.
	People can:		
H5	Cycle or walk to work	No systematic reviews were identified in this area.	
H6	Take opportunities to better their lives and their families' lives, through education, training and employment	There is a consistent and continuous gradient between the prevalence of cardiovascular disease and socioeconomic status, such that people from lower socioeconomic status have more disease.[a] The principal measures of socioeconomic status in research have been education, occupation, income or a combination of these.[b] No evidence could be found to support the view that individuals taking responsibility to better their lives results in a reduction of disease prevalence. For many individuals, social circumstances may make it impossible for them to better their lives. Structural and legislative measures are the most effective interventions in reducing health inequalities.[c]	a. **Acheson D. Independent inquiry into inequalities in health report. Department of Health, London, 1998.** Kaplan GA, Keil JE. Socioeconomic factors and cardiovascular disease: a review of the literature. Circulation 1993;88:1973-98. b. **Acheson D. Independent inquiry into inequalities in health report. Department of Health, London, 1998.** c. Gepkens A, Gunning SL. Interventions to reduce socioeconomic health differences: A review of the international literature. European Journal of Public Health 1996;6:218-26.

HEART DISEASE AND STROKE: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
H7	Encourage employers and others to provide a smoke-free environment for non-smokers	Environmental tobacco smoke is associated with an increased incidence of cardiovascular disease.[a] Passive smoking at the workplace has similar coronary heart disease risks to exposure at home.[b] Daily consumption of cigarettes at work can be reduced by employers encouraging a smoke free work environment, but smokers may compensate by smoking more during non-working hours.[c] More recent evidence shows that smoke-free workplaces appear to reduce the overall consumption of cigarettes by a substantial amount.[d] A total ban on cigarettes in the workplace coupled with monetary incentives to quit can improve cessation rates substantially.[c] Work place tobacco policies can reduce tobacco consumption at work and worksite environmental tobacco smoke exposure.[e] A review of interventions for preventing tobacco use in public places is currently being prepared.[f]	a. Law MR, Morris JK, Wald NJ. Environmental tobacco smoke exposure and ischaemic heart disease: an evaluation of the evidence. BMJ 1997;3:973-80. b. Wells AJ. Heart disease from passive smoking in the workplace. Journal of the American College of Cardiology 1998;31:1-9. c. Fielding JE. Smoking control in the workplace. Annual Review of Public Health 1991;12:209-34. d. Chapman S, Borland R, Scollo M, Brownson RC, Dominello A, Woodward S. The impact of smoke-free workplaces on declining cigarette consumption in Australia and the United States. American Journal of Public Health 1999;89:1018-23. e. Erikson MP, Gottlieb NH. A review of the health impact of smoking control at the workplace. American Journal of Health Promotion 1998;13:83-104. Fielding JE. Smoking control in the workplace. Annual Review of Public Health 1991;12:209-34. f. **Serra C, Cabezas C, Bonfill X, Pladevall-Vila M. Interventions for preventing tobacco use in public places [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	Local Players and Communities can:		
H8	Through local employers and others, provide a smoke-free environment for non-smokers	Passive smoking at the workplace is associated with similar coronary heart disease risks as exposure at home.[a] Daily consumption of cigarettes at work can be reduced by employers encouraging a smoke free work environment, but smokers may compensate by smoking more during non-working hours.[b] More recent evidence shows that smoke-free workplaces appear to reduce the overall consumption of cigarettes by a substantial amount.[c] A total ban on cigarettes in the workplace coupled with monetary incentives to quit can improve cessation rates substantially.[b] A review of interventions for preventing tobacco use in public places is currently being prepared.[d]	a. Wells AJ. Heart disease from passive smoking in the workplace. Journal of the American College of Cardiology 1998;31:1-9. b. Fielding JE. Smoking control in the workplace. Annual Review of Public Health 1991;12:209-34. c. Chapman S, Borland R, Scollo M, Brownson RC, Dominello A, Woodward S. The impact of smoke-free workplaces on declining cigarette consumption in Australia and the United States. American Journal of Public Health 1999;89:1018-23. d. **Serra C, Cabezas C, Bonfill X, Pladevall-Vila M. Interventions for preventing tobacco use in public places [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

HEART DISEASE AND STROKE: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H9	Through employers and staff, work in partnership to reduce stress at work	Job insecurity is associated with high blood pressure and raised mortality rates.[a] No systematic reviews of the effects of interventions to reduce stress at work were identified.	a. Schnall PL, Landsbergis PA. Job strain and cardiovascular disease. Annual Review of Public Health 1994;15:381-411.
H10	Implement the Integrated Transport Policy – *A New Deal for Transport*: *Better for Everyone* – including a national cycling strategy and measures to make walking more attractive	Reducing air pollutants due to traffic benefits health. Exposure to air pollutants is associated with earlier deaths and hospital admissions for respiratory and cardiovascular disease. Evidence regarding the effects of particles, ozone and sulphur dioxide is sufficient for the size of the effect to be quantified. For nitrogen dioxide and carbon dioxide there is insufficient evidence to allow quantification but there is evidence to suggest exposure affects health.[a]	a. **Glaister S, Graham D, Hoskins E. COMPEAD statement on: 'Transport and Health in London'. Committee on the Medical Effects of Air Pollutants. Department of Health, October, 1999.**
H11	Provide safe cycling and walking routes	Public health exercise promotion strategies aimed at modifying the environment, to encourage walking and cycling, are likely to reach a greater proportion of the inactive population than efforts that aim to increase the use of exercise facilities.[a]	a. Hillsdon M, Thorogood M. A systematic review of exercise promotion strategies. British Journal of Sports Medicine 1996;30:84-9.
	People can:		
H12	Protect others from second-hand smoke	Residential exposure to passive smoke is associated with increased risk of coronary heart disease, although conclusive evidence of a causal relationship is not presently available.[a] A reduction in residential passive smoking is likely to be particularly effective in protecting the health of children.[b] A systematic review on family/carer smoking control programmes for reducing children's exposure to environmental tobacco smoke is in preparation.[c] Policy makers should be aware that there are many contradictory reviews in this area – those published studies suggesting that passive smoking is not harmful were 88 times more likely to have an author affiliated with the tobacco industry.[d]	a. **Department of Health. Guidance on commissioning cancer services: improving outcomes in lung cancer. Leeds: Department of Health, 1998.** Law MR, Morris JK, Wald NJ. Environmental tobacco smoke exposure and ischaemic heart disease: an evaluation of the evidence. BMJ 1997;3:973-80. He J, Vupputuri S, Allen K, Prerost M, Hughes J, Whelton P. Passive smoking and the risk of coronary heart disease - a meta-analysis of epidemiologic studies. New England Journal of Medicine 1999;340:920-6. b. Hackshaw AK, Law MR, Wald MJ. The accumulated evidence on lung cancer and environmental tobacco smoke. BMJ 1997;315:980-8. c. **Waters E, Campbell R, Webster P, Spencer N. Family and carer smoking control programmes for reducing children's exposure to environmental tobacco smoke [Protocol for a Cochrane review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. Barnes DE, Bero LA. Why review articles on the health effects of passive smoking reach different conclusions. JAMA 1998;279:1566-70.

HEART DISEASE AND STROKE: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
H13	Control advertising and promotion of cigarettes	Control of advertising is an effective intervention to reduce smoking.[a] Interventions aimed at retailers to enforce the legal age limit on selling cigarettes to young people reduces their access to cigarettes but there is no evidence that this affects smoking behaviour.[b] Restricting access to cigarette vending machines limits access, but has not been shown to affect behaviour.[c] Stronger regional, national and international strategies are required if restriction of youth access is to contribute to a reduction in smoking prevalence in this age group.[d]	a. **Department of Health. Guidance on commissioning cancer services improving outcomes in lung cancer. Leeds: Department of Health, 1998.** **Smee C. Effect of tobacco advertising on tobacco consumption: a discussion document reviewing the evidence. London: Department of Health, 1992.** Sone T. Effects of tobacco advertising regulations in various countries. Nippon Koshu Eisei. Zasshi 1995;42:1017-28. b. **Department of Health. Guidance on commissioning cancer services improving outcomes in lung cancer. Leeds: Department of Health, 1998.** US Department of Health and Human Resources. Preventing tobacco use among young people: a report of the Surgeon General, 1994. c. **Anonymous. Smoking kills executive summary. London: Department of Health, 1998**. US Department of Health and Human Resources. Preventing tobacco use among young people: a report of the Surgeon General, 1994. d. **Lancaster T, Stead LF. Interventions for preventing tobacco sales to minors [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.**
H14	Develop healthy living centres	There is no evidence that community heart health interventions (eg education, use of local media, screening and case-finding, sports clubs and involving local industry) affect smoking prevalence, physical activity level, mean blood pressure, mean cholesterol level or cardiovascular disease mortality. Community level analysis may mask an effect on high-risk groups.[a] Once the intervention is stopped even the most significant treatment effects are not maintained.[b]	a. Dobbins M, Beyers J. The effectiveness of community-based heart health projects: A systematic overview update. Ontario Public Health Research, Education & Development Program 1999. **Ebrahim S, Davey–Smith G. Health promotion in older people for cardiovascular disease prevention - a systematic review and meta-analysis. London: Health Education Authority, 1996.** b. Dobbins M, Beyers J. The effectiveness of community-based heart health projects: A systematic overview update. Ontario Public Health Research, Education & Development Program, 1999.

HEART DISEASE AND STROKE: Personal behaviour

POLICY

H15 Ensure access to and availability of, a wide range of foods for a healthy diet *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

Fresh fruit and vegetables

Eating more fresh fruit and vegetables is associated with a lower risk of coronary heart disease and stroke.[a]

There are no controlled intervention studies of the effects of eating more fruit and vegetables, so the size and nature of any real effect remains uncertain.[b] The associations reported could be due to the fact that socioeconomic status is associated with both diet and risk of cardiovascular disease.[c]

Saturated fats and fatty acids

Diets high in saturated fats and cholesterol increase blood cholesterol and the risk of coronary heart disease.[d]

Reduction in saturated dietary fat is associated with reduction in cardiovascular events if sustained for at least two years.[e]

Available evidence suggests that consumption of oily fish – rich in omega-3 fatty acids - is associated with reduced mortality from coronary heart disease in high risk groups, but not in low risk groups.[f]

Fish oil supplements or advice to eat more fish in coronary heart disease patients reduces mortality.[g]

Vitamins

There is no evidence that beta-carotene[h] and vitamin E[i] supplements affect cardiovascular disease.

A review of the effects of antioxidant vitamins for coronary heart disease prevention is in preparation.[j]

While changes in diet are feasible in controlled settings in the short term and can result in reductions in cardiovascular risk factors,[d] changing diets of free-living individuals through counselling and education is rarely possible.[k]

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Klerk M, Jansen MCJF, van't Veer P, Kok FJ. Fruits and vegetables in chronic disease prevention. Grafisch Bedrijf Ponsen & Looijen: Wageningen, 1998.

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c. Serdula MK, Byers T, Mokdad AH, Simoes E, Mendlein JM, Coates RJ. The association between fruit and vegetable intake and chronic disease risk factors. Epidemiology 1996;7:161-5.

d. Clarke R, Frost C, Collins R, Appleby P, Peto R. Dietary lipids and blood cholesterol: a quantitative meta-analysis of metabolic ward studies. BMJ 1997;314:112-17.

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f. Marckmann P, Gronbaek M. Fish consumption and coronary heart disease mortality. A systematic review of prospective cohort studies. European Journal of Clinical Nutrition 1999;53:585-90.

g. Hooper L, Ness A, Higgins JPT, Moore T, Ebrahim S. Correspondence re GISSI-Prevenzione trial. Lancet 1999;354:1557.

h. Ness A, Egger M, Powles J. Fruit and vegetables and ischaemic heart disease: systematic review or misleading meta-analysis? European Journal of Clinical Nutrition 1999;53:900-2.

i. Hooper L, Ness A, Davey Smith G. The HOPE trial. New

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H15	*(cont)* Ensure access to and availability of, a wide range of foods for a healthy diet	Low socioeconomic status is associated with a poorer diet and there is a growing disparity in diet between the rich and poor in the UK. Households in the lower end of income distribution spend a greater proportion of their income on food than those at the top. Low income restricts both the ability to afford many healthy foods and access to food retailers where healthy food can be purchased more cheaply.[l] Adverse dietary patterns are reinforced by poverty as pricing policy encourages purchase and consumption of cholesterol-raising diets. By extending VAT to the main sources of dietary saturated fat, cardiovascular disease could be avoided and tax revenue generated.[m] However it is unclear whether this will improve poor peoples' diets or worsen health by increasing poverty.	England Journal of Medicine 2000 (in press) j. **Hooper L, Capps N, Clements G, et al. Anti-oxidant foods or supplements for preventing cardiovascular disease in patients with and without ischemic heart disease [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** k. Tang JL, Armitage JM, Lancaster T et al. Systematic review of dietary intervention trials to lower total cholesterol in free-living subjects. BMJ 1998;316:1220. l. James WPT, Nelson M, Ralph A, Leather S. Socioeconomic determinants of health: The contribution of nutrition to inequalities in health. BMJ 1997;314:1545-53. m. Marshall T. Exploring a fiscal food policy: the case of diet and ischaemic heart disease. BMJ 2000;320:301-5.
H16	Provide sound information on the health risks of smoking, poor diet and lack of physical activity	Health education campaigns which provide information but no additional interventions are only effective in altering the behaviour of higher status socio-economic groups.[a] Programmes providing information together with personal support can be used to change behaviour across all socio-economic groups.[a]	a. Gepkens A, Gunning SL. Interventions to reduce socioeconomic health differences: A review of the international literature. European Journal of Public Health:1996;6:218-26.
	Local Players and Communities can:		
H17	Encourage the development of healthy schools and healthy workplaces *(cont)*	**School interventions** Didactic knowledge based programmes have no effect on behaviour. Interactive programmes are more effective at changing behaviour than non-interactive ones.[a] Drug use prevention programmes and sexual risk reduction programmes have been the most comprehensively evaluated.[a] School based programmes which use social reinforcement techniques (and not simply education or information) reduce the uptake of smoking.[b] Healthy school programmes concerned with healthy eating, fitness, injuries and mental health are more successful at increasing knowledge than those tackling substance abuse, safe sex and oral hygiene.[c] Dietary interventions have been shown to lower fat intake slightly but have had	a. Thomas H, Siracusa L, Ross G et al. Effectiveness of School-Based Interventions in Reducing Adolescent Risk Behaviour: A Systematic Review of Reviews. Ontario Public Health Research Education & Development Program, March, 1999. b. **NHS Centre for Reviews and Dissemination. Preventing the uptake of smoking in young people. Effective Health Care 1999;5:12.** c. **Lister Sharp D, Chapman S, Stewart-Brown S, Sowden A. Health promoting schools and health promotion in schools: two systematic reviews. Health Technology Assessment 1999;3(22).** d. **Roe L, Hunt P, Bradshaw H, Rayner M. Health promotion interventions to promote healthy eating in the general population: a review. London: Health Education Authority, 1997.** e. Brug J, Campbell M, van Assema P. The application and impact of computer generated personalised nutrition education: a review of the literature. Patient Education and

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H17	*(cont)* Encourage the development of healthy schools and healthy workplaces	no impact on intake of fibre, fruit or vegetables has been detected.[d] Computer generated nutrition education is more likely to be read, remembered and experienced as personally relevant than are standard educational materials.[e] School-based interventions encouraging healthy eating behaviours of 9-10 year old children have significant positive effects in attitude and knowledge,[f] but only slight changes in eating.[g] A systematic review of school programmes for prevention of smoking is in preparation.[h] More widespread community interventions operating at multiple sites may have an impact on smoking rates.[i] Mass media campaigns may be effective in preventing uptake of smoking among young people, but the intensity and duration of campaigns are important in determining their effects.[j] **Workplace interventions** Individual programmes (eg smoking counselling, risk factor screening and comprehensive risk assessment) have been effective in influencing behaviour.[k] Healthy eating interventions based at work sites can be effective in lowering blood cholesterol levels.[d] Workplace programmes for detection and control of high blood pressure have been only poorly evaluated and have not been shown to offer any benefits.[l] Work place tobacco policies can reduce tobacco consumption at work and worksite environmental tobacco smoke exposure.[m]	Counselling 1999;36:145-56. f. McArthur DB. Heart healthy eating behaviors of children following a school-based intervention: a meta-analysis. Issues Comprehensive Pediatric Nursing 1998;21:35-48. Levy SR, Iverson BK, Walberg HJ. Nutrition-education research: An interdisciplinary evaluation and review. Health Education Quarterly 1980;7:107-26. g. Hursti UK, Sjoden P. Changing food habits in children and adolescents: experiences from intervention studies. Scandinavian Journal of Nutrition 1997;41:102-10. h. **Thomas R, Busby K. School based programmes for preventing smoking [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** i. **Sowden AJ, Arblaster L. Mass media interventions for preventing smoking in young people [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** j. **Sowden A, Arblaster L. Community interventions for preventing smoking in young people [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** k. **Peersman G. Effectiveness of health promotion interventions in the workplace: a review. Health Education Authority, 1998.** l. **Ebrahim S. Detection, adherence and control of hypertension for the prevention of stroke: a systematic review. Health Technology Assessment 1998;2(11)**. m. Erikson MP, Gottlieb NH. A review of the health impact of smoking control at the workplace. American Journal of Health Promotion 1998;13:83-104. Fielding JE. Smoking control in the workplace. Annual Review of Public Health 1991;12:209-34.
H18	Enforce the ban on illegal sale of cigarettes to underage smokers	Interventions aimed at retailers to enforce the legal age limit reduces young people's access to cigarettes but there is no evidence that this affects smoking behaviour.[a] Targeting retailers with educational programmes alone is less effective than combined education and enforcement (warnings or visits by police or health officials), but sustained effects require enforcement at least 4-6 times a year.[b]	a. **NHS Executive. Improving outcomes in lung cancer. London: Department of Health, 1998.** b. **Lancaster T, Stead LF. Interventions for preventing tobacco sales to minors [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H19	Target information about a healthy life on groups and areas where people are most at risk	Targeting information – in conjunction with other health promotion activities - on high-risk groups may be more effective in reducing cardiovascular risk factors than community wide use of heart health interventions but definitive evidence is lacking.[a] Individuals with a central pattern of obesity are at particularly high risk of cardiovascular mortality, hypertension and non-insulin dependent diabetes.[b] The following groups are also at high risk of obesity and consequent heart disease: children in families with one or more overweight parents; lower status socio-economic groups, in particular women in these groups; people with learning disabilities; particular ethnic groups, including the south Asian and Afro-Caribbean communities; those who have given up smoking; and the elderly.[b] A review of healthy eating interventions in ethnic minorities shows a dearth of UK studies, poor methodology and considerable uncertainty about how to develop programmes suitable for a multi-cultural society.[c] Interventions promoting smoking cessation are more likely to be effective if they are based on a knowledge of differences in smoking patterns amongst ethnic and other population groups.[d]	a. **Ebrahim S, Davey–Smith G. Health promotion in older people for cardiovascular disease prevention - a systematic review and meta-analysis. London: Health Education Authority, 1996.** Sellars D, Crawford SL, Bullock K, McKinlay JB. Understanding the variability in the effectiveness of community health programmes: a meta-analysis. Social Science and Medicine 1997;44:1325-39. **Ebrahim S, Davey Smith G. Multiple risk factor interventions for primary prevention of coronary heart disease [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Dobbins M, Beyers J. The effectiveness of community-based heart health projects: A systematic overview update. Ontario Public Health Research, Education & Development Program, 1999. b. **NHS Centre for Reviews and Dissemination. The prevention and treatment of obesity. Effective Health Care 1997;3(2).** **NHS Centres for Reviews and Dissemination. Systematic review in the treatment and prevention of obesity. Report 10. University of York: NHS Centre for Reviews and Dissemination, 1997.** c. **White M. Effectiveness of interventions to promote healthy eating in people from minority ethnic groups: a review. Health Education Authority, 1998.** d. **NHS Centre for Reviews and Dissemination. Smoking cessation: What the Health Service can do? Effectiveness Matters 1998;3.**
	People can:		
H20	Manage their blood pressure if they are at risk of or suffering from circulatory disease *(cont)*	Observational studies have demonstrated a strong relationship between blood pressure and risk of coronary heart disease and stroke with no evidence of any threshold below which further reductions are not associated with greater benefits.[a] Drug treatment of hypertension decreases the risk of fatal and non-fatal stroke, cardiac events, and total mortality. The biggest benefit is seen in those with highest baseline risk of cardiovascular disease[b] and in elderly people.[c]	a. MacMahon S. Blood pressure and the risks of cardiovascular disease. In: Swales JD (ed). Textbook of Hypertension. Blackwell Scientific Publications. Oxford. 1994:46-57. b. Gueyffier F, Froment A, Gouton M. New meta-analysis of treatment trials of hypertension: improving the estimate of therapeutic benefit. Journal of Human Hypertension 1996;10:1-8. c. **Mulrow C, Lau J, Cornell J, Brand M. Pharmacotherapy for hypertension in the elderly [Cochrane Review]. In: The Cochrane Library, Issue 2,**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H20	*(cont)* Manage their blood pressure if they are at risk of or suffering from circulatory disease	For some high-risk groups, such as diabetics, trials have shown that intensive lowering of blood pressure (to levels of 150/85 or below) reduces the risk of cardiovascular events more effectively than less intensive regimes.[d] Weight reduction in obese hypertensive patients produces only a small reduction in blood pressure (about –3 mmHg systolic) and may reduce medication dosage requirements.[e] Salt restriction in hypertensive patients has only a small effect on blood pressure which may be due to concomitant weight reduction.[f] Considerable controversy surrounds the salt-blood pressure relationship. While there is little doubt that population levels of blood pressure are associated with dietary salt intake,[g] the size of this effect is open to debate.[h] Studies of the effects of dietary salt restriction show variable results. While small, short-term experiments of salt restriction using cross-over designs are able to show modest reductions in blood pressure, larger, longer term (ie over 6 months), parallel group trials show much smaller effects on blood pressure, particularly among normotensive adults reflecting the difficulties of maintaining a low salt diet. Among children, there is evidence from one well-designed large trial that salt restriction has a prolonged effect on blood pressure.[i] The public health impact of reducing dietary salt (through lower hidden salt in processed foods) may be smaller than might be predicted from systematic reviews including both long and short term trials, but could be expected to have an effect in children.	**2000. Oxford: Update Software**. d. Hansson L, Zanchetti A, Comuthers SG. Effects of intensive blood pressure lowering and low-dose aspirin in patients with hypertension: principal results of the Hypertension Optimal Treatment (HOT) randomised trial. Lancet 1998;351:1755-62. UK Prospective Diabetes Study Group. Tight blood pressure control and risk of macrovascular and microvascular complications in type 2 diabetes: UKPDS 38. BMJ 1998;317:703-13. e. **Mulrow CD, Chiquette E, Angel L, Cornell J, Summerbell C, Anagnostelis B, Grimm R Jr, Brand MB. Dieting to reduce body weight for controlling hypertension in adults [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software**. f. Cutler JA, Follmann D, Allender PS: Randomized trials of sodium reduction: an overview. American Journal of Clinical Nutrition 1997;65:643S-651S. Ebrahim S, Davey Smith G. Lowering blood pressure: a systematic review of sustained effects of non-pharmacological interventions. Journal of Public Health Medicine 1998;20:441-8. Graudal NA, Galloe AM, Anders M, et al: Effects of sodium restriction on blood pressure, renin, aldosterone, catecholamines, cholesterols and triglyceride: a meta-analysis. JAMA 1998;279:1383-91. Law MR, Frost CD, Wald NJ. By how much does dietary salt reduction lower blood pressure? III - Analysis of data from trials of salt reduction. BMJ 1991;302:819-24. Midgley JP, Matthew AG, Greenwood CM, et al: Effect of reduced dietary sodium on blood pressure: a meta-analysis of randomized controlled trials. JAMA 1996;275:1590-7. g. Elliott P, Stamler J, Nichols R, Dyer AR, Stamler R, Kesteloot H, Marmot M. Intersalt revisited: further analyses of 24 hour sodium excretion and blood pressure within and across populations. BMJ 1996;312:1249-53. h. Davey Smith G, Phillips AN. Inflation in epidemiology: "The proof and measurement of association between two things" revisited. BMJ 1996;312:1659-64. i. Hofman A, Hazebroek A, Valkenburg HA. A randomized

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			trial of sodium intake and blood pressure in newborn infants. JAMA 1983;250:370-3.
H21	Stop smoking or cut down, watch what they eat and take regular physical activity	In overweight people, any level of weight loss has significant health benefits. This could usefully be emphasised in health promotion campaigns.[a] Attempts to lower blood pressure and blood cholesterol by increasing physical activity have not been shown to be effective.[b] The health benefits of increasing physical activity are considerable.[c] It is now recognised that regimens need not be intensive (eg three times a week for at least 20 minutes) to improve health outcomes.[c] For further relevant evidence see H24 and H31.	a. **NHS Centre for Reviews and Dissemination. The prevention and treatment of obesity. Effective Health Care 1997;3(5).** **NHS Centre for Reviews and Dissemination. Systematic review in the treatment and prevention of obesity. Report 10. University of York: NHS Centre for Reviews and Dissemination, 1997.** b. **Ebrahim S, Davey-Smith G. Health promotion in older people for cardiovascular disease prevention - a systematic review and meta-analysis. London: Health Education Authority, 1996.** c. Fentem PH. Benefits of exercise in health and disease. BMJ 1994;308:1291-5.

HEART DISEASE AND STROKE: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
H22	Encourage doctors and nurses and other health professionals to give advice on healthier living, and deliver effective and efficient services *(cont)*	**Stopping smoking** Advice by physicians to quit smoking has a small but definite effect on cessation rates. More intensive interventions are only marginally more effective.[a] Smoking advice given by nurses is also effective but direct comparisons of nurses and doctors have not been conducted.[b] There is no evidence that brief advice augmented by nurse follow up is more effective than brief advice alone.[b] Summary guidelines have been published.[c] Training health professionals increases the degree to which they offer anti-smoking interventions, and their effectiveness in doing so.[d] **Diet and obesity** Opportunistic screening for obesity at the primary care level, particularly amongst known high risk groups, may be a useful preventive intervention.[e] Primary health care teams will be more effective in this context if they are given adequate training in the prevention and treatment of obesity.[e] Promoting physical activity in children helps reduce weight and family therapy can be beneficial in high risk children.[e] Drug treatments are only helpful in the short term.[e] Dietary interventions have been shown to lower fat intake slightly but have had no impact on intake of fibre, fruit or vegetables has been detected.[f] Computer generated nutrition education is more likely to be read, remembered and experienced as personally relevant than are standard educational materials.[g] **Diet and cardiovascular risk factors** Reductions in blood pressure and blood cholesterol can be achieved by dietary changes promoted through advice and education.[h] However there is little consequent impact on overall mortality and improvements tend to be among the more socially 'advantaged' participants.[h] The effects of dietary advice given by dieticians compared with other health professionals will be addressed in a forthcoming review.[i]	a. **NHS Centre for Reviews and Dissemination. Smoking cessation: what the health service can do. Effectiveness matters 1998;3(1).** **Silagy C, Ketteridge S. Physician advice for smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. **Rice VH, Stead LF. Nursing interventions for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Lancaster T, Dobbie W, Vos K, Yudkin P, Murphy M, Fowler G. Randomized trial of nurse-assisted strategies for smoking cessation in primary care. British Journal of General Practice 1999;49:191-4. c. Raw M, McNeill A,West R. Smoking cessation: evidence based recommendations for the healthcare system. BMJ1999;318:182-5. d. **Lancaster T, Silagy C, Fowler G, Spiers I. Training health professionals in smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** e. **NHS Centre for Reviews and Dissemination. The prevention and treatment of obesity. Effective Health Care 1997;3(2)**. **NHS Centre for Reviews and Dissemination. Systematic review in the treatment and prevention of obesity. Report 10. University of York: NHS Centre for Reviews and Dissemination, 1997.** f. **Roe L, Hunt P, Bradshaw H, Rayner M. Health promotion interventions to promote healthy eating in the general population: a review. London: Health Education Authority, 1997.** g. Brug J, Campbell M, van Assema P. The application and impact of computer generated personalised nutrition education: a review of the literature. Patient Education and Counselling 1999;36:145-56 h. **Ebrahim S, Davey-Smith G. Health promotion in older people for cardiovascular disease prevention - a systematic review and meta-analysis. London: Health Education Authority 1996**.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H22	*(cont)* Encourage doctors and nurses and other health professionals to give advice on healthier living, and deliver effective and efficient services *(cont)*	Intensive efforts to detect, treat and follow up patients with hypertension reduces stroke mortality and socio-economic variations in stroke mortality.[j] **Physical activity** Advice to promote physical activity in primary care has been inadequately studied, with few UK trials. Only small effects have been found.[k] **Alcohol intake** Routine opportunistic detection and brief treatment of patients in primary care and hospital settings has been shown to reduce alcohol consumption by up to 20% in those with consumption levels above recommended guidelines.[l] Brief interventions are as effective as more expensive specialist treatment in this context, and they may have a concomitant impact on the incidence of alcohol related heart disease.[m] **Professional organisation and practice** Use of computers can improve the administrative aspects of hypertensive patient care.[n] In different clinical settings, computer aided decision support appears to improve prescribing and preventive care, but effects on patient outcomes have not been widely studied.[o] Computer aided decision support for hypertension management has not been shown to be more effective than with manual systems for assessing risk.[p] Decision aids for patients following screening improve knowledge and allow patients to be more active in decision making without increasing anxiety.[q] No systematic reviews of the effects of nurse-led clinics in primary care focussing on secondary prevention have been identified. One trial has shown that they are able to increase the amount of secondary prevention – both through lifestyle changes and pharmacological treatments - for coronary heart disease.[r] Printed educational materials, conferences and workshops appear to have very little effect on professional practice and health outcomes.[s] Outreach visits and use of local opinion leaders are more likely to achieve professional behaviour	Brunner E, White I, Thorogood M, Bristow A, Curle D, Marmot M. Can dietary interventions change diet and cardiovascular risk factors? A meta-analysis of randomized controlled trials. American Journal of Public Health 1997;87:1415-22. i. **Thompson RL, Summerbell CD, Higgins JPT, Little PS, Talbot D, Ebrahim S. Dietary advice given by a dietitian versus other health professional or self-help methods to reduce blood cholesterol [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000 Oxford: Update Software.** j. **NHS Centre for Reviews and Dissemination. Review of the research on the effectiveness of Health Service interventions to reduce variations in health. Report 3. University of York. NHS Centre for reviews and Dissemination, 1995.** k **Riddoch C. Effectiveness of physical activity promotion schemes in primary care: a review. Health Education Authority, 1998.** l. Kahan M, Wilson C, Becker L. Effectiveness of physician-based interventions with problem drinkers: a review. Canadian Medical Association Journal 1995;152:851-9. **NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. Effective Health Care 1993;1(7)**. Fleming MF, Barry KL, Manwell LB, Johnson K, London R. Brief physician advice for problem alcohol drinkers. A randomized controlled trial in community-based primary care practices. JAMA 1997;277:1039-45. m. Kahan M, Wilson C, Becker L. Effectiveness of physician-based interventions with problem drinkers: a review. Canadian Medical Association Journal 1995;152:851-9. **NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. Effective Health Care 1993;1(7).** n Montgomery AA, Fahey T. A systematic review of the use of computers in the management of hypertension. Journal of Epidemiology & Community Health 1998;52:520-5. o. Hunt DL, Haynes RB, Hanna SE, Smith K. Effects of computer-based clinical decision support systems on physician performance and patient outcomes. JAMA

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H22	*(cont)* Encourage doctors and nurses and other health professionals to give advice on healthier living, and deliver effective and efficient services *(cont)*	change.[s] However professional outreach visits combined with social marketing are more promising and have an effect on prescribing levels.[t] Audit and feedback may also be effective in altering prescribing, but enhancements to the process do not appear to yield greater effects.[u] Clinical guidelines (produced internally, with explicit dissemination, education and implementation strategies, and using patient-specific reminders at the time of consultation) used by physicians in both primary care and hospitals improve the process of care, and patient outcomes where this has been measured.[v] Another review examining the effects of clinical practice guidelines in primary care only found little evidence that guidelines improve patient outcomes.[w] In professions allied to medicine (including mainly nurses), there is some evidence that guideline driven care is effective at changing the process and outcome of care.[x] Reviews examining the effects of paper reminders[y] and computerised reminders on professional practice, health outcomes[z] and drug prescribing[aa] are currently being prepared. A further review will focus on educational, financial and regulatory interventions to promote implementation of preventive services.[ab] The effects on preventive care of substituting nurses for doctors in primary care will also be examined.[ac] A review of the effect of target payments to primary care physicians is currently being prepared.[ad]	1998;280:1339-46. p. Montgomery AA, Fahey T, Peters TJ, MacIntosh C, Sharp DJ. Evaluation of a computer-based clinical decision support system and risk chart for the management of hypertension in primary care: a randomised controlled trial. British Journal of General Practice 2000 (in press). q. O'Connor AM. Decision aids for patients facing health treatment or screening decisions: systematic review. BMJ 1999;319:731-4. r. Campbell NC, Ritchie LD, Thain J, Deans HG, Rawles JM, Squair JL. Secondary prevention in coronary heart disease: a randomised trial of nurse led clinics in primary care. Heart 1998;80:447-52. s. **Freemantle N, Harvey EL, Wolf F, Grimshaw JM, Grilli R, Bero LA. Printed educational materials: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor V. Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? JAMA 1999;282:867-74. t. **Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Educational outreach visits: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** u. **Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback versus alternative strategies: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** v. Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practise: a systematic review of rigorous evaluations. Lancet 1993;34:1317-22. **NHS Centre for Reviews and Dissemination. Implementing clinical practice guidelines: can guidelines be used to improve clinical practice? Effective Health Care 1994;8:1-12.**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H22	*(cont)* Encourage doctors and nurses and other health professionals to give advice on healthier living, and deliver effective and efficient services		w. Worrall G, Chaulk P, Freake D. The effects of clinical practice guidelines on patient outcomes in primary care: a systematic review. Canadian Medical Association Journal 1997;156:1705-12. x. **Thomas L, Cullum N, McColl E, Rousseau N, Soutter J, Steen N. Guidelines in professions allied to medicine. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** y. **Rowe R, Wyatt J, Grimshaw J, et al. Manual paper reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** z **Gordon RB, Grimshaw JM, Eccles M, Rowe RE, Wyatt JC. On-screen computer reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** aa. **Walton RT, Harvey EL, Dovey S, Freemantle N. Computerised advice on drug dosage: effects on prescribing practice [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** ab. **Hulscher MEJL, Wensing M, Van der Weijden T, Grol R, Van Weel C. Interventions to implement prevention in primary care [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. ac. **Laurant M, Sergison M, Sibbald B. Substitution of doctors by nurses in primary care [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** ad. **Giuffrida A, Leese B, Forland F, Gosden T, Kristiansen I, Sergison M et al. Target payments in primary care: effects on professional practice and health care outcomes [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
H23	Develop National Service Frameworks and work towards their implementation	The National Service Framework for coronary heart disease has focused on smoking cessation, healthy eating, physical activity and reducing obesity and overweight among the general population, and GPs are expected to focus on	a. **National Service Framework for Coronary Heart Disease. Modern Standards & Service Models. Department of Health, London, 2000.** b. **Freemantle N, Harvey EL, Wolf F, Grimshaw JM,**

HEART DISEASE AND STROKE: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H23	*(cont)* Develop National Service Frameworks and work towards their implementation	secondary prevention and identifying those at high risk of developing cardiovascular disease.[a] Although it does not refer explicitly and systematically to the relevant evidence base, it draws on much of the evidence referred to in this report. Implementation of service frameworks will depend on influencing health professionals. Printed educational materials, conferences and workshops appear to have very little effect on professional practice and health outcomes; outreach visits and use of local opinion leaders are more likely to achieve professional behaviour change.[b] However professional outreach visits combined with social marketing are more promising and have an effect on prescribing levels.[c] Audit and feedback may also be effective in altering prescribing, but enhancements to the process do not appear to yield greater effects.[d] Clinical guidelines (produced internally, with explicit dissemination, education and implementation strategies, and using patient-specific reminders at the time of consultation) applied in both primary care and hospitals may improve the process of care, but have not been shown to improve patient outcomes.[e] Reviews examining the effects of paper reminders,[f] and computerised reminders on professional practice, health outcomes[g] and drug prescribing[h] are currently being prepared. A further review will focus on educational, financial and regulatory interventions to promote implementation of preventive services.[i] The effects on preventive care of substitution of nurses for doctors in primary care will also be examined.[j]	**Grilli R, Bero LA. Printed educational materials: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor V. Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? JAMA 1999;282:867-74. c. **Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Educational outreach visits: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. **Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback versus alternative strategies: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. e. Grimshaw JM, Russell IT. Effect of clinical guidelines on medical practise: a systematic review of rigorous evaluations. Lancet 1993;34:1317-22. Worrall G, Chaulk P, Freake D. The effects of clinical practice guidelines on patient outcomes in primary care: a systematic review. Canadian Medical Association Journal 1997;156:1705-12. f. **Rowe R, Wyatt J, Grimshaw J, et al. Manual paper reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** g. **Gordon RB, Grimshaw JM, Eccles M, Rowe RE, Wyatt JC. On-screen computer reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** h. **Walton RT, Harvey EL, Dovey S, Freemantle N. Computerised advice on drug dosage: effects on prescribing practice [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford:**

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POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
		Update Software. i. **Hulscher MEJL, Wensing M, Van der Weijden T, Grol R, Van Weel C. Interventions to implement prevention in primary care [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** j. **Laurant M, Sergison M, Sibbald B. Substitution of doctors by nurses in primary care [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
Local Players and Communities can:		
H24 Provide help to people who want to stop smoking *(cont)*	A number of interventions are effective in promoting smoking cessation.[a] These include nicotine replacement therapy (inhalers and patches appear to be slightly more effective than chewing gum);[b] behaviour modification, combined with advice and social skills training;[c] and encouragement and brief advice given by well trained GPs or other health professionals during routine consultations (which is particularly effective with more motivated patients).[d] Among patients with coronary heart disease, smoking cessation advice increases quit rates by 45% compared with usual care.[e] Patient education and counselling have been shown to significantly reduce smoking and drinking rates. Larger effects are seen using behavioural techniques, particularly self monitoring.[f] There is no evidence that silver acetate,[g] aversion treatments,[h] lobeline,[i] acupuncture,[j] anxiolytics or antidepressants[k] are effective in smoking cessation.	a. Law M, Tang JL. An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine 1995;155:1933-41. b. **NHS Centre for Reviews and Dissemination. Smoking cessation: What the Health Service can do? Effectiveness Matters 1998;3**. Law M, Tang JL. An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine 1995;155:1933-41. **Juni P, Fux C, Hertog MGL, Egger M, Ernst E. A Tibetan herbal preparation, Padma 28, for the treatment of intermittent claudication. [Protocol for Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Silagy C, Mant D, Fowler G, Lancaster T. Nicotine replacement therapy for smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. **NHS Centre for Reviews and Dissemination. Smoking cessation: What the Health Service can do? Effectiveness.Matters 1998;3**. Law M, Tang JL. An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine 1995;155:1933-41. d. **NHS Centre for Reviews and Dissemination. Smoking cessation: What the Health Service can do? Effectiveness.Matters 1998;3.** **Silagy C, Ketteridge S. Physician advice for smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software .**

HEART DISEASE AND STROKE: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H24	(*cont)* Provide help to people who want to stop smoking		**Lancaster T, Silagy C, Fowler G, Spiers I. Training health professionals in smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software .** Law M, Tang JL. An analysis of the effectiveness of interventions intended to help people stop smoking. Archives of Internal Medicine 1995;155:1933-41. e. van Berkel T.F, Boersma,H, Roos-Hesselink JW, Erdman RAM, Simoons ML. Impact of smoking cessation and smoking interventions in patients with coronary heart disease. European Heart Journal 1999, 20:1773-82. f. Mullen PD. Simons-Morton DG. Ramirez G. Frankowski RF. Green LW. Mains DA. A meta-analysis of trials evaluating patient education and counseling for three groups of preventive health behaviors. Patient Education and Counseling. 1997;32:157-73. g. **Lancaster T, Stead L. Silver acetate for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** h. **Hajek P, Stead LF. The effect of aversive smoking on smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** i **Stead LF, Hughes JR. Lobeline for smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** j. **White AR, Rampes H. Acupuncture in smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** k. **Hughes JR, Stead LF, Lancaster TR. Anxiolytics and antidepressants in smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
H25	Improve access to a variety of affordable food in deprived areas	Low socioeconomic status is associated with a poorer diet and there is a growing disparity in diet between the rich and poor in the UK. Households at the lower end of income distribution spend a greater proportion of their income on food than those at the top. Low income restricts both the ability to afford many healthy foods and access to food retailers where healthy food can be purchased more cheaply.[a]	a. James WPT, Nelson M, Ralph A, Leather S. Socioeconomic determinants of health: The contribution of nutrition to inequalities in health. British Medical Association 1997;314:1545-53.

HEART DISEASE AND STROKE: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H26	Provide facilities for physical activity and relaxation and decent transport to help people get to them	Interventions promoting physical activity amongst the general public are more likely to be effective if they involve activities which can fit into an individual's daily routine than if they require attendance at exercise facilities.[a]	a. Hillsdon M, Thorogood M. A systematic review of exercise promotion strategies. British Journal of Sports Medicine 1996;30:84-9.
H27	Reduce waiting times for coronary artery surgery and angioplasty	Consultants involved in both the NHS and private care determine who gets what and how long they wait under the NHS. While this arrangement may be convenient for government and health authorities,[a] it may increase NHS waiting lists. No systematic reviews of the determinants of length of waiting lists were found. There is evidence of unequal access to testing and re-vascularisation by gender, ethnicity and socio-economic group.[b] Monitoring testing and introducing procedures to promote equity may reduce inequality.[b]	a. Klein R, Day P, Redmayne S. Rationing in the NHS: the dance of the seven veils-in reverse. British Medical Bulletin. 1995;51:769-80. b. **NHS Centre for Reviews and Dissemination. Management of stable angina. Effective Health Care 1997;3(5).**
H28	Aim to reduce the incidence of second strokes	Lowering blood pressure in hypertensive stroke survivors reduces risk of further stroke.[a] Antiplatelet agents such as aspirin reduce risk of stroke recurrence.[b] For stroke survivors in atrial fibrillation, warfarin is more effective than aspirin.[c] Carotid endarterectomy reduces the risk of stroke in patients with severe carotid artery stenosis who have recently suffered a transient ischaemic attack in the part of the brain supplied by the diseased artery.[d]	a. Gueyffier F, Boissel JP, Boutitie F, et al. Effect of antihypertensive treatment in patients having already suffered from stroke: gathering the evidence. Stroke 1997;28:2557-62. b. Antiplatelet Trialists' Collaboration. Collaborative overview of randomised trials of antiplatelet therapy: I: Prevention of death, myocardial infarction, and stroke by prolonged antiplatelet therapy in various groups of patients. BMJ 1994;308:81-106. c. **Koudstaal P. Antiplatelet therapy for preventing stroke in patients with nonrheumatic atrial fibrillation and a history of stoke or transient ischemic attacks. [Cochrane Review]. The Cochrane Library, Issue 1, 2000. Oxford: Update Software. 2000.** **Koudstaal P. Anticoagulants for preventing stroke in patients with nonrheumatic atrial fibrillation and a history of stroke or transient ischemic attacks [Cochrane Review]. The Cochrane Library, Issue 1, 2000. Oxford: Update Software. 2000.** **Koudstaal P. Anticoagulants versus antiplatelet therapy for preventing stroke in patients with nonrheumatic atrial fibrillation and a history of stroke or transient ischemic attacks [Cochrane Review]. The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. **Cina CS, Clase CM, Haynes RB. Carotid**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			endarterectomy for symptomatic carotid stenosis [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.
H29	Support those suffering from coronary heart disease and stroke, and their carers	Depressive symptoms and social support have direct effects on prognosis after myocardial infarction, suggesting that treating depression and mobilising social support may be beneficial.[a] For reviews on cardiac rehabilitation, see H31: rehabilitation. Caring for people with stroke is associated with significant emotional and social problems.[b] A number of simple interventions to reduce patient and carer psycho-social problems have been studied, but there is insufficient evidence to judge whether any of these work.[c] Systematic reviews assessing the effects of information provision and stroke liaison workers are in preparation.[d]	a. Hemingway H, Marmot M. Evidence based cardiology: psychosocial factors in the aetiology and prognosis of coronary heart disease. Systematic review of prospective cohort studies. BMJ 1999;318:1460-7. b. Low JTS, Payne S, Roderick P. The impact of stroke on informal carers: a literature review. Social Science & Medicine 1999;49:711-25. c. Knapp P, Young J, House A, Forster A. Non-drug strategies to resolve psycho-social difficulties after stroke. Age & Ageing 2000;29:23-30. d. **Forster A, Young J, Smith J, Knapp P, House A, Wright J. Information provision for stroke patients and their caregivers [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Mant J, Langhorne P, Dennis M, Winner S. Stroke liaison workers for stroke survivors and their carers [Protocol for a Cochrane Review]. Forthcoming in: The Cochrane Library.**
H30	Implement the National Service Frameworks *(cont)*	The National Service Framework for coronary heart disease has focused on smoking cessation, healthy eating, physical activity and reducing obesity and overweight among the general population. GPs are expected to focus on secondary prevention and identifying those at high risk of developing cardiovascular disease.[a] Although it does not refer explicitly and systematically to the relevant evidence base, it draws on much of the evidence referred to in this report. Implementation of service frameworks will depend on influencing health professionals. Printed educational materials, conferences and workshops appear to have very little effect on professional practice and health outcomes; outreach visits and use of local opinion leaders are more likely to achieve professional behaviour change.[b] However professional outreach visits combined with social marketing are more promising and have an effect on prescribing levels.[c] Audit and feedback may also be effective in altering prescribing, but enhancements to the process do not appear to yield greater effects.[d]	a. **National Service Framework for Coronary Heart Disease. Modern Standards & Service Models. Department of Health, London, 2000.** b. **Freemantle N, Harvey EL, Wolf F, Grimshaw JM, Grilli R, Bero LA. Printed educational materials: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Davis D, O'Brien MA, Freemantle N, Wolf FM, Mazmanian P, Taylor V. Impact of formal continuing medical education: do conferences, workshops, rounds, and other traditional continuing education activities change physician behavior or health care outcomes? JAMA 1999;282:867-74. c. **Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Educational outreach visits: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

HEART DISEASE AND STROKE: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H30	*(cont)* Implement the National Service Frameworks	Use of clinical practice guidelines in primary care have not been shown to improve patient outcomes.[e] Reviews examining the effects of paper reminders,[f] and computerised reminders on professional practice, health outcomes [g] and drug prescribing[h] are currently being prepared. A further review will focus on educational, financial and regulatory interventions to promote implementation of preventive services.[i] The effects on preventive care of substitution of nurses for doctors in primary care will also be examined.[j] The national service framework for coronary heart disease, although it does not refer explicitly and systematically to the relevant evidence base, draws on much of the evidence referred to in this report.[k]	d. **Thomson O'Brien MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback versus alternative strategies: effects on professional practice and health care outcomes [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. e. Worrall G, Chaulk P, Freake D. The effects of clinical practice guidelines on patient outcomes in primary care: a systematic review. Canadian Medical Association Journal 1997;156:1705-12. f. **Rowe R, Wyatt J, Grimshaw J, et al. Manual paper reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** g. **Gordon RB, Grimshaw JM, Eccles M, Rowe RE, Wyatt JC. On-screen computer reminders: effects on professional practice and health care outcomes [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** h. **Walton RT, Harvey EL, Dovey S, Freemantle N. Computerised advice on drug dosage: effects on prescribing practice [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** i. **Hulscher MEJL, Wensing M, Van der Weijden T, Grol R, Van Weel C. Interventions to implement prevention in primary care [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** j. **Laurant M, Sergison M, Sibbald B. Substitution of doctors by nurses in primary care [Protocol for a Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** k. **National Service Framework for Coronary Heart Disease. Modern Standards & Service Models. Department of Health, London, 2000.**
H31	Identify those at risk of heart disease and stroke and provide high quality services *(cont)*	Access to healthcare facilities for high risk ethnic minorities could be improved through the use of focused inner city facilities with well trained and bilingual staff and also by improving referral mechanisms to secondary care.[a]	a. **NHS Centre for Reviews and Dissemination. Ethnicicty and health. Report 5. University of York. NHS Centre for Reviews and Dissemination, 1996.**

HEART DISEASE AND STROKE: Services interventions

POLICY	SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE	REFERENCES
H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*	**Prevention: Targeting obesity** There is no evidence that community based interventions using educational and social learning methods aimed at reducing the prevalence of obesity among adults are successful.[b] Financial incentives in combination with educational programmes result in minor weight loss, but appeal most to those who are not over-weight.[b] Interventions designed to reduce sedentary behaviour are effective in reducing overweight in children.[b] Family therapy can prevent and reduce obesity in high risk children. It has been shown to be more effective than standard dietary and exercise interventions in this context.[b] Drug treatments are effective in reducing obesity over the short term. In general they are best used as an adjunct to diet and lifestyle management in the treatment of obesity.[b] Surgery is the most effective and possibly the most cost-effective way to reduce weight in morbidly obese people. Particularly effective techniques are gastric bypass and vertical banded gastroplasty.[b] Long-term follow up and the use of maintenance interventions in weight loss programmes are necessary to sustain weight loss over time.[b] Reviews on prevention and treatment of obesity in children,[c] the effect of low-fat diets for reducing obesity,[d] and the organisation of care for managing overweight and obese people are currently in preparation.[e]	b. **NHS Centre for Reviews and Dissemination. The prevention and treatment of obesity. Effective Health Care 1997;3(2).** **NHS Centre for Reviews and Dissemination. Systematic review in the treatment and prevention of obesity. Report 10. University of York: NHS Centre for Reviews and Dissemination, 1997.** c. **NHS Centre for Reviews and Dissemination. Cholesterol and coronary heart disease: screening and treatment. Effective Health Care 1998;4(1).** **Campbell K, Waters E, O'Meara S, Summerbell C. Interventions for preventing obesity in children. [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. **Summerbell CD, Glasziou P. Advice on low-fat diets for reducing obesity [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** e. **Harvey EL, Glenny A, Kirk SFL, Summerbell CD. Improving health professionals' management and the organisation of care for overweight and obese people [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	Prevention: Targeting hypertension Intensive programmes of hypertension detection and treatment following protocols, not only reduces cardiovascular mortality, but also narrow social class mortality differences.[a]	a. **Ebrahim S. Detection, adherence and control of hypertension for the prevention of strokes: a systematic review. Health Technology Assessment 1998;2(11).** **NHS Centre for Reviews and Dissemination. Review of the research on the effectiveness of Health Service interventions to reduce variations in health. Report 3. NHS Centre, or Reviews and Dissemination, 1995.**

HEART DISEASE AND STROKE: Services interventions

POLICY

H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

There is no evidence that screening programmes in shopping centres or housing blocks increase detection or reach disadvantaged people, as intended.[a] Case finding is particularly useful when linked with professional training, protocols and reminders, given to both patients and doctors.[a] The diagnosis of hypertension should take into account the full clinical picture, including risk factors such as obesity and smoking, and should not rely solely on measurement of blood pressure values.[b]

Non-pharmacological interventions – salt restriction, alcohol reduction, stress management, physical exercise - for controlling blood pressure in hypertensive people have only small effects compared with drug therapy.[c] Weight reduction stands out as showing modest but important effects.[d] Trials of salt reduction have shown only very small reductions in blood pressure among normotensive people and the findings do not support a general recommendation to reduce salt intake.[e]

Anti-hypertensive drug therapy is effective in treating those at high risk of stroke, particularly the elderly.[f] Up to the age of 80 years, drug treatment is more beneficial in terms of numbers-needed-to-treat than among younger adults aged less than 60 years.[f] Above this age, the benefits of treatment have not been established.[g] Physicians should take particular care to ensure that the specific drugs used are suited to patient characteristics and are the most cost-effective available.[h]

Tight control of blood pressure (aiming for a blood pressure of 150/85) in patients with diabetes significantly reduces the risk of stroke and mortality due to diabetic complications (stroke, coronary heart disease, peripheral vascular disease, renal failure and microvascular complications).[i]

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HEART DISEASE AND STROKE: Services interventions

POLICY

H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

Prevention: Targeting cholesterol levels

General population screening for blood cholesterol is not advisable as cholesterol level, by itself, is a relatively poor predictor of coronary heart disease events. Cholesterol reduction in people at high risk of coronary heart disease, even if

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UK Prospective Diabetes Study Group. Tight blood pressure control and risk of macrovascular complications in type 2 diabetes: UKPDS 38. BMJ 1998;317:703-13.

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Ebrahim S, Davey Smith G, McCabe C, Payne N, Pickin M, Sheldon TA, Lampe F, Sampson F, Ward S,

HEART DISEASE AND STROKE: Services interventions

POLICY

H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

their cholesterol levels are not raised, reduces mortality.[a]

Dietary interventions may lower blood cholesterol in metabolic wards,[b] prisons and psychiatric hospitals, but their effects in "free-living" populations is limited by the lack of long-term adherence to such diets.[c] If dietary interventions are applied for at least two years, they may reduce cardiovascular disease events, but the evidence is weak.[d]

More specific dietary changes, such as increasing fibre[e] and garlic,[f] show only small effects in trials that were poorly designed.

Drug therapy, in particular the use of statins, to lower cholesterol levels, is effective, and cost effective when targeted at people who are at high risk of coronary heart disease.[g]

Use of statins for primary prevention has been shown to reduce combined primary outcomes of vascular events and revascularisation procedures even in people with only average levels of blood cholesterol (5.7mmol/l) in a major trial. In higher risk men with a mean blood cholesterol of 7.0mmol/l in Scotland, statins were effective.[a]

Prevention: Other dietary interventions

Both a "Mediterranean" diet and increased consumption of oily fish for secondary prevention appear to have dramatic effects in reducing recurrence and mortality and are very cost-effective compared with statins, but have only been examined in small trials that have not been replicated.[h]

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HEART DISEASE AND STROKE: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H31	*(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*		Hebert PR, Gaziano JM, Chan KS, Hennekens CH. Cholesterol lowering with statin drugs, risk of stroke, and total mortality: an overview of randomized trials. JAMA 1997;278:313-21. Bucher H C, Griffith L E, Guyatt G H. Effect of HMGcoA reductase inhibitors on stroke: a meta- analysis of randomized controlled trials. Annals of Internal Medicine 1998;128:89-95. h. **Ebrahim S, Davey Smith G, McCabe C, Payne N, Pickin M, Sheldon TA, Lampe F, Sampson F, Ward S, Wannamethee G. What role for statins? A review and economic model. Health Technology Assessment 1999;3:19**. **NHS Centre for Reviews and Dissemination. Cholesterol and coronary heart disease: screening and treatment. Effective Health Care 1998;4(1).**
		Prevention: Targeting other risk factors Multiple risk factor interventions (eg smoking cessation, dietary advice, physical activity) for primary prevention used in primary care have not been shown to have convincing effects on cardiovascular events, and have only small effects on risk factors.[a] Observational data suggest that blood homocysteine levels are associated with increased risk of heart disease and stroke. Lowering blood homocysteine with folic acid and vitamin B6 or B12 supplements is feasible and may therefore reduce cardiovascular disease.[b] Trials of folic acid and vitamin supplementation measuring substantive outcomes have not yet reported. Modest alcohol intake of one to four drinks per day may lower coronary heart disease incidence.[c] The beneficial effects of alcohol may be mediated through increases in high density lipoprotein cholesterol and haemostatic factors.[d] However, even low alcohol intake may have adverse effects on various cancers, cirrhosis, haemorrhagic stroke, blood pressure, injuries and accidents.[e] No specific intervention programmes preventing alcohol misuse by young people can yet be recommended as there is little evidence that any presently available programmes are effective in the long term.[f] Short and medium term reductions in	a. **Ebrahim S, Davey Smith G. Multiple risk factor interventions for primary prevention of coronary heart disease [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. Brattstrom L, Landgren F, Israelsson B, et al. Lowering blood homocysteine with folic acid based supplements: Meta-analysis of randomised trials. BMJ 1998;316:894-8. c. Cleophas TJ. Wine, beer and spirits and the risk of myocardial infarction: A systematic review. Biomedicine and Pharmacotherapy 1999;53:417-23. d. Rimm EB, Williams P, Fosher K, Criqui M, Stampfer MJ. Moderate alcohol intake and lower risk of coronary heart disease: Meta-analysis of effects on lipids and haemostatic factors. BMJ 1999;319:1523-8. e. Corrao G, Bagnardi V, Zambon A, Arico S. Exploring the dose-response relationship between alcohol consumption and the risk of several alcohol-related conditions: A meta-analysis. Addiction 1999;94:1551-73. f. Foxcroft DR, Lister SD, Lowe G. Alcohol misuse prevention for young people: a systematic review reveals methodological concerns and lack of reliable evidence of effectiveness. Addiction 1997;92:531-7. g. Danesh J, Youngman L, Clark S, Peto R, Collins R. Helicobacter pylori infection and early onset myocardial infarction: case-control and sibling pairs study. BMJ

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POLICY		SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE
H31	(*cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*	drinking were found in several trials but these were of low methodological quality.[f] Infection with Helicobacter pylori is associated with moderately increased risk of coronary heart disease not accounted for by other measured risk factors, but the more methodologically robust prospective studies failed to show a statistically significant relationship.[g] No cardiovascular benefits have been detected from the use of hormone replacement therapy (HRT).[h] Atrial fibrillation is an important independent risk factor for stroke.[i] This risk can be reduced substantially by treatment with warfarin or more modestly by treatment with aspirin.[j] Treatment choice for individual patients can be guided by decision analysis tools which take into account underlying stroke risk and risk of haemorrhage (which is greater on warfarin than on aspirin).[k] A number of interventions are effective in promoting smoking cessation.[l] These include nicotine replacement therapy (inhalers and patches appear to be slightly more effective than chewing gum);[m] behaviour modification, combined with advice and social skills training;[n] and encouragement and brief advice given by well trained GPs or other health professionals during routine consultations (which is particularly effective with more motivated patients).[o] Among patients with coronary heart disease, smoking cessation advice increases quit rates by 45% compared with usual care.[p] Patient education and counselling have been shown to significantly reduce smoking and drinking rates. Larger effects are seen using behavioural techniques, particularly self monitoring.[q] There is no evidence that silver acetate,[r] aversion treatments,[s] lobeline,[t] acupuncture,[u] anxiolytics or antidepressants[v] are effective in smoking cessation.

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H31 (*cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
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		<u>Treatment and secondary prevention: Surgical and invasive interventions</u> **Coronary heart disease** Angina sufferers are an easily identifiable target group for potential surgical or other invasive interventions for coronary artery problems, which are known to be effective in treating angina.[a] The relative effectiveness of Coronary Artery Bypass Grafting (CABG), Percutaneous Transluminal Coronary Angioplasty (PTCA) and medical treatment depends on the severity of the disease, the responsiveness of patients with less severe disease to medical intervention, and is changing as new technologies and techniques are introduced.[b] In acute coronary syndromes, emergency PTCA is superior to thrombolysis for short term outcomes, but is only an option in centres with considerable experience.[c] Long term low dose aspirin and lipid-lowering reduce the risk of re-stenosis, myocardial infarction, stroke or vascular death in post PTCA and CABG patients.[d]	a. **NHS Centre for Reviews and Dissemination. Management of stable angina. Effective Health Care 1997;3(5).** b. **NHS Centre for Reviews and Dissemination. Management of stable angina. Effective Health Care 1997; 3(5)**. Johansson SR, Brorsson B, Bernstein S. Indications for and Results of Coronary Artery Revascularization. Coronary artery bypass graft and percutaneous transluminal coronary angioplasty - A literature review and ratings of appropriateness and necessity. The Swedish Council on Technology Assessment in Health Care, 1994. Sim I, Gupta M, Mcdonald K, Bourassa MG, Hlatky MA. A meta-analysis of randomized trials comparing coronary artery bypass grafting with percutaneous transluminal coronary angioplasty in multivessel coronary heart disease. American Journal of Cardiology 1995;76:1025-9. Yusuf S, Zucker D, Peduzzi P, et al. Effect of coronary artery bypass graft surgery on survival: overview of 10-year results from randomised trials by the Coronary Artery Bypass Graft Surgery Trialists Collaboration. Lancet 1994;344:563-70. **Sculpher MJ, Petticrew M, Kelland JL et al. Resource allocation for chronic stable angina: a systematic review of effectiveness, costs and cost-effectiveness of alternative interventions. Health Technology**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H31	*(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*		**Assessment 1998;2:10.** c. **Cucherat M, Bonnefoy E, Tremeau G. Primary angioplasty versus intravenous thrombolysis for acute myocardial infarction [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. **NHS Centre for Reviews and Dissemination. Management of stable angina. Effective Health Care 1997;3(5).**
		<u>Treatment and secondary prevention: Surgical and invasive interventions</u> **Stroke** Carotid endarterectomy reduces the risk of stroke in patients with severe carotid artery stenosis who have recently suffered a transient ischaemic attack in the part of the brain supplied by the diseased artery.[a] The operation probably also reduces risk of stroke in asymptomatic patients with carotid artery stenosis, but the overall benefit is small.[b] A variety of surgical techniques are used, but there is insufficient evidence to prefer the use of any particular approach.[c] The risks from surgery are related to a number of patient-specific factors. Taking account of these might help decision making for individual patients.[d] There is insufficient evidence to judge whether acute surgical interventions for primary intracerebral haemorrhage should be performed.[e] Elective surgery to prevent sub-arachnoid haemorrhage from intracranial aneurysms is associated with important postoperative mortality and permanent morbidity.[f] A review is exploring the timing of surgery to prevent re-bleeding following a sub-arachnoid haemorrhage.[g] Systematic reviews about the effects of percutaneous transluminal angioplasty in the treatment of carotid and vertebral artery stenosis found no completed trials.[h] There is no reliable evidence to suggest that extracranial-intracranial bypass reduces the rate of stroke in comparison to medical management.[i]	a. **Cina CS, Clase CM, Haynes RB. Carotid endarterectomy for symptomatic carotid stenosis [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. b. Benavente O. Carotid endarterectomy for asymptomatic carotid stenosis: a meta-analysis. BMJ 1998;317:1477-80. **Chambers BR, You RX, Donnan GA. Carotid endarterectomy for asymptomatic carotid stenosis [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. **Counsell C, Salinas C, Naylor R, Warlow C. Routine or selective carotid artery shunting during carotid endarterectomy and the different methods of monitoring in selective shunting. [Cochrane Review].In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Counsell C, Salinas R, Warlow R, Naylor R. Patch angioplasty compared to primary closure in carotid endarterectomy. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Counsell C, Warlow C, Naylor R. Patches of different types for carotid patch angioplasty. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Tangkanacul C, Counsell C, Warlow C. Local versus general anaesthetic for carotid endarterectomy. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Cao PG, De Rango P, Zannetti S, Giordano G, Ricci S, Celani MG. Eversion versus conventional carotid endarterectomy for preventing stroke [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1,**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H31	*(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*		**2000. Oxford: Update Software.** d. Rothwell PM, Slattery J, Warlow CP. Clinical and angiographic predictors of stroke and death from carotid endarterectomy: systematic review. BMJ 1997;315:1571-7. e. Hankey GJ, Hon C. Surgery for primary intracerebral hemorrhage: is it safe and effective? a systematic review of case series and randomized trials. Stroke 1997;28:2126-32. **Prasad K, Shrivastava A. Surgical treatment in patients with primary supratentorial intracerebral haemorrhage. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** f. Raaymakers TW, Rinkel GJ, Limburg M, Algra A. Mortality and morbidity of surgery for unruptured intracranial aneurysms: a meta-analysis. Stroke 1998;29:1531-8. g. **Whitfield PC, Kirkpatrick PJ. Timing of surgery for subarachnoid haemorrhage [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** h. **Crawley F, Brown MM. Percutaneous transluminal angioplasty and stenting for carotid artery stenosis [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Crawley F, Brown MM. Percutaneous transluminal angioplasty and stenting for vertebral artery stenosis [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** i. Holohan TV. Extracranial-intracranial bypass to reduce the risk of ischemic stroke. Rockville, Agency for Health Care Policy and Research, 1990.
		<u>Treatment and secondary prevention: Drug therapies</u> **Coronary heart disease** Use of low dose aspirin in patients at high risk of coronary heart disease is highly cost-effective in terms of cost per life saved. There is no evidence to support the addition of heparin to aspirin therapy in the treatment of myocardial infarction.[a] Long term beta-blockade following myocardial infarction, with propranolol,	a. **NHS Centre for Reviews and Dissemination. Management of stable angina. Effective Health Care 1997;3(5).** Collins R, MacMahon S, Flather M. Clinical effects of anticoagulant therapy in suspected acute myocardial infarction: systematic overview of randomised trials. BMJ 1996;313:652-9. **NHS Centre for Reviews and Dissemination. Aspirin and myocardial infarction. Effectiveness.Matters 1995; 1**.

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H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

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timolol and metoprolol, is safe and effective.[b]

Amiodarone may reduce mortality in high-risk patients following myocardial infarction, heart failure or a history of cardiac arrest, but is poorly tolerated by many patients. Most of the benefits are obtained in those with heart failure.[c]

Class 1 anti-arrhythmic drugs given in the acute phase of myocardial infarction increase mortality and should not be used.[d]

Statins (HMG Co-A reductase inhibitors) reduce blood cholesterol and clinical events (including revascularisations) in patients following myocardial infarction.[j] Statins are effective over a wide range of blood cholesterol levels, including those considered "normal" in Britain.[e]

High-intensity oral anticoagulation (INR 2.8-4.8) in patients with coronary heart disease reduces the risk of recurrence, total mortality and stroke but is associated with a six fold increase of major bleeding. Moderate intensity oral anticoagulation (INR 2-3) reduces the risk of recurrence and stroke (reduction of total mortality is not significant) but is associated with a seven fold increase in major bleeding. Low intensity oral anticoagulation together with aspirin is not superior to aspirin alone. There is currently insufficient evidence to assess the effect of high / moderate intense regimens with aspirin.[f]

Pooled data from controlled trials of hormone replacement therapy (HRT) do not support the idea that that postmenopausal HRT prevents cardiovascular events. In women with known ischaemic heart disease one large well designed trial failed to detect any reduction in cardiovascular disease events or all cause mortality in those allocated to a minimum of 4 years treatment with HRT. HRT significantly increased the risk of venous thrombosis and gall bladder disease.[g]

Heart failure

Phosphodiesterase inhibitors *increase* mortality in patients suffering from chronic heart failure.[h]

Angiotensin converting enzyme (ACE) inhibitors can reduce left ventricular hypertrophy.[i] In patients with mild or moderate heart failure, beta-blockade reduces mortality but this effect is in addition to benefits obtained by ACE

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	POLICY	SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE
H31	*(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*	inhibitors.[j] The effects on mortality are reduced in sensitivity analyses excluding less robust trials.[k] Patients with severe heart failure may be adversely affected by beta-blockers. It is not clear whether one beta-blocker is better than another, and their effects in older patients and those with more severe heart failure require further study.[l]

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H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

Treatment and secondary prevention: Drug therapies

Stroke: acute treatment

In acute stroke, aspirin therapy is safe and reduces the risk of early stroke recurrence and improves long term outcome.[a] Thrombolysis increases risk of death, but reduces dependency in survivors so that, overall, risk of death or dependency is reduced.[b] Indirect comparison of the different thrombolytic agents that have been used in trials suggests that recombinant tissue plasminogen activator is associated with fewer deaths and greater chance of a good outcome (alive and independent).[c] There is no evidence that routine anti-coagulants and calcium antagonists are effective in acute stroke.[d] There have been reviews of several other therapies in acute stroke, but there is insufficient evidence to justify use of any of them outside randomised controlled trials.[e] Nine further reviews are being prepared on other medical interventions for acute stroke.[f]

In subarachnoid haemorrhage, use of nimodipine reduces the risk of a poor outcome (death or dependency), probably through reducing secondary cerebral ischaemia.[g] There is no evidence to support the use of antifibrinolytic therapy.[h] Two reviews are being prepared on other aspects of management of subarachnoid haemorrhage.[i]

Echocardiography can identify cardiac sources of embolus in patients with stroke and clinical evidence of cardiac disease. There is evidence from observational studies that patients with intra-cardiac thrombus benefit from anticoagulation.[j]

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H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

Stroke: Secondary prevention

Aspirin has a net benefical effect in secondary prevention of stroke,[k] despite causing a small increase in risk of haemorrhagic stroke.[l] There is no evidence that higher (eg 300mg per day) doses of aspirin are any more effective than lower doses (eg 75mg per day).[m] The Antithrombotic Trialists' Collaboration is reviewing whether the addition of dipyridamole to aspirin is more effective than aspirin alone.[n] Thienopyridine derivatives (for example clopidogrel and ticlopidine) are effective, but more expensive, alternative for patients who cannot take aspirin.[o] Anticoagulant therapy slightly reduces the risk of recurrence after non-embolic ischaemic stroke or transient ischaemic attack, but this benefit is more than outweighed by a much larger increase in the risk of intracranial haemorrhage (so there is a net hazard).[p]

For patients with atrial fibrillation, warfarin (substantially) and aspirin (moderately) reduce risk of stroke.[q] Warfarin is associated with greater risk of haemorrhage than aspirin.[r] Combining aspirin therapy with warfarin is associated with a further increase in risk of haemorrhage.[s] A review of anticoagulants versus antiplatelet agents in atrial fibrillation is in preparation.[t]

Four further reviews are in preparation looking at the role of antiplatelet agents and anticoagulants in various sub-groups of patients who are at increased risk of stroke.[u]

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HEART DISEASE AND STROKE: Services interventions

POLICY

H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality service *(cont)*

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HEART DISEASE AND STROKE: Services interventions

POLICY

H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

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POLICY

H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

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H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

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HEART DISEASE AND STROKE: Services interventions

POLICY	SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE	REFERENCES
H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*	**<u>Rehabilitation</u>** **Coronary Heart Disease** Cardiac rehabilitation programmes can improve recovery and survival in patients who have had a heart attack or invasive heart procedure.[a] Programmes combining exercise, psychosocial and educational interventions tend to be more effective, whereas exercise alone may be insufficient to reduce recurrence and mortality.[a] The essential components of a successful service, the duration of rehabilitation required, and effects in different types of patient are all largely unknown. Variation in provision and uptake is considerable. A review is being prepared examining the effects of exercise programmes for coronary heart disease.[b]	a. Hotta SS. Cardiac rehabilitation programs: heart transplant, percutaneous transluminal coronary angioplasty, and heart valve surgery patients. Agency for Health Care Policy and Research, 1991. **NHS Centre for Reviews and Dissemination. Cardiac rehabilitation. Effective Health Care 1998;4:1-12.** b. **Jolliffe JA, Taylor RS, Thompson D, Oldridge N. Exercise based rehabilitation for coronary heart disease [Protocol for Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	Stroke Observational studies using historical controls suggest that recognising and treating swallowing difficulties in stroke patients will reduce risk of pneumonia.[a] However, there is a lack of evidence available to guide care and feeding of these patients.[b] A review of pharmacological treatments for dysphasia is underway.[c] There is some evidence that more intensive rehabilitation leads to better outcome.[d] There is a lack of evidence about the effects of speech and language therapy after stroke.[e] Other systematic reviews are available or planned looking at specific treatments in stroke rehabilitation.[f] Recent trials have suggested that domiciliary occupational therapy is effective both for stroke patients who stay at home and for those discharged from hospital.[g]	a. Agency for Health Care Policy and Research (AHCPR).. Diagnosis and treatment of swallowing disorders (dysphagia) in acute-care stroke patients. Rockville, MD: Agency for Health Care Policy and Research, 1999. b. **Bath PMW, Bath FJ, Smithard DG. Interventions for dysphagia in acute stroke [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. c. **Greener J, Enderby P, Whurr R. Pharmacological treatment for aphasia following stroke. [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. d. Kwakkel G, Wagenaar RC, Koelman TW, Lankhorst GJ, Koetsier JC. Effects of intensity of rehabilitation after stroke: a research synthesis. Stroke 1997;28:1550-6. Langhorne P, Wagenaar R, Partridge C. Physiotherapy after stroke: more is better? Physiotherapy Research International 1996;1:75-88. e. **Greener J, Enderby P, Whurr R. Speech and language therapy for aphasia following stroke [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. f. Moreland JD, Thomson MA, Fuoco AR. Electromyographic biofeedback to improve lower extremity function after stroke: a meta-analysis. Archives of Physical Medicine and Rehabilitation 1998;79:134-40.

HEART DISEASE AND STROKE: Services interventions

POLICY

H31 *(cont)* Identify those at risk of heart disease and stroke and provide high quality services *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

Service issues

Coronary heart disease

Evaluations show that many patients are not being given appropriate treatment to reduce risks of recurrence, and that access to treatment is often delayed, inadequate and inequitable.[a]

There is also variation in provision of cardiac rehabilitation services.[b]

There is evidence that coronary artery bypass grafting surgery is associated with lower post-operative mortality rates in hospitals operating on more than 100 patients per year, and post-PTCA mortality rates fall with increased operator experience and hospital volumes.[c]

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b. **NHS Centre for Reviews and Dissemination. Cardiac rehabilitation. Effective Health Care 1998;4:1-12.**

c. **Sowden A, Deeks JJ, Sheldon T. Volume and outcome in coronary artery bypass graft surgery: true association or artifact? BMJ 1995;311:151-5.**

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HEART DISEASE AND STROKE: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H31	*(cont)* Identify those at risk of heart disease and stroke and provide high quality services	**Stroke** Organised in-patient care in stroke units leads to better survival, less dependency, and greater likelihood of patients living at home after one year as compared to conventional in-patient care. Stroke unit care is not associated with any increase in hospital length of stay.[a] There is no evidence that services which aim to avoid hospital admission for stroke patients can achieve the same benefits as inpatient stroke units.[b] Models of care that support early discharge from hospital reduce length of stay, but the effects on patient and carer outcomes and on overall costs of this approach are unclear.[c] There are similar uncertainties over the effects of day-hospital rehabilitation.[d]	a. **Stroke Unit Trialists' Collaboration. Organised inpatient (stroke unit) care for stroke [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. b. **Langhorne P, Dennis MS, Kalra L, Shepperd S, Wade DT, Wolfe CDA. Services for helping acute stroke patients avoid hospital admission [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. **Early Supported Discharge Trialists. Services for reducing duration of hospital care for acute stroke patients [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Weir RP. Rehabilitation of cerebrovascular disorder (stroke): early discharge and support: a critical review of the literature. Christchurch: New Zealand Health Technology Assessment, 1999. d. Dekker R, Drost EA, Groothoff JW, Arendzen JH, van Gijn JC, Eisma WH. Effects of day-hospital rehabilitation in stroke patients: a review of randomized clinical trials. Scandinavian Journal of Rehabilitation Medicine 1998;30:87-94.
	People can:		
H32	Learn how to recognise a heart attack and what to do, including resuscitation skills	Bystander cardiopulmonary resuscitation following sudden cardiac arrest and defibrillator-capable emergency services increases survival.[a] No systematic reviews or trials of the effects of training in cardio-pulmonary resuscitation were found.	a. Nichol G, Stiell IG, Laupacis A, Wells GA. A cumulative meta-analysis of the effectiveness of defibrillator-capable emergency medical services for victims of out-of-hospital cardiac arrest. Annals of Emergency Medicine 1999;34:17-25. Auble TE, Menegazzi JJ, Paris PM. Effect of out-of-hospital defibrillation by basic life support providers on cardiac arrest mortality: a meta-analysis. Annals of Emergency Medicine 1995;25:642-48.
H33	Have their blood pressure checked regularly	Intensive programmes of hypertension detection and treatment following protocols, not only reduces cardiovascular mortality, but also narrow social class mortality differences.[a]	a. **NHS Centre for Reviews and Dissemination. Review of the research on the effectiveness of Health Service interventions to reduce variations in health. Report 3. NHS Centre, for reviews and Dissemination, 1995.** **Ebrahim S, Davey SG. Health promotion in older people for cardiovascular disease prevention - a systematic review and meta-analysis. London: Health Education Authority, 1996.** **Ebrahim S. Detection, adherence and control of hypertension for the prevention of strokes: a systematic**

HEART DISEASE AND STROKE: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
H34	Take medicine as it is prescribed	Current methods of improving adherence for chronic health problems are mostly complex and not very effective.[a] More studies of innovative approaches to assist patients to follow medication prescriptions are needed.	**review. Health Technology Assessment 1998;2(11)**. a. **Ebrahim S. Detection, adherence and control of hypertension for the prevention of strokes: a systematic review. Health Technology Assessment 1998;2(11).** **Haynes RB, Montague P, Oliver T, McKibbon KA, Brouwers MC, Kanani R. Interventions for helping patients follow prescriptions for medications [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Schroeder K, Fahey T, Ebrahim S. Interventions used to improve the adherence with treatment in patients with high blood pressure in ambulatory settings [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Roter DL. Effectiveness of interventions to improve patient compliance: a meta-analysis. Medical Care 1998;36:1138-61.

A NATIONAL CONTRACT ON ACCIDENTS

ACCIDENTS: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
A1	Develop *New Deal for Communities*	No systematic reviews were identified in this area.	
A2	Remove obstacles to partnership	Community-based coalitions can be effective, and may be essential in working with some populations. They have been particularly effective in injury prevention.[a]	a. Kuhn M, Doucet C, Edwards N. Effectiveness of coalitions in heart health promotion, tobacco use reduction, and injury prevention: A systematic review of the literature 1990-1998 Public Health Research, Education and Development Program, Public Health Branch, Ontario Ministry of Health 1999.
A3	Promote parental education (*Sure Start)*	Group-based parent-training programmes have a positive impact on the behaviour of children between the ages of 3 and 10 years. They also appear more successful than methods that involve working with parents on an individual basis.[a]	a. Barlow J. Systematic Review of the Effectiveness of parent-training programmes in improving behaviour problems in children aged 3-10 years (second edition). Health Services Research Unit, Department of Public Health, University of Oxford July 1999.
A4	Improve provision of consistent monitoring data	Injury prevention interventions need to be based on accurate data derived from surveillance systems .[a] Community-wide campaigns which use local injury data have resulted in a reduction in the reported incidence of injuries in the home.[b]	a. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b. Speller V. Preventing injury in children and young people: a review of the literature and current practice. Wessex Institute of Public Health Medicine 1995;1-61.
A5	Co-ordinate Government strategy on accident prevention	No systematic reviews were identified in this area.	

ACCIDENTS: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Local Players and Communities can:		
A6	Monitor care homes for older people	No systematic reviews were identified in this area.	
A7	Promote safety practices at work	General training and education campaigns have generally been unsuccessful in reducing injury rates, but health and safety legislation has been associated with a reduction of injuries in the UK.[a] Back injury prevention interventions in the workplace, such as back belt programmes and exercise/flexibility programmes, may be beneficial in preventing back injuries, but more research is needed.[b] A review is underway to compare effectiveness of different strategies in reducing time lost from work and in increasing functional status of workers with back and neck pain.[c]	a Speller V. Preventing injury in children and young people: a review of the literature and current practice. Wessex Institute of Public Health Medicine 1995;1-61. b Karas BE. Back injury prevention interventions in the workplace: an integrative review. AAOHN Journal 44:189-96. c **Schonstein E, Kenny DT, Keating J, Koes BW. Work conditioning, work hardening and functional restoration for workers with back and neck pain [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford. Update Software.**
A8	Tackle social exclusion (*New Deal, urban regeneration*)	There is a strong association between poverty and the rate of childhood injuries,[a] but it is not clear which interventions are likely to be most effective in diminishing this association. The design of Victorian streets with terraced housing means that there are few available play areas and that on-street parking is ubiquitous. These aspects of housing design are associated with higher rates of accident casualties.[a] Structural and legislative measures are known to be the most effective interventions in reducing inequalities.[b] Interventions which appear to have been successful at reducing variations in health include systematic and intensive approaches to delivering effective interventions, improvement of accessibility to services, prompts to encourage use of services, multifaceted strategies, collaboration between interest groups, and involvement of peers in the delivery of interventions such as home visiting.[c]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996;2:(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b Gepkens A, Gunning-Schepers LJ. Interventions to reduce socioeconomic health differences: A review of the international literature. European Journal of Public Health 1996;6:218-26. c **NHS Centre for Reviews and Dissemination. Review of the research on the effectiveness of health service interventions to reduce variations in health1995;3**.
A9	Work within health improvement programmes on local partnership to improve local accident	Targeting of high risk households is likely to make the most impact in the prevention of injuries in children,[a] especially when supported by home safety equipment loans or subsidised equipment schemes.[b]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996;2(5).** b **Towner E, Dowswell T, Simpson G, Jarvis S. Health**

ACCIDENTS: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	prevention initiatives, eg better identification of highest risks/ priorities/ targets	There is some evidence that Accident Prevention Committees in high risk, deprived populations reduce injuries.[a] Coalitions can reduce head injuries, drownings, road crashes, and fractures in older people.[c]	**promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** c Kuhn M, Doucet C, Edwards N. Effectiveness of coalitions in heart health promotion, tobacco use reduction, and injury prevention: A systematic review of the literature 1990-1998 Public Health Research, Education and Development Program, Public Health Branch, Ontario Ministry of Health 1999.
A10	Promote safety measures to community groups	Community-wide campaigns have resulted in a reduction in the reported incidence of injuries in the home.[a]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996;2:(5).** Speller V. Preventing injury in children and young people: a review of the literature and current practice. Wessex Institute of Public Health Medicine 1995;1-61. **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**
A11	Raise public awareness of risks	No systematic reviews were identified in this area.	
	People can:		
A12	Take opportunities to improve their education, training and employment	No systematic reviews were identified in this area.	

ACCIDENTS: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
A13	Develop road safety strategy	Area-wide traffic schemes in the UK (such as traffic calming) appear to have resulted in some reductions in pedestrian injuries[a] and can reduce the total number of accidents by over 10%.[b] Guard rails and crash cushions (impact attenuators) can reduce the rate and severity of accidents.[c] Graduated driver licensing systems and night time curfews have been found to reduce young driver crashes in the USA.[d]	a Harborview Injury Prevention and Research Center. Child Pedestrian Injury Interventions. University of Washington. http://depts.washington.edu/hiprc/childinjury. Speller V. Preventing injury in children and young people: a review of the literature and current practice. 1995; Wessex Institute of Public Health Medicine 1997:1-61. b **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996;2(5).** c Elvik R. The safety of guard rails and crash cushions: a meta-analysis of evidence from evaluation studies. Accident Analysis and Prevention 1995;27:523-49. d Foss RD. Effectiveness of graduated driver licensing in reducing motor vehicle crashes. American Journal of Preventive Medicine1999;16:47-56.
A14	Ensure safety standards in new buildings	No systematic reviews were identified in this area.	
A15	Continue work on improving product standards	Incidence and severity of head injury are lower in cyclists wearing helmets, and these effects appear to be increased with robustness of helmet design.[a] Child-resistant container closures have been shown to reduce home injuries.[b]	a Coleman P. The effectiveness of interventions to prevent accidental injury to young persons aged 15-24 years: a review of the evidence. Medical Care Research Unit 1996;1-89. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b Speller V. Preventing injury in children and young people: a review of the literature and current practice. Wessex Institute of Public Health Medicine 1995;1-61. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).**

ACCIDENTS: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
A16	Monitor standards for sports facilities and equipment	Safety rules for organised sport can reduce injuries in the 15-24 year age group.[a] Ankle supports (semi-rigid orthoses or air-cast braces) are effective in preventing ankle injuries during high risk sporting activities.[b] Mouth guards can help prevent injuries in rugby.[a]	a Coleman P, Munro J, Nicholl J, Harper R, Kent, G, Wild D. The effectiveness of interventions to prevent accidental injury to young persons aged 15-24 years: a review of the evidence. Medical Care Research Unit 1996:1-89. b **Quinn K, Parker P, de Bie R, Rowe B, Handoll H. Interventions for preventing ankle ligament injuries [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
A17	Monitor water safety co-ordination at national level	Promoting and monitoring the use of straightforward safety measures in protecting high risk areas eg pool fencing[a] can have a substantial impact on overall associated death or injury rates.[b] Legislation can help promote the routine use of measures known to be effective.[b]	a **Thompson DC, Rivara FP. The evaluation of the effectiveness of pool fencing to prevent drowning in children. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5)**. **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**
A18	Promote *Design for Safety*	Incidence and severity of head injury are lower in cyclists wearing helmets, and these effects appear to be increased with robustness of helmet design.[a] Child resistant container closures have been shown to reduce home injuries.[b]	a Coleman P. The effectiveness of interventions to prevent accidental injury to young persons aged 15-24 years: a review of the evidence. Medical Care Research Unit 1996;1-89. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b Speller V. Preventing injury in children and young people: a review of the literature and current practice. Wessex Institute of Public Health Medicine 1995;1-61. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).**

ACCIDENTS: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
A19	Monitor vehicle safety standards	No evidence was found for formal periodic motor vehicle safety checks and random roadside inspections.[a]	a Coleman P, Munro J, Nicholl J, Harper R, Kent, G, Wild D. The effectiveness of interventions to prevent accidental injury to young persons aged 15-24 years: a review of the evidence. Medical Care Research Unit 1996:1-89.
A20	Support for pilot schemes and voluntary bodies (eg Child Safety Week)	No systematic reviews were identified in this area.	
A21	Implement EC regulations on accident prevention	No systematic reviews were identified in this area.	
	Local Players and Communities can:		
A22	Give greater priority to walking and cycling in local transport plans	No systematic reviews were identified in this area.	
A23	Adopt school travel and green transport plans	No systematic reviews were identified in this area.	
A24	Develop traffic calming and other measures for local safety schemes as part of local transport plans	Area wide traffic schemes in the UK (such as traffic calming) appear to have resulted in some reductions in pedestrian injuries[a] and can reduce the total number of accidents by over 10%.[b] The provision of crossing patrollers, adoption of measures to redistribute traffic and improvement of the safety parameters of individual roads can reduce the rate and severity of childhood accidents.[a]	a Harborview Injury Prevention and Research Center. Child Pedestrian Injury Interventions. University of Washington. 1997 http://depts.washington.edu/hiprc/childinjury. Speller V. Preventing injury in children and young people: a review of the literature and current practice. Wessex Institute of Public Health Medicine 1995:1-61. b **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**
A25	Develop safe play areas	There has been little evaluation of the effects of playground layout, equipment and surfacing on injury rates.[a] Wood chips and sand appear safer surfacing materials than mats, gravel, grass and asphalt, but more research on playgrounds is needed.[b]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**

ACCIDENTS: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			b Harborview Injury Prevention and Research center. Fall Injury Interventions. University of Washington. 1997;http://depts.washington.edu/hiprc/childinjury.
A26	Install smoke alarms in local and health authority properties	Smoke detector give away programmes appear effective in reducing fire injuries, while community education has not been shown to be effective. The effect on injuries of individual counseling or education has not been studied.[a] The use of safety devices in the home, such as smoke detectors and thermostat control for tap water, can reduce the risk of home injuries.[a] Targeting of households at high risk, for example low-income households, combined with home visits, education and free distribution of devices is likely to have the greatest impact.[b]	a Warda L, Tenenbein M, Moffatt ME. House fire Injury prevention update. Part II. A review of the effectiveness of preventive interventions. Injury Prevention 1999;5:212-25. DiGuiseppi C, Higgins JPT. Interventions to promote smoke alarms: systematic reviews of controlled trials. Archives of Disease in Childhood 2000;82;341-8. b **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**
A27	Encourage private sector safety checks on appliances	No systematic reviews were identified in this area.	
A28	Promote/maintain home safety checks for older people	Some falls in the elderly can be prevented by ensuring that the drug regimens used with elderly people are chosen to reduce unwanted side-effects.[a] Home assessment and surveillance can reduce falls in frail elderly people. This can be carried out by a variety of health care workers or volunteers.[b] Falling in the elderly can be reduced by targeting multiple, identified risk factors in individual patients by behavioural interventions and targeting environmental hazards and other risk factors.[b]	a Hanlon JT, Cutson T, Ruby CM. Drug-related falls in the older adult. Topics in Geriatric Rehabilitation 1995;273:1341-7. b **Gillespie LD, Gillespie WJ, Cumming R, Lamb SE, Rowe BH. Interventions for preventing falls in the elderly. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **NHS Centre for Reviews and Dissemination. Preventing falls and subsequent injury in older people. Effective Health Care 1996:2(4).**
A29	Maintain highways, pavements and playgrounds	Wood chips and sand appear safer surfacing materials than mats, gravel, grass and asphalt, but more research on playgrounds is needed.[a]	a Harborview Injury Prevention and Research center. Fall Injury Interventions. University of Washington. 1997; http://depts.washington.edu/hiprc/childinjury.
A30	Identify/safeguard potentially hazardous sites (rivers, railways, dumps etc)	No systematic reviews were identified in this area.	
A31	Undertake community safety audits/risk assessment	No systematic reviews were identified in this area.	

ACCIDENTS: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
A32	Ensure well-developed emergency planning	Hospitals with up to date equipment and medical staff trained in trauma care have lower case – fatality rates among accident victims.[a] Other factors, such as the use of triage and rapid transportation from the site of the accident to the hospital, can also improve outcome.[a] There is no evidence that mortality from major trauma is lower in high volume accident and emergency units or specialised trauma centres than in other facilities.[b]	a Nygren Å, Alberts A, Brismar B, Dahlgren H, Lekander T, Magnusson S, et al. The treatment and rehabilitation of traffic accident victims (Trafikolycksfall). Stockholm: The Swedish Council on Technology Assessment in Health Care/ Statensberedning för utvärdering av medicinsk metodik (SBU) 1994:182. b **NHS Centre for Reviews and Dissemination. Hospital volume and healthcare outcomes, costs and patient access. Effective Health Care 1996:2(8).**
	People can:		
A33	Maintain household appliances to reduce accidents in the home	No systematic reviews were identified in this area.	
A34	Install and maintain smoke alarms	The use of safety devices in the home, such as smoke detectors and thermostat control for tap water, can reduce the risk of home injuries.[a] Targeting of households at high risk, for example low-income households, combined with home visits, education and free distribution of devices is likely to have the greatest impact.[a] Counselling as part of child health surveillance may increase smoke alarm ownership and function, but its effect on injuries are unevaluated.[b] Smoke detector give away programmes appear effective in reducing fire injuries, while community education has not been shown to be effective. The effect on injuries of individual counselling or education has not been studied.[b] Community programmes which involve local participation and use a broad range of interventions can reduce childhood injuries from a wide variety of causes.[a]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b Warda L, Tenenbein M, Moffatt ME. House fire injury prevention update. Part II. A review of the effectiveness of preventive interventions. Injury Prevention 1999;5:212-25. DiGuiseppi C, Higgins JPT. Interventions to promote smoke alarms: systematic reviews of controlled trials. Archives of Disease in Childhood 2000;82;341-8.

ACCIDENTS: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
A35	Drive safely and within speed limits	The speed at which a car is driven affects the severity of pedestrian injuries. However, no evaluations of the effectiveness of speed limits were identified.[a]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**
A36	Wear seatbelts on car journeys	Wearing seat belts reduces the risk of serious injury in road traffic accidents.[a]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996;2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**
A37	Ensure that they play an effective role in workplace safety procedures	No systematic reviews were identified in this area.	

ACCIDENTS: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
A38	Provide education/publicity on drink-drive	Evidence suggests that benzodiazepine use approximately doubles the risk of motor vehicle accidents.[a] Remedial interventions with drink/driving offenders can reduce recidivism and subsequent alcohol-related crashes.[b]	a Thomas RE. Benzodiazepine use and motor vehicle accidents: Systematic review of reported association. Canadian Family Physician. 1998;44:799-807. b **Dinh-Zarr T, DiGuiseppi C, Heitman E, Roberts I. Preventing injuries through interventions for problem drinking: a systematic review of randomised controlled trials. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Wells-Parker E, Bangert-Drowns R, McMillen M, Williams M. Final results from a meta-analysis of remedial interventions with drink/drive offenders. Addiction 1995;90: 907-26.
A39	Provide education/publicity on speed management	School/young people's education and training for drivers (eg pre-licence driver education) have not been shown to reduce accident rates.[a]	a Vernick JS. Effects of high school driver education on motor vehicle crashes, violations, and licensure. American Journal of Preventive Medicine 1999;16:40-6. Coleman P. The effectiveness of interventions to prevent accidental injury to young persons aged 15-24 years: a review of the evidence. Medical Care Research Unit 1996:1-89.
A40	Promote accident prevention through schools programmes (Healthy Schools Award)	School health promotion initiatives can have a positive impact on children's health and behaviour but do not do so consistently. Interventions are able to increase children's knowledge but changing attitudes and behaviour is harder. A multifaceted approach is likely to be most effective.[a] School/young people's education[b] and training for drivers (e.g pre-licence driver education) have not been shown to reduce accident rates.[c]	a **Lister-Sharp D, Chapman S, Stewart-Brown S, Sowden A. Health promoting schools and health promotion in schools: two systematic reviews. Health Technology Assessment 1999;3(22).** b **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** c Vernick JS. Effects of high school driver education on motor vehicle crashes, violations, and licensure. American Journal of Preventive Medicine 1999;16:40-6. Coleman P. The effectiveness of interventions to prevent accidental injury to young persons aged 15-24 years: a review of the evidence. Medical Care Research Unit 1996:1-89.

ACCIDENTS: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
A41	Promote *Safer Routes to School*	No systematic reviews were identified in this area.	
A42	Set up Youth Networks, playgroup associations	No systematic reviews were identified in this area.	
A43	Target health action zones/education action zones/ Single Regeneration Budget (SRB)/*New Deal for Communities*	There is a strong association between poverty and the rate of childhood injuries.[a]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996;2(5).** Gepkens A, Gunning-Schepers LJ. Interventions to reduce socioeconomic health differences: A review of the international literature. European Journal of Public Health 1996;6:218-26. **NHS Centre for Reviews and Dissemination. Review of the research on the effectiveness of health service interventions to reduce variations in health 1995;3**. **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**
	Local Players and Communities can:		
A44	Ensure effective provision/loans of safety equipment to target groups	When properly used, child car seat restraints reduce car occupant injuries.[a] In the USA, legislation for the under 4s has been shown to increase the use of car restraints and reduce the rate of injury and death.[b] Free car seat loans and reward/incentive/reinforcement programme increases car restraint use.[b]	a **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b DiGuiseppi C. Individual-level injury prevention strategies in the clinical setting. Future Child (in press). Segui-Gomez M. Evaluating interventions that promote the use of rear seats for children. American Journal of Preventive Medicine 1999;16:23-9.
A45	Conduct local campaigns (LEAs) on accidental injury prevention	Community and clinical educational programmes can increase child motor vehicle restraint use in children,[a] but the effect appears to decrease over time.[b] There is no evidence that counselling of children and their parents by physicians in the clinical setting increases bike helmet purchase.[c] Primary care based injury prevention counselling can reduce injuries.[d]	a Grossman DC. Effectiveness of health promotion programs to increase motor vehicle occupant restraint use among young children. Am J Prev Med. 1999;16:12-22. Segui-Gomez M. Evaluation interventions that promote the use of rear seats for children. Am J Prev Med 1999;16:23-9. b Grossman DC. Effectiveness of health promotion programs to increase motor vehicle occupant restraint use among young children. American Journal of Preventive Medicine.

ACCIDENTS: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
		Smoke detector give away programmes appear effective in reducing fire injuries, while community education has not been shown to be effective. The effect on injuries of individual counselling or education has not been studied.[e]	1999;16:12-22. c DiGuiseppi C. Individual-level injury prevention strategies in the clinical setting. Future Child (in press). d Bass JL. Childhood injury prevention counseling in primary care settings: a critical review of the literature. Pediatrics 1993;92:544-50. e Warda L. House fire injury prevention update. Part II. A review of the effectiveness of preventive interventions. Injury Prevention 1999;5:212-25. DiGuiseppi C, Higgins JPT. Interventions to promote smoke alarms: systematic reviews of controlled trials. Archives of Disease in Childhood 2000;82;341-8.
A46	Ensure more effective enforcement – fire, police, trading standards	No systematic reviews were identified in this area.	
A47	Put measures in place on prevention (eg stairgates, car seats) and rehabilitation (eg aids for older people)	Soft hip protector pads can reduce the risk of hip fractures amongst elderly people in an institutional setting.[a] Free car seat loans and reward/incentive/reinforcement programmes increase car restraint use.[b] When properly used, child car seat restraints reduce car occupant injuries.[c] In the USA, legislation for the under 4s has increased the use of car restraints and reduced the rate of injury and death.[c]	a **Parker MJ , Gillespie LD, Gillespie WJ. Hip protectors for preventing hip fractures in the elderly [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software .** **NHS Centre for Reviews and Dissemination. Preventing falls and subsequent injury in older people. Effective Health Care 1996:2(4).** b. DiGuiseppi C. Individual-level injury prevention strategies in the clinical setting. Future Child (in press). c. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**
A48	Develop private sector promoting safety culture for occupational road use	Evidence suggests that laws and campaigns introducing daytime running lights for cars reduces the number of multi-party daytime accidents by 3-12%.[a] However, daytime running car headlights have not been shown to reduce pedestrian injuries.[b] Vehicle modifications may reduce the risk of pedestrian injuries.[b]	a. Elvik R. A meta-analysis of studies concerning the safety effects of daytime running lights on cars. Accident Analysis and Prevention 1996;28:685-94. b. Harborview Injury Prevention and Research Center. Child Pedestrian Injury Interventions. University of Washington. 1997;http://depts.washington.edu/hiprc/childinjury.

ACCIDENTS: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
A49	Promote swimming training	No systematic reviews were identified in this area.	
	People can:		
A50	Ensure that cyclists, especially children and young people, wear cycle helmets	The use of cycle helmets by children substantially reduces the rates of serious injury from road traffic accidents.[a] Incidence and severity of head injury are lower in cyclists wearing helmets, and these effects appear to be increased with robustness of helmet design.[b] Helmets substantially reduce the risk of head, brain and severe brain injury, and injuries to the upper and mid-facial areas.[c] Legislation increases the use of helmets in those who continue to cycle and substantially reduces the rates of serious head injury.[a] There is no evidence that counselling of children and their parents by physicians in the clinical setting increases bike helmet purchase.[d]	a. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b Coleman P. The effectiveness of interventions to prevent accidental injury to young persons aged 15-24 years: a review of the evidence. Medical Care Research Unit 1996;1-89. c. **Thompson DC. Helmets for preventing head and facial injuries in bicyclists [Cochrane Review]. In The Cochrane Library, Issue 1, 2000. Oxford Update Software.** d. DiGuiseppi C. Individual-level injury prevention strategies in the clinical setting. Future Child (in press).
A51	Avoid drinking and driving *(cont)*	Remedial interventions with drink/driving offenders can reduce recidivism and subsequent alcohol-related crashes.[a] No specific intervention programmes for alcohol misuse prevention in young people have been shown to be effective in the long term.[b] Brief interventions in primary care, including assessment of intake and provision of information and advice, have been shown to reduce alcohol consumption by up to 20% in those with consumption levels above recommended guidelines. Brief interventions are as effective as more expensive specialist treatment in this context.[c] Alcohol ignition interlock devices appear to be effective in reducing drink driving recidivism.[d] In the USA administrative per se laws (the enabling legislation for this action defines failing an alcohol concentration test as suitable grounds for license suspension) seem to have reduced drink driving recidivism in some states but not in others, compared with drivers who were sanctioned through other	a. **Dinh-Zarr T, DiGuiseppi C, Heitman E, Roberts I. Preventing injuries through interventions for problem drinking: a systematic review of randomised controlled trials. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. Wells-Parker E, Bangert-Drowns R, McMillen M, Williams M. Final results from a meta-analysis of remedial interventions with drink/drive offenders. Addiction 1995;90: 907-26. b. Foxcroft DR, Lister-Sharp D, Lowe G. Alcohol misuse prevention for young people: a systematic review reveals methodological concerns and lack of reliable evidence of effectiveness. Addiction 1997;92:531-7. c. **NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. Effective Health Care 1993:1(7).** d. Coben JH, Larkin GL. Effectiveness of ignition interlock devices in reducing drunk driving recidivism. American Journal of Preventive Medicine 1999;16:81-7. e. McArthur DL. The specific deterrence of administrative per se laws in reducing drunk driving recidivism. American Journal of Preventive Medicine 1999;16:68-75.

ACCIDENTS: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
A51	*(cont)*Avoid drinking and driving	conventional judicial processes.[e] Random screening can substantially reduce crash fatalities and injuries.[f] Laws in the USA requiring lower legal blood alcohol concentration limits among younger drivers reduce injuries and crashes.[g]	f. Peek-Asa C. The effect of random alcohol screening in reducing motor vehicle crash injuries. American Journal of Preventive Medicine 1999;16:57-67. g. Zwerling C. Evaluation of the effectiveness of low blood alcohol concentration laws for younger drivers. American Journal of Preventive Medicine 1999;1:76-80.
A52	Undertake effective training to improve road safety skills	A review on education for pedestrians is currently underway.[a] School/young people's education and training for drivers (e.g pre-licence driver education) have not been shown to reduce accident rates.[b]	a. **Duperrex O. Safety education of pedestrians for injury prevention [Protocol for a Cochrane Review]. In The Cochrane Library, Issue 1, 2000. Oxford Update Software.** b. Vernick JS. Effects of high school driver education on motor vehicle crashes, violations, and licensure. American Journal of Preventive Medicine 1999;16:40-6. Coleman P. The effectiveness of interventions to prevent accidental injury to young persons aged 15-24 years: a review of the evidence. Medical Care Research Unit 1996;1-89.
A53	Ensure that children and young people take up cycle/pedestrian training	There is little reliable evidence that children can be successfully trained to avoid injury on the roads, although some changes to knowledge and skills have been reported.[a] A systematic review on education of pedestrians for injury prevention is currently underway.[b]	a. Harborview Injury Prevention and Research Center. Child Pedestrian Injury Interventions. University of Washington. 1997;http://depts.washington.edu/hiprc/childinjury. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b. **Duperrex O. Safety education of pedestrians for injury prevention [Protocol for a Cochrane Review]. In The Cochrane Library, Issue 1, 2000. Oxford Update Software.**
A54	Take up physically active lifestyles (to improve bone density and prevent osteoporotic fractures) *(cont)*	There have been mixed findings about the effect of physical activity to prevent bone loss in postmenopausal women. Some reviews have found that physical activity appears to delay or reduce the loss of bone mineral density (BMD), reduce the risk of osteoporosis,[a] and reduce risk factors for hip fracture.[b] One review found that exercise training programes prevented or reversed bone loss of almost 1% per year compared to the controls.[c] However, another review found no statistically significant effect on bone mineral density.[d]	a. Ernst E. Extercise for female osteoporosis - a systematic review of randomised controlled trials. Sports Medicine. 1998;25:359-68. Kelley GA. Exercise and regional bone mineral density in postmenopausal women: a meta-analytic review of randomized trials. American Journal of Physical Medicine and Rehabilitation 1998;77:76-87. Kelley G. Aerobic exercise and lumbar spine bone mineral density in postmenopausal women: a meta-analysis. Journal

ACCIDENTS: Personal behaviour

POLICY

A54 *(cont)* Take up physically active lifestyles (to improve bone density and prevent osteoporotic fractures) *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

Screening post-menopausal women for low bone density has not been shown to reduce the incidence of fractures.[e]

There is some evidence to suggest that exercise such as balance training is effective in preventing falls and subsequent injury in older people.[f] It is not known whether other single interventions such as exercise alone or health education classes, prevent falls in the elderly. Interventions targeted at both intrinsic and environmental risk factors of individual patients may be more effective.[g]

As smoking is a risk factor for osteoporosis, effective smoking prevention interventions may reduce the incidence of osteoporosis.[h]

See evidence relevant to C22, H26 in Cancer and Heart Disease and Stroke chapters.

Bisphonates appear to prevent and reverse bone loss[i] and may reduce the risk of fracture[j].

Protocols for seven reviews of interventions to prevent and treat osteoporosis are available.[k]

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of the American Geriatrics Society 1998;46:143-52.

Wolff I. The effect of exercise training programs on bone mass: a meta-analysis of published controlled trials in pre- and postmenopausal women. Osteoporosis International 1999;9:1-12.

b. Joakimsen RM. Physical activity and predisposition for hip fractures - a review. Osteoporosis International 1997;7:503-13.

c. Berard A. Meta-analysis of the effectiveness of physical activity for the prevention of bone loss in postmenopausal women. Osteoporosis International 1997;7:331-7.

d. Wolff I. The effect of exercise training programs on bone mass: a meta-analysis of published controlled trials in pre- and postmenopausal women. Osteoporosis International 1999;9:1-12.

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f. **NHS Centre for Reviews and Dissemination. Preventing falls and subsequent injury in older people. Effective Health Care 1996:2(4).**

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g. **Gillespie LD, Gillespie WJ, Cumming R, Lamb SE, Rowe BH. Interventions for preventing falls in the elderly [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford. Update Software.**

h. **NHS Centre for Reviews and Dissemination: Smoking cessation: What the Health service can do. Effectiveness Matters 1998:3(1)**.

ACCIDENTS: Personal behaviour

POLICY

A54 *(cont)* Take up physically active lifestyles (to improve bone density and prevent osteoporotic fractures)

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

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j. Karpf DB, Shapiro DR, Seeman E et al. Prevention of nonvertebral fractures by alendronate: a meta-analysis. JAMA. 1997;227:1159-64.

k. **Bonaiuti D, Shea B, Lovine R, Negrini S, Wells G, Cranney A, Gillespie W, Hanley D, Tugwell P. Exercise for osteoporosis in postmenopausal women [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

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See Tai S, Parsons T, Rutherford O, Illiffe S. Physical activity for the prevention and treatment of osteoporosis

ACCIDENTS: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
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A55	Ensure a healthy diet (with sufficient calcium and vitamin D intake for bone health)	Vitamin D and calcium supplements for people on steroids can prevent osteoporosis.[a] It is not yet clear whether Vitamin D injections with or without the addition of calcium supplements in healthy people can prevent osteoporosis.[b]	a. Gepkens A, Gunning-Schepers LJ. Interventions to reduce socioeconomic health differences: A review of the international literature. European Journal of Public Health 1996;6:218-26. **Homik J, Suarez-Almazor ME, Shea B, Cranney A, Wells G, Tugwell P. Calcium and vitamin D for corticosteroid-induced osteoporosis [Cochrane Review]. In: The Cochrane Library. Issue 1, 2000. Oxford Update Software** . b. **Gillespie WJ, Henry DA, O'Connell DL, Robertson J. Vitamin D and Vitamin D analogues for preventing of fractures associated with involutional and post-menopausal osteoporosis [Cochrane Review]. In The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **NHS Centre for Reviews and Dissemination. Preventing falls and subsequent injury in older people. Effective Health Care 1996:2(4).** **Homik J, Suarez-Almazor ME, Shea B, Cranney A, Wells G, Tugwell P. Calcium and vitamin D for corticosteroid-induced osteoporosis [Cochrane Review]. In: The Cochrane Library. Issue 1, 2000. Oxford Update Software** .

ACCIDENTS: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
A56	Develop and implement *National Service Framework for Older People*	No systematic reviews were identified in this area.	
	Local Players and Communities can:		
A57	Continue reviews of medication, eyesight in older people (over 75 check)	There is no evidence that community-based screening of asymptomatic older people results in improvements in vision.[a]	a **Smeeth L, Iliffe S. Community screening for visual impairment in the elderly [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**.
A58	Promote safety awareness, with risk assessment of fallers, on discharge from hospital	Soft hip protector pads can reduce the risk of hip fractures amongst elderly people in an institutional setting.[a] Some falls in the elderly can be prevented by ensuring that the drug regimens used by elderly people are chosen to reduce unwanted side-effects.[b] Home assessment and surveillance can reduce falls in frail elderly people. This can be carried out by a variety of health care workers or volunteers.[c] Falling in the elderly can be reduced by targeting multiple, identified risk factors in individual patients by behavioural interventions, and by targeting environmental hazards and other risk factors.[d] Screening for osteoporosis has not been shown to be effective in preventing fractures in the elderly.[e]	a **Parker MJ, Gillespie LD, Gillespie WG. Hip protectors for preventing hip fractures in the elderly [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **NHS Centre for Reviews and Dissemination. Preventing falls and subsequent injury in older people. Effective Health Care 1996:2(4)**. b Hanlon JT, Cutson T, Ruby CM. Drug-related falls in the older adult. Topics in Geriatric Rehabilitation 1995;273:1341-7. c **Gillespie LD, Gillespie WJ, Cumming R, Lamb SE, Rowe BH. Interventions for preventing falls in the elderly [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. **NHS Centre for Reviews and Dissemination. Preventing falls and subsequent injury in older people. Effective Health Care 1996:2(4).** d **Gillespie LD, Gillespie WJ, Cumming R, Lamb SE, Rowe BH. Interventions for preventing falls in the elderly. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **NHS Centre for Reviews and Dissemination. Preventing falls and subsequent injury in older people. Effective Health Care 1996:2(4)**. Province MA, Hadley EC, Hornbrook MC, Lipsitz LA, Miller JP, Mulrow CD, Ory MG, Sattin RW, Tinetti ME, Wolf SL. The effects of exercise on falls in elderly patients:

ACCIDENTS: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			a preplanned meta-analysis of the FICSIT trials. JAMA 1996;11:38-54. e **NHS Centre for Reviews and Dissemination. Screening for osteoporosis to prevent fractures. Effective Health Care 1992:1(1).**
A59	Promote local initiatives on physical activity in older people	There is some evidence to suggest exercise such as balance training is effective in preventing falls and subsequent injury in older people.[a] There is some evidence to suggest that exercise such as balance training is effective in preventing falls and subsequent injury in older people.[a] It is not known whether other single interventions such as exercise alone or health education classes, prevent falls in the elderly. Interventions targeted at both intrinsic and environmental risk factors of individual patients may be more effective.[b]	a **NHS Centre for Reviews and Dissemination. Preventing falls and subsequent injury in older people. Effective Health Care 1996:2(4).** Province MA, Hadley EC, Hornbrook MC, Lipsitz LA, Miller JP, Mulrow CD, Ory MG, Sattin RW, Tinetti ME, Wolf SL. The effects of exercise on falls in elderly patients: a preplanned meta-analysis of the FICSIT trials. JAMA 1996;11:38-54. b **Gillespie LD, Gillespie WJ, Cumming R, Lamb SE, Rowe BH. Interventions for preventing falls in the elderly [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford. Update Software.**
A60	Promote family support – accident awareness, parenting skills	Child resistant containers have been shown to reduce home injuries.[a] There is some evidence to suggest that childhood injury prevention counselling in primary care settings can be effective in increasing the use of safety equipment in the home.[b] Home based social support, such as that provided by health visitors, is effective in reducing child injury rates.[a] Home visiting programmes have the potential to significantly reduce the rates of childhood injury.[c] Families are more likely to test and lower hot water temperature after receiving counselling in the clinical setting.[d]	a. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** Speller V. Preventing injury in children and young people: a review of the literature and current practice. Wessex Institute of Public Health Medicine1995;1-61. **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b. Bass JL, Christoffel KK, Widome M, Boyle W, Scheidt MD, Stanwick R, Roberts K. Childhood injury prevention counselling in primary care settings: a critical review of the literature. Pediatrics 1993;92:544-50. DiGuiseppi C. Individual-level injury prevention strategies in the clinical setting. Future-Child (in press). **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.**

ACCIDENTS: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			c. Roberts I. Does home visiting prevent childhood injury: a systematic review of randomised controlled trials. BMJ 1996;312:29-33. **Hodnett ED, Roberts I. Home-based social support for socially disadvantaged mothers [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software** . d. DiGuiseppi C. Individual-level injury prevention strategies in the clinical setting. Future Child (in press).
A61	Take part in *Healthy Schools* programmes	School health promotion initiatives can have a positive impact on children's health and behaviour but do not do so consistently. Interventions are able to increase children's knowledge but changing attitudes and behaviour is harder. A multifaceted approach is likely to be most effective.[a]	a. **Lister-Sharp D , Chapman S, Stewart-Brown S, Sowden A. Health promoting schools and health promotion in schools: two systematic reviews. Health Technology Assessment 1999;3:(22).**
A62	Provide local alcohol services	No systematic reviews were identified in this area.	
A63	Ensure integrated service provision	No systematic reviews were identified in this area.	
A64	Provide pedestrian training for children	There is no strong evidence to suggest that children can be successfully trained to avoid injury on the roads.[a] A systematic review is currently underway on safety education for pedestrians.[b]	a. **NHS Centre for Reviews and Dissemination. Preventing unintentional injuries in children and young adolescents. Effective Health Care 1996:2(5).** **Towner E, Dowswell T, Simpson G, Jarvis S. Health promotion in childhood and young adolescence for the prevention of unintentional injuries, Health promotion effectiveness reviews. London: Health Education Authority 1996;1.** b. **Duperrex O. Safety education of pedestrians for injury prevention [Protocol for a Cochrane Review]. In The Cochrane Library, Issue 1, 2000. Oxford Update Software.**
A65	Promote cycle proficiency schemes	No systematic reviews were identified in this area.	
	People can:		
A66	Have regular eye-tests	There is no evidence that community-based screening of asymptomatic older people results in improvements in vision.[a]	a. **Smeeth L, Illiffe S. Community screening for visual impairment in the elderly [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford. Update Software.**

ACCIDENTS: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
A67	Learn basic resuscitation/emergency skills	Defibrillation by basic life support personnel appears to reduce the risk of mortality among out-of-hospital cardiac arrest victims in ventricular fibrillation.[a]	a. Auble TE, Menegazzi JJ, Paris PM. Effect of out-of-hospital defibrillation by basic life support providers on cardiac arrest mortality: a metaanalysis. Annals of Emergency Medicine 1995;25:642-8. Nichol G, Stiell IG, Laupacis A, Wells G A. A cumulative meta-analysis of the effectiveness of defibrillator-capable emergency medical services for victims of out-of-hospital cardiac arrest. Annals of Emergency Medicine 1999;34:517-25.

ACCIDENTS: Additional evidence

Treatment of trauma

There is no evidence that medical anti-shock trousers (pneumatic anti-shock garments) reduce mortality, length of hospitalisation or length of ICU stay in trauma patients.[a]

High dose methylprednisolone in the acute management of spinal cord injury can improve neurological recovery.[b]

Treatment of critically ill patients

There is no evidence that colloid solutions are of any benefit in fluid resuscitation, either used alone or in combination with hypertonic crystalloids.[c]

There is no evidence that one colloid solution is more effective or safe than any other in the treatment of critically ill patients.[d]

There is evidence that albumin increases the risk of death in critically ill patients.[e]

Hyperbaric oxygen in the treatment of nonpregnant adults with acute carbon monoxide poisoning has not been shown to reduce neurologic symptoms one month after treatment.[f]

Treatment for musculoskeletal injuries

Shock absorbing insoles in footwear reduce stress fractures in athletes and military personnel. Rehabilitation after tibial stress fractures is aided by pneumatic bracing.[g]

Antibiotic prophylaxis reduces wound, urinary and respiratory tract infections in patients undergoing surgery for closed fracture fixation.[h]

Condylocephalic nails (in particular Ender nails) for hip fractures increase fracture healing complications, re-operation, residual pain and deformity compared with extramedullary implants.[i]

a **Dickinson K, Roberts I. Medical anti-shock trousers (pneumatic anti-shock garments) for circulatory support in patients with trauma [Cochrane Review]. In The Cochrane Library, Issue 1, 2000. Oxford Update Software .**

b **Bracken MB. Pharmacological interventions for acute spinal cord injury [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

c **Alderson P, Schierhout G, Roberts I, Bunn F. Colloids versus crystalloids for fluid resuscitation of critically ill patients [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software .**

d **Bunn F, Alderson P, Hawkins V. Colloid solutions for fluid resuscitation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software .**

e **The Albumin Reviewers (Alderson P, Bunn F, Lefebvre C, Li Wan Po A, Li L, Roberts I, Schierhout G). Human albumin solution for resuscitation and volume expansion in critically ill patients [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

f **Juurlink DN, Stanbrook MB, McGuigan MA. Hyperbaric oxygen for carbon monoxide poisoning [Cochrane Review]. In The Cochrane Library, Issue 2, 2000. Oxford Update Software .**

g **Gillespie WJ, Grant I. Interventions for preventing and treating stress fractures and stress reactions of bone of the lower limbs in young adults [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

h **Gillespie WJ, Walenkamp G. Antibiotic prophylaxis for surgery for proximal femoral and other closed long bonefractures. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

i **Parker MJ, Handoll HHG, Bhonsle S, Gillespie WJ. Condylocephalic nails versus extramedullary implants for extracapsular hip fractures. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

j **Cranney A, Welch V, Adachi JD, Homik J, Shea B, Suarez-Almazor ME, Tugwell P, Wells G. Calcitonin for the treatment and prevention of corticosteroid-induced osteoporosis [Cochrane Review]. In: The Cochrane Library. Issue 1, 2000. Oxford: Update Software .**

k **Handoll HHG, Madhok R Conservative interventions for treating distal radial fractures in adults [Cochrane Review]. In: The Cochrane Library Issue 1, 2000. Oxford. Update Software.**

l **Alderson P, Roberts I. Corticosteroids in acute traumatic brain injury. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software .**

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Howell JR, Handoll HHG. Surgical treatment for meniscal injuries of the knee in adults [Cochrane Review]. In: The Cochrane Library. Issue 1, 2000. Oxford Update Software.

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Parker MJ, Griffiths R, Appadu BN. Nerve blocks (subcostal, lateral cutaneous, femoral, triple, psoas) for hip fractures [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

ACCIDENTS: Additional evidence

The efficacy of calcitonin for fracture prevention in steroid-induced osteoporosis remains to be established.[j]

No differences have been found in comparisons of methods of conservative treatment for wrist fractures.[k]

Reviews of the effective and safe management of specific accidental injuries are the focus of 23 further complete Cochrane reviews[l] and 29 protocols for Cochrane reviews.[m]

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m **Bryden DC, Lecky F, Moulton C, Little RA. Emergency intubation for acutely ill and injured patients [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

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A NATIONAL CONTRACT ON MENTAL HEALTH

MENTAL HEALTH: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
M1	Tackle joblessness and social exclusion	Rates of mental ill health are consistently associated with indicators of poverty and deprivation.[a] Pre-school day care increases the chance of being in well paid employment over 20 years later.[b]	a. **NHS Centre for Reviews and Dissemination. Mental health promotion in high risk groups. Effective Health Care 1997:3(3).** b. **Zoritch B, Roberts I , Oakley A. Day care for pre-school children [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
M2	Consider the mental health impact when developing policy on employment, education, social welfare, child abuse, children in care and leaving care, refugees and substance misuse	Factors associated with low income (poor housing, overcrowding, high rise living, dissatisfaction with housing) are also associated with poor physical and mental health.[a] Supported employment within a normal working environment, for those recovering from serious mental illnesses, is more acceptable and effective at keeping people in employment, than work within especially designed 'sheltered' institutions.[b] Psychosocial rehabilitation within community support appears to be successful in reducing symptoms, increasing community adjustment, medication compliance, preventing relapse and reducing use of hospitals and other restrictive settings, for persons with severe mental illness. Such interventions also appear to be cost-effective.[c] There is no experimental evidence of the effects of income supplementation on physical or mental health.[d] Extended home visitation can prevent physical abuse and neglect among disadvantaged families.[e] Group treatment for sexually abused children and adolescents may be effective, but reviews on which these conclusions rest may have over estimated treatment effects.[f]	a. Hwang S, Fuller-Thomson E, Hulchanski JD, Bryant T, Habib Y, Regoeczi W. Housing and population health: a review of the literature. University of Toronto: Centre for Applied Social Work, May 1999. b. **Crowther R, Marshall M, Bond G, Huxley P. Vocational rehabilitation for people with severe mental disorders. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. Barton R. Psychosocial rehabilitation services in community support systems: a review of outcomes and policy recommendations. Psychiatric Services 1999;50:525-34. d. Connor J, Rodgers A, Priest P. Randomised studies of income supplementation: a lost opportunity to assess health outcomes. Journal of Epidemiological Community Health 1999;53:725-30. Lafave HJ. de Souza HR, Prince PN et al. Partnerships for people with serious mental illness who live below the poverty line. Psychiatric Services 1995;46:1071-98. e. MacMillan HL, MaMillan JH, Offord DR. Primary Prevention of child physical abuse and neglect: A critical review. Journal of Child Psychology and Psychiatry and Allied Disciplines ;35:835-56. f. Recker J, Ensing D, Elliott R. A meta-analytic investigation for group treatment outcomes for sexually abused children. Child Abuse and Neglect 1997;21:669-80.

MENTAL HEALTH: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M3	Develop *New Deal for Communities*	No systematic reviews were identified in this area.	
M4	Ensure responsible media reporting of suicides and homicides	Experimental studies randomly allocating students to a film about violence or suicide, or a neutral film suggest that the media may either increase or decrease suicidal behaviour in vulnerable people.[a] Research before and after reports of suicide in the media suggest that self-harm may be increased but evidence is not conclusive.[b]	a. Biblarz A, Brown RM, Biblarz DN, Pilgrim M, Baldree BF. Media influence on attitudes toward suicide. Suicide and Life-Threatening Behavior 1991;21:374-84. b. Platt S. The aftermath of Angie's overdose: is soap (opera) damaging to your health? BMJ 1987;294:954-7.
M5	Improve provision of mental health systems and collection of information	No systematic reviews were identified in this area.	
M6	Tackle alcohol and drug misuse *(cont)*	Brief interventions in primary care including assessment of alcohol intake, and provision of information and advice can reduce alcohol consumption in those with consumption levels above recommended guidelines.[a] Brief interventions are as effective as more expensive specialist treatment in this context.[b] Outpatient treatment is as effective as in-patient or residential treatment in reducing alcohol abuse.[c] Family management is a promising intervention in decreasing the severity and rate of drug abuse.[d] Pre-school education can decrease arrests and arrests specifically for drug dealing behaviour.[e] Current research evidence is inadequate to allow confident recommendations to plan and implement substance abuse policies for young people. No specific intervention programmes for substance misuse prevention in young people have been shown to be effective in the long term.[f] However, substance abuse interventions using educational approaches have a positive effect on knowledge and attitudes but have little success in changing behaviour patterns in key target groups such as adolescents.[g] Social reinforcement and developmental behaviour modification methods seem	a. Ashenden R, Silagy C, Weller D. A systematic review of the effectiveness of promoting lifestyle change in general practice. Family Practice 1997;14:160-75. **NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. Effective Health Care 1993:1(7).** Poikolainen K. Effectiveness of brief interventions to reduce alcohol intake in primary health care populations. Preventive Medicine 1999;28:503-9. b. **NHS Centre for Reviews and Dissemination. Brief interventions and alcohol use. Effective Health Care 1993:1(7).** c. Mattick RP, Jarvis T. In-patient setting and long duration for the treatment of alcohol dependence. Out patient care is as good. Drug and Alcohol Review 1994;13:127-35. d. Stanton MD, Shadish WR. Outcome, attrition and family-couples treatment for drug abuse: a meta-analysis and review of the controlled comparative studies. Psychological Bulletin 1997;122:170-91. e. **Zoritch B, Roberts I, Oakley A. Day care for pre-school children. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** f. **White D, Pitts M. Health promotion with young people for the prevention of substance misuse. London. Health Education Authority, 1997.** Foxcroft DR, Lister-Sharp D, Lowe G. Alcohol misuse prevention for young people: a systematic review reveals methodological concerns and lack of reliable evidence of

MENTAL HEALTH: Social and economic interventions

POLICY

M6 *(cont)* Tackle alcohol and drug misuse *(cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

to be more effective than traditional awareness programmes for informing adolescents about the health risks associated with tobacco and alcohol abuse.[h]

Peer-led programmes[i] seem to have a superior effect on students' knowledge, attitudes and behaviour than teacher-led initiatives. Also interactive peer-led interventions[j] seem to be more effective than non-interactive didactic lecture programmes led by teachers or researchers.

The effects of naltrexone treatment remain uncertain, but may be useful as an adjunct in people for whom the consequences of relapse are severe (parolees, health care professionals).[k]

No systematic reviews of the effects of fiscal interventions relating to alcohol advertising, age limits for drinking and the opening hours of pubs/clubs were identified.

Relapse prevention (a cognitive-behavioural technique) appears to be most effective when applied to alcohol and poly-substance use disorders, combined with the adjunctive use of medication.[l]

Contingency management reduces supplemental drug use for people on outpatient methadone treatment.[m]

A range of effective interventions are available for reducing recidivism and more generally reducing alcohol consumption in those convicted of a drink/ drive offence.[a] For example, psychotherapy/ counselling, education and contact based interventions, probation, Alcoholics Anonymous, Antabuse, primary care based treatment and advice and combinations of these interventions may reduce rates of recidivism.[n]

There is no evidence that any particular programme is more effective than any other in people with severe mental illness and substance abuse.[o]

Attending conventional Alcoholics Anonymous meetings is worse than no treatment or alternative treatment but several components of Alcoholics Anonymous were supported (recovering alcoholics as therapists, peer-led, self-help therapy groups, teaching the Twelve Step process, and doing an honest

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effectiveness. Addiction 1997;92:531-7.

g. Bangert-Drowns RL. The effects of school-based substance abuse education – a meta-analysis. Journal of Drug Education 1988;18:243-64.

h. Rundall TG, Bruvold WH. A meta-analysis of school-based smoking and alcohol use prevention programs Health Education Quarterly 1988;15:317-34.

i. Bangert Drowns RL. The effects of school-based substance abuse education--a meta-analysis. Journal of Drug Education. 1988;18:243-64.

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MENTAL HEALTH: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M6	*(cont)* Tackle alcohol and drug misuse	inventory).[p] Interventions aimed at drink-drivers are effective in reducing suicide attempts, domestic violence, falls, drinking-related injuries and injury hospitalisations and deaths.[q]	n. Wells-Parker E, Bangert-Drowns R, McMillen R, Williams M. Final results from a meta-analysis of remedial interventions with drink/drive offenders. Addiction 1995;90:907-26. o. **Ley A, Jeffery DP, McLaren S, Siegfried N. Treatment programmes for people with both severe mental illness and substance misuse [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** p. Kownacki R.J, Shadish WR. Does Alcoholics Anonymous Work? The results from a meta-analysis of controlled experiments. Substance Use and Misuse 1999;34:1897-916. q. **Dinh-Zarr T, DiGuiseppi C, Heitman E, Roberts I. Interventions for preventing injuries in problem drinkers [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	Local Players and Communities can:		
M7	Work with health improvement programmes to develop local mental health initiatives on prevention, better identification and treatment, including help for at-risk groups such as recently bereaved, lone parents, unemployed people, refugees *(cont)*	Psychological debriefing ("counselling") after disasters may increase long term distress.[a] Multiple community agency home visiting programmes for prenatal or postnatal women and babies decreases re-hospitalisation, and promotes factors associated with bonding and positive child development.[b] Professional emotional support of pregnant women caring for additional young children can decrease rates of post-natal depression.[c] Home based social support for pregnant women at high-risk of depression improves the mental well being of mothers and their children.[d] Support and teaching of coping skills to newly separated people can improve mental health over the long term.[e] A variety of cognitive behavioural and socially based interventions are effective with children who experience adverse life events such as parental separation, divorce and bereavement.[e] The use of social support and problem solving or cognitive behavioural training in unemployed people can improve mental health and employment	a. **Wessely S, Rose S, Bisson J. Brief psychological interventions ("debriefing") for the treatment of immediate trauma related symptoms and the prevention of post-traumatic stress disorder. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. Ciliska D, Mastrilli P, Ploeg J, Hayward S, Brunton G, Underwood J. The effectiveness of home visiting as a delivery strategy for public health nursing interventions to clients in prenatal and postnatal period: a systematic review. Prepared by the Effective Public Health Practice Project for the Public Health Branch, Ontario Ministry of Health, 1999. c. **Ray KL, Hodnett ED. Caregiver support for postpartum depression. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. **Hodnett ED. Support during pregnancy for women at increased risk [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** e. **NHS Centre for Reviews and Dissemination. Mental health promotion in high risk groups. Effective Health Care 1997:3(3).**

MENTAL HEALTH: Social and economic interventions

POLICY

M7 *(cont)* Work with health improvement programmes to develop local mental health initiatives on prevention, better identification and treatment, including help for at-risk groups such as recently bereaved, lone parents, unemployed people, refugees

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

outcomes.[e]

The available research is inadequate to assess the effects of interventions providing support for women and families following perinatal death.[f]

The available evidence is insufficient to know if health visitors can reduce the risk of child abuse in at risk parents. There is no evidence on the effectiveness of treatments for victims of child sexual abuse.[g]

There is insufficient evidence to support routine grief therapy in the UK.[h]

The effects of any form of medical, nursing, social or psychological support and/or counselling to mothers and families after perinatal death is unknown.[i]

Screening of patients in geriatric homes has not been demonstrated to have effects on mental health.[j]

Respite care only temporarily alleviates mental health problems commonly experienced by long term carers but there is some evidence that it may delay institutionalisation.[k]

Studies, predominantly from the USA, suggest that psychological interventions may prevent marital/couple distress or ameliorate it once it occurs. There is a need, however, to evaluate these interventions with more diverse couples than has hitherto been the case and in real-world settings.[l]

Home-based social support for socially disadvantaged mothers appears to result in a slight reduction in injuries to children and may contribute to reductions in child abuse and neglect, and associated psychological sequelae.[m]

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MENTAL HEALTH: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M8	Tackle inequity and social exclusion	Interventions to improve the mental development of children through training of parents have been shown to be successful.[a]	a. Gepkens A, Gunning-Schepers LJ. Interventions to reduce socio- economic health differences: An evaluation of Dutch and foreign interventions to reduce socio-economic health differences. Institute of Social Medicine, Amsterdam 1995.
M9	Encourage positive local media reporting to reduce stigma surrounding mental illness	No systematic reviews were identified in this area.	
M10	Develop job and volunteering opportunities for people with mental illness	Supported employment, within a real working environment, is more effective than sheltered workshops in helping severely mentally ill people to obtain competitive employment.[a] Supported employment schemes help integrate those with severe mental illness into the world of work. Integration of mental health and vocational services within a single service team and the avoidance of pre-placement training appear to be particularly important.[b] Community team management can increase the likelihood that people with mental illness are able to work.[c] 'Assertive community treatment', as a complete community care package, helps the seriously mentally ill find employment and live independently. It also reduces hospital re-admission rates.[d] Implementing a policy of short stays (eg 28 days maximum) for mentally ill people needing admission to hospital can improve care and also help people stay in or gain employment.[e] Existing studies have not shown that providing education and support to the families of people with schizophrenia improves employment rates.[f] There is no evidence that the 'care plan approach' for serious mental illness (currently a statutory obligation in UK) is effective in helping unemployed, mentally ill people back to work, and it doubles hospital admission rates.[g]	a. **Crowther R, Marshall M, Bond G, Huxley P. Vocational rehabilitation for people with severe mental disorders. [Cochrane review] In: The Cochrane Library, Issue 3, 2000. Oxford: Update Software.** b. Bond GR, Drake RE, Mueser KT, Becker DR. An update on supported employment for people with severe mental illness. Psychiatric Services 1997;48:335-46. c. **Tyrer P, Coid J, Simmonds S, Joseph P, Marriott S. Community mental health teams (CHMTs) for people with severe mental illnesses and disordered personality. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.** d. **Marshall M, Lockwood A. Assertive Community Treatment for people with severe mental illness. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** e. **Johnstone P, Zolese G. Length of hospitalisation for people with severe mental illness. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** f. **Pharoah F, Mari JJ, Streiner D. Family intervention for schizophrenia. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.** g. **Marshall M, Gray A, Lockwood A, Green R. Case management for people with severe mental disorders. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.**

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M11	Develop local strategies to support the needs of mentally ill people from black and minority ethnic groups	There is evidence both of unmet need and referral problems in respect of psychological disorders and mental health within ethnic minority groups, therefore making GPs and other primary health care professionals aware of the risk status of high risk groups, such as south Asian women, may improve mental health and reduce suicide.[a]	a. **NHS Centre for Reviews and Dissemination. Ethnicity and health: Reviews of literature and guidance for purchasers in the areas of cardiovascular disease, mental health and haemoglobinopathies. Report 5. University of York: NHS Centre for Reviews and Dissemination 1996**.
	People can:		
M12	Develop parenting skills	Support visits for new parents can improve mental health in children and parents in disadvantaged communities.[a] School based interventions and parent training programmes for children with behavioural problems can improve both conduct and mental well being.[a] Professionally led, parental empowerment groups promote positive parenting styles over time (children under 6 years old).[b] Group parental skills programmes are more cost-effective than individual family training.[b] Continuous support from a trained laywoman during childbirth can improve obstetric and psychosocial outcomes. Labour support by fathers does not appear to produce similar benefits.[c] Parent-training, particularly cognitive-behavioural or social learning based interventions, can improve parenting in high risk groups, including parents with intellectual disabilities and parents who are abusive or neglectful or at risk of abuse or neglect.[d]	a. **NHS Centre for Reviews and Dissemination. Mental health promotion in high risk groups. Effective Health Care 1997:3(3).** b. Thomas H, Camiletti Y, Cava M, Feldman L, Underwood J, Wade K. Effectiveness of parenting groups with professional involvement in improving parent and child outcomes. Prepared by the Effective Public Health Practice Project for the Public Health Branch, Ontario Ministry of Health 1999. c. Scott KD, Klaus PH, Klaus MH. The obstetrical and postpartum benefits of continuous support during childbirth Journal of Women's Health and Gender-Based Medicine. 1999;8:1257-64. d. Barlow J. Systematic review of the effectiveness of parent-training programmes in improving behaviour problems in children aged 3-10 years. Oxford, Health Services Research Unit, Institute of Health Sciences. ISBN: 1874551251. Macdonald G, Winkley A. What works in child protection? Barnardo's Barkingside. 1999. Feldman MA. Parenting education for parents with intellectual disabilities: a review of outcome studies. Research in Developmental Disabilities 1994;15:299-332.
M13	Support friends at times of stress – be a good listener	There is some evidence that informal social support can reduce the risk of postpartum depression.[a] Social support by lay mothers can prevent declines in levels of mental well-being.[b]	a. **Ray KL, Hodnett ED. Caregiver support for postpartum depression. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.** b. **NHS Centre for Reviews and Dissemination. Mental health promotion in high risk groups. Effective Health Care 1997:3(3).** **Ray KL, Hodnett ED. Caregiver support for postpartum depression. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.**

MENTAL HEALTH: Social and economic interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M14	Work to understand the needs of people with mental illness	No systematic reviews were identified in this area.	
M15	Participate in support networks and self-help groups	Family interventions alleviate the burden of relatives of psychiatric patients. Interventions of more than 12 sessions are more effective than shorter programmes.[a]	a. Cuijpers P. The effects of family interventions on relatives' burden: A meta-analysis. Journal of Mental Health 8(3): 275-85. **Pharoah F, Mari JJ, Streiner D. Family intervention for schizophrenia. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.**
M16	Take opportunities to improve their education, training and employment	High quality pre-school education can increase children's IQ, and has beneficial effects on behavioural development and school achievement. Long-term follow up demonstrates increased employment, lower teenage pregnancy rates, higher socio-economic status and decreased criminal behaviour. There are positive effects on mothers' education, employment and interaction with children.[a]	a. **NHS Centre for Reviews and Dissemination. Mental health promotion in high risk groups. Effective Health Care 1997:3(3).** **Zoritch B, Roberts I, Oakley A. Day care for pre-school children. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.**

MENTAL HEALTH: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
M17	Continue to invest in housing, supported housing, to reduce discrimination and stigmatisation and reduce homelessness	Over-crowding is associated with high rates of suicide.[a] There is little reliable research on the effects of re-housing on health, but there is some evidence that it can reduce mental illness in those who identified housing as a cause of their anxiety and depression.[b]	a. http://www.doh.gov.uk/pub/docs/doh/housing21.pdf b. **Marshall M, Gray A, Lockwood A, Green R. Case management for people with severe mental disorders. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.** **NHS Centre for Reviews and Dissemination. Review of the research on the effectiveness of Health Service interventions to reduce variations in health. : Report 3. University of York: NHS Centre for Reviews and Dissemination, 1995.**
M18	Encourage employers to develop workplace health policies which address mental health	Evidence suggests that organisation-wide approaches (targeting the structure and management of organisations, not simply individuals or groups within the workforce) are the most effective response to occupational stress management.[a]	a. Van der Hek H, Plomp HN. Occupational stress management programmes – a practical overview of published effect studies. Occupational Medicine 1997;47:133-41.
M19	Reduce isolation through equitable transport policy	At present, there is little good evidence on the impact of transport policy on social isolation.	
M20	Promote healthy schools and include mental as well as physical health education *(cont)*	Curriculum-based suicide prevention programmes may improve suicide-related knowledge and attitudes as well as increase self-esteem.[a] Negative effects of curriculum-based suicide prevention programmes have been identified, especially for males who may be at higher risk of suicide (eg socially isolated, multiple family problems, past history of self harm).[a] School-based programmes aimed at primary prevention of child sexual abuse help change knowledge and self-protection skills in children of all ages. Programmes that include specific behavioural training in self-protection skills are more effective than others, younger children and children from lower socio-economic groups appear to show greater gains than others, and longer, more intensive programmes achieve better results. For all groups, gains fade over time and 'booster' sessions may be necessary to maintain gains. There is, as yet, no evidence on the transferability of knowledge and 'proxy' skills to real life situations in which children are at risk of sexual abuse.[b]	a. Ploeg J, Ciliska D, Brunton G, MacDonnell J, O'Brien M. The effectiveness of school-based curriculum suicide prevention programs for adolescents. Prepared by the Effective Public Health Practice Project for the Public Health Branch, Ontario Ministry of Health. 1999. b. Rispens J, Aleman A, Goudena PP. Prevention of Child Sexual Abuse Victimization: A Meta-Anlysis of School Programs. Child Abuse and Neglect 1997;21:975-87. MacMillan H.L, MacMillan J.H, Offord DR, Griffith L, MacMillan A. Primary Prevention of Child Sexual Abuse: A Critical Review. Part 2' Journal of Child Psychology and Psychiatry and Allied Professions 1994; 34:857-76**.** c. **Lister-Sharp D , Chapman S, Stewart-Brown S, Sowden A. Health promoting schools and health promotion in schools: two systematic reviews. Health Technology Assessment 1999;3:(22).**

MENTAL HEALTH: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*
M20	*(cont)* Promote healthy schools and include mental as well as physical health education	School health promotion initiatives can have a positive impact on children's health and behaviour but do not do so consistently. Interventions are able to increase children's knowledge but changing attitudes and behaviour is harder. A multifaceted approach is likely to be most effective.[c]
M21	Promote healthy prisons and address mental illness in prisons	Mental disorders among offenders is common.[a] Treatment in juvenile residential facilities can improve psychological and institutional adjustment.[b] Intensive treatments in prison can improve behaviour of less serious psychopaths when they are less than 30 years of age and have no drug abuse problem.[c] Cognitive restructuring programmes reduce prisoners' impulsive thinking and behaviour.[d] Therapeutic communities have a positive effect on prisoners' behaviour.[e] There are limited data on the effectiveness of strategies designed to treat mentally disordered offenders.[f] Services in secure psychiatric settings either provide gender blind services (in which the particular needs of women are not considered) or include women as an 'afterthought' and do not address their needs, who often have histories of physical and sexual abuse. Research has not addressed the impact of available services on women and the effects of psychiatric care for women in secure accommodation.[g] Risk assessment of mentally disordered offenders can be enhanced with more attention to the social psychological criminological literature and less reliance on models of psychopathology.[h] Available evidence does not support the use of anti-libidinal drugs in the diversion of sex offenders.[i] The value of group support/therapy, as an intervention in the diversion of sex offenders, is unclear.[i]

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f. **NHS Centre for Reviews and Dissemination. Scoping Review on the Health and Care of Mentally Disordered Offenders. Report 16. University of York: NHS Centre for Reviews and Dissemination, 1999.**

g. **NHS Centre for Reviews and Dissemination. Women and secure psychiatric services: a literature review. Report 14. University of York: NHS Centre for Reviews and Dissemination, 1999**.

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			and Violent Recidivism Among Mentally Disordered Offenders: A Meta-Analysis. Psychological Bulletin 1998;123:123-42. i. **White P, Bradley C, Ferriter M. Managements for people with disorders of sexual preference and for convicted sexual offenders [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	Local Players and Communities can:		
M22	Develop effective housing strategies which meet the needs of local communities	Over-crowding is associated with high rates of suicide.[a] There is little reliable research on the effects of re-housing on health, but there is some evidence that it can reduce mental illness in those who identified housing as a cause of their anxiety and depression.[b]	a. http://www.doh.gov.uk/pub/docs/doh/housing21.pdf b. **Marshall M, Gray A, Lockwood A, Green R. Case management for people with severe mental disorders. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.** **NHS Centre for Reviews and Dissemination. Review of the research on the effectiveness of Health Service interventions to reduce variations in health. : Report 3. University of York: NHS Centre for Reviews and Dissemination, 1995.**
M23	Reduce stress in workplace	Evidence suggests that organisation-wide approaches (targeting the structure and management of organisations, not simply individuals or groups within the workforce) are the most effective response to occupational stress management.[a]	a. Van der Hek H, Plomp HN. Occupational stress management programmes – a practical overview of published effect studies. Occupational Medicine 1997;47:133-41.
M24	Develop school programmes for mental health promotion including coping strategies, social supports and anti-bullying strategies, substance misuse, detection and treatment *(cont)*	Programmes that modify school environments, provide individually focussed mental health promotion, and attempt to help children negotiate stressful transitions yielded significant changes in success rates.[a] Programmes addressing skills and knowledge that oppose the use of violent and abusive behaviour toward intimate partners cause positive changes in violence-related attitudes and knowledge, reductions in self-reported dating violence.[b] School-based / community based programmes targeting illicit use of drugs (including alcohol and tobacco) have, at best, only a small impact, with dissipation of programme gains over time. Interventions targeting hard to reach groups have not been evaluated adequately.[c]	a. Durlak JA, Wells AM. Primary prevention mental health programmes for children and adolescents: A meta-analytic review. American Journal of Community Psychology 1997;25:115-52. b. Wekerle C, Wolfe DA. Dating violence in mid-adolescence: theory, significance and emerging prevention initiatives. Clinical Psychology Review 1999;19:435-56. c. White D, Pitts M. Educating young people about drugs: a systematic review. Addiction 1998;93:1475-87. d. Tobler NS, Lessard R, Marshall D, Ochshorn P, Roona, M. Effectiveness of school based drug prevention programs for maijuana use. School Psychology International 1999;20:105-37. Pereiro ML, Fraguela JA, Martin MAL. Meta-analysis and

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M24	*(cont)* Develop school programmes for mental health promotion including coping strategies, social supports and anti-bullying strategies, substance misuse, detection and treatment	Programmes which foster the development of social competencies (as opposed to enhancing knowledge or targeting affective components of drug use) result in greater reductions in drug *use*, particularly when aimed at populations at risk.[d] Cognitive-behavioural interventions help people with problems of anger management.[e] School-based counselling and psychotherapy, provided on a group basis, can provide effective support to children and adolescents.[f] See Education Reviews (chapter 5) on Health Promotion, Sexual Health, Tackling Drugs (Alcohol, Smoking, Other Substances), Nutrition and Diet	school-based drug use prevention: a review. Addiciones, 9:601-16. e. Beck R, Ephrem F. Cognitive-behavioral therapy in the treatment of anger: a meta-analysis Cognitive Therapy and Research 1998;22:63-74. f. Prout S, Thompson H. A Meta-analysis of school-based studies of counseling and psychotherapy: An update. Journal of School Psychology 1998;36:121-36.
M25	Encourage use of open spaces for leisure and social events	No systematic reviews were identified in this area.	
M26	Develop local programmes to tackle dyslexia in schools	There is little evidence available on how best to tackle dyslexia. Only one systematic review was identified, which showed that piracetam may help the acquisition of reading skills for children with dyslexia and other reading difficulties.[a]	a. Wilsher CR. Pharmacological Treatments of Dyslexia. In:Van den Bos, Kees, Siegel et al, Current Directions in Dyslexia Research, Lisse, The Netherlands, Swets and Zeitlinger. 1994;135-45.
M27	Develop local initiatives to reduce crime and violence and improve community safety	Police crackdowns or sudden increases in officer presence and activity for specific offences or specific places can have initial, but very short-term effects.[a] Crime prevention measures such as removing or modifying the target for criminal activity (ie measures taken by retail stores or businesses) are the most likely to succeed.[b] Precisely targeted increases in street lighting generally have crime reduction effects.[c] Closed-circuit television (CCTV) can be effective in deterring property crime, but its effects are mixed in relation to personal crime, public order offences and fear of crime.[d]	a. Sherman LW. Police crackdowns: initial and residual deterrence. Michael Tonry and Norval Morris (eds). Crime and Justice: An Annual Review of Research Chicago: University of Chicago Press 1988;12:1-48. b. Poyner B. What works in crime prevention: an overview of evaluations. Ronald VG. Clarke (ed.) Crime Prevention Studies. NY: Criminal Justice Press 1993;1:7-34. c. Pease K. A review of street lighting evaluations: crime reduction effects. Kate Painter and Nick Tilley (eds.) Surveillance of Public Space: CCTV, Street Lighting and Crime Prevention. Crime Prevention Studies, Monsey, NY: Criminal Justice Press 1999;10:47-76. d. Phillips C. A review of CCTV evaluations: crime reduction effects and attitudes toward its use. Kate Painter and Nick Tilley (eds.) Surveillance of Public Space: CCTV, Street Lighting and Crime Prevention. Crime Prevention Studies, volume. Monsey, NY: Criminal Justice Press 1999;10:123-56

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	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	People can:		
M28	Improve workload management	Evidence suggests that organisation-wide approaches (targeting the structure and management of organisations, not simply individuals or groups within the workforce) are the most effective response to occupational stress management.[a]	a. Van der Hek H, Plomp HN. Occupational stress management programmes – a practical overview of published effect studies. Occupational Medicine 1997;47:133-41.
M29	Support colleagues	No systematic reviews were identified in this area.	
M30	Visit elderly friends and family who are isolated	Older people who volunteer can enhance their sense of well-being. Most older people who receive services from an older volunteer (eg peer counselling of nursing home residents) are less depressed than those in similar circumstances who do not.[a]	a. Wheeler FA, Gore KM, Greenblatt B. The beneficial effects of volunteering for older volunteers and the people they serve: A meta-analysis. International Journal of Aging and Human Development 1998;47:69-79.
M31	Encourage children to read	Parents reading to pre-school children promote growth of language, literacy and reading achievement.[a] Reading helps incidental word learning[b] and the skill of deriving the meaning from context.[c] Multimedia personal and video game computerised phonological awareness training enhances reading ability.[d] Reading ability is enhanced through use of alternative grouping formats (student pair, small groups, combinations of different formats) compared to whole class instruction.[e] The reading abilities of people with moderate and severe disabilities is improved by 'Site Word Instruction' in general education classes, using either heterogeneous groups or peer tutoring.[f]	a. Bus AG, Van Ijzendoorn MH, Pellegrini AD. Joint book reading makes for success in learning to read: a meta-analysis of intergenerational transmission of literacy. Review of Educational Research 1995;65:1-21. b. Swanborn MSL, de Glopper K. Incidental word learning while reading: a meta-analysis. Review of Educational Research 1999;69:261-85. c. Fukkink RG, de Glopper K. Effects of instruction in deriving work meaning from context. Review of Educational Research 1998;68:450-69. d. Bus AG, Van Ijzendoorn MH. Phonological awareness and early reading: a meta-analysis of experimental training studies Journal of Educational Psychology 1999;91:403-14. f. Elbaum B, Vaughn S, Hughes M, Moody SW. Grouping practices and reading outcomes for students with disabilities. Exceptional Children 1999;65:399-415. Browder DM, Xin YP. A meta-analysis and review of sight word research and its implications for teaching functional reading to individuals with moderate and severe disabilities. Journal of Special Education 1998;32:130-53.
M32	Encourage children to adopt a healthy diet and take physical activity *(cont)*	Dietary interventions have been shown to lower fat intake slightly but have had no impact on intake of fibre, fruit or vegetables has been detected.[a] Computer generated nutrition education is more likely to be read, remembered and experienced as personally relevant than are standard educational materials.[b]	a. **Roe L, Hunt P, Bradshaw H, Rayner M. Health promotion interventions to promote healthy eating in the general population: a review. London: Health Education Authority, 1997.** b. Brug J, Campbell M, van Assema P. The application and impact of computer generated personalised nutrition education: a review of the literature. Patient Education and

MENTAL HEALTH: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M32	*(cont)* Encourage children to adopt a healthy diet and take physical activity	School-based interventions encouraging healthy eating behaviours of 9-10 year old children have significant positive effects in attitude and knowledge,[c] but only slight changes in changes in eating habits.[d]	Counselling 1999;36:145-56. c. McArthur DB. Heart healthy eating behaviors of children following a school-based intervention: a meta-analysis. Issues Comprehensive Pediatric Nursing 1998;21:35-48. Levy SR, Iverson BK, Walberg HJ. Nutrition-education research: An interdisciplinary evaluation and review. Health Education Quarterly 1980;7:107-26. d. Hursti UK, Sjoden P. Changing food habits in children and adolescents: experiences from intervention studies. Scandinavian Journal of Nutrition 1997;41:102-10.
M33	Be alert to bullying at school	A systematic review of interventions to reduce violence in schools is in preparation.[a]	a. **Mytton J, DiGuiseppi C. School based prevention programmes for reducing violence [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
M34	Be alert to glue sniffing and substance misuse in schools *(cont)*	Current research evidence is inadequate to allow confident recommendations to plan and implement substance abuse policies for young people. No specific intervention programmes for substance misuse prevention in young people have been shown to be effective in the long term.[a] However, school based intervention programmes aimed at preventing the use of various harmful substances (tobacco, alcohol, marijuana) have a positive effect on students' knowledge and attitudes but a very limited effect on changing behaviour.[b] Social reinforcement and developmental behaviour modification methods seem to be more effective than traditional awareness programmes for informing adolescents about the health risks associated with tobacco and alcohol abuse.[c] Peer-led programmes[d] seem to have a superior effect on students' knowledge, attitudes and behaviour than teacher-led initiatives. Also interactive peer-led interventions[e] seem to be more effective than non-interactive didactic lecture programmes led by teachers or researchers. For evidence on smoking cessation see C27 and H22.	a. **White D, Pitts M. Health promotion with young people for the prevention of substance misuse. London. Health Education Authority, 1997.** Foxcroft DR, Lister-Sharp D, Lowe G. Alcohol misuse prevention for young people: a systematic review reveals methodological concerns and lack of reliable evidence of effectiveness. Addiction 1997;92:531-7. b. Bruvold WH. A meta-analysis of the California school-based risk reduction programme. Journal of Drug Education 1990;20:139-52. Bangert Drowns RL. The effects of school-based substance abuse education--a meta-analysis. Journal of Drug Education 1988;18:243-64. c. Rundall TG, Bruvold WH. A meta-analysis of school-based smoking and alcohol use prevention programs Health Education Quarterly 1988;15:317-34. d. Bangert Drowns RL. The effects of school-based substance abuse education--a meta-analysis. Journal of Drug Education. 1988;18:243-64. Black DR, Tobler NS, Sciacca JP. Peer helping/involvement: an efficacious way to meet the challenge of reducing alcohol, tobacco and other drug use among youth: a meta-analysis. Journal of School Health 1998;68:87-93. Tobler NS. Meta-analysis of 143 adolescent drug prevention programs - Quantitative outcome results of program participants compared to a control or comparison

MENTAL HEALTH: Environmental interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M34	*(cont)* Be alert to glue sniffing and substance misuse in schools		group. Journal of Drug Issues 1986;16:537-67. Schaps E, Churgin S, Palley CS, Takata B. Primary prevention research: a preliminary review of programme outcome studies. International Journal of Addiction 1980;15:657-76. e. Tobler NS, Lessard T, Marshall D, Ochshorn P, Roona M. Effectiveness of school-based drug prevention programmes for marijuana use. a meta-analysis. School Psychology International 1999;20:105-37. Ennett ST, Tobler NS, Ringwalt CL, Flewelling RL. How effective is drug abuse resistance education? A meta-analysis. American Journal of Public Health 1994;85:873-4.
M35	Engage in regular parent-teacher dialogue	Regular parent-teacher contact was a major component of research on the effects of pre-school day care, which has a variety of beneficial effects.[a]	a. **Zoritch B, Roberts I, Oakley A. Day care for pre-school children [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**.
M36	Ensure children have safe access to public open space	No systematic reviews were identified in this area.	

MENTAL HEALTH: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
M37	Increase public awareness and understanding of mental health and mental illness	No systematic reviews were identified in this area.	
M38	Reduce access to means of suicide	Changing access to means of self-harm changes total suicide rate.[a]	a. Lester D. Effects of the detoxification of domestic gas on suicide rates in six nations. Psychological Reports 1995;77:294. Lester D. A study of opportunity-based suicide rates: the use of guns. Psychological Reports 1990;67:498.
M39	Develop healthy living centres	No systematic reviews were identified in this area.	
	Local Players and Communities can:		
M40	Support people with severe mental illness and ensure their access to other mainstream services for physical health as well as the mental health care they need	Contact with health services, prior to death by suicide, is commonplace. Whether these people show characteristic patterns of care and or particular risk factors to allow a targeted approach to be developed is in urgent need of research.[a] Persons with severe mental illness are at greatly increased risk of HIV infection due to increased likelihood of high-risk sexual behaviours and intravenous drug use.[b]	a. Pirkis J, Burgess P. Suicide and recency of health care contacts. A systematic review. British Journal of Psychiatry 1998;173:462-74. b. Sullivan, G, Koegel, P, Kanouse, DE, Cournos, F, McKinnon K, Young, AS, Bean D. HIV and people with serious mental illness: the public sector's role in reducing HIV risk and improving care. Psychiatric Services. 1999;50:648-52.
	People can:		
M41	Use opportunities for relaxation and physical exercise and try to avoid using alcohol/ smoking to reduce stress	Regular exercise has a modest beneficial effect on cognitive function.[a] Regular exercise can reduce mental illness.[b] Gentle exercise improves mental health in the elderly.[c] Aerobic exercise is associated with reductions of anxiety.[d]	a. Etnier JL, Salazar W, Landers DM, Petruzzello SJ, Han M, Nowell P. The influence of physical fitness and exercise upon cognitive functioning: a meta-analysis. Journal of Sport and Exercise Psychology 1997;19:249-77. b. Nicholl JP, Coleman P, Brazier JE. Health and healthcare costs and benefits of exercise. Pharmacoeconomics 1994;5:109-22. Weyerer S, Kupfer B. Physical exercise and psychological health. Sports Medicine 1994;17:108-16. c. Burckhardt C. The effect of therapy on the mental health of the elderly. Research in Nursing and Health 1987;10:277-85.

MENTAL HEALTH: Personal behaviour

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
			d. Petruzzello SJ, Landers DM, Hatfield BD, Kubitz KA, Salazar W. A meta-analysis on the anxiety-reducing effects of acute and chronic exercise. Outcomes and mechanisms. Sports Medicine 1991;11:143-82. Weyerer S, Kupfer B. Physical exercise and psychological health. Sports Medicine 1994;17:108-16.
M42	Increase understanding of what good mental health is	No systematic reviews were identified in this area.	
M43	Contribute to the creation of happy and healthy work and school environments	Evidence from the USA suggests that day-care and pre-school education increases children's IQ and has beneficial effects on behavioural development, school achievement and other social outcomes within disadvantaged groups. Long-term follow up also demonstrates increased employment, lower teenage pregnancy rates, higher socio-economic status and decreased criminal behaviour. Such interventions also have a positive effect on mother's education, employment and interaction with children.[a]	a. **Zoritch B, Roberts I, Oakley A. Day care for pre-school children. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000, Oxford: Update Software.**

MENTAL HEALTH: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
	Government and National Players can:		
M44	Develop the *National Service Framework for Mental Health*	Audit and feedback can be effective in improving the practice of health care professionals, in particular in prescribing and diagnostic test ordering. However, it should not be relied on to improve practice.[a] A significant proportion of cases classifiable as major depression are currently unrecognised. Educational programmes for GPs can be used to improve the diagnosis of depression in primary care.[b] Mental health care can be improved by making physicians aware of the problem of diagnostic overshadowing (failure to recognise the presence of multiple disorders because one disorder is prominent) in the assessment of patients showing both mental retardation and further psychiatric complications.[c] If it is possible to identify local opinion leaders, they may be important change agents for some problems. However, the evidence is not strong.[d]	a. **Thompson MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback: effects on professional practice and health care outcomes. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. **NHS Centre for Reviews and Dissemination. The treatment of depression in primary care. Effective Health Care 1993:1(5).** c. White MJ, Nichols CN, Cook RS, Spengler PM, Walker BS, Look KK. Diagnostic overshadowing and mental retardation: a meta-analysis. American Journal on Mental Retardation 1995;100:293-8. d. **Thompson MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Local opinion leaders: effects on professional practice and health care [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
M45	Provide incentives to emphasise good mental health care	Small financial incentives for patients (including parents of behaviourally disordered children and cocaine addicts) encourages compliance with treatment.[a] Different policies of payment of professional caregivers are under review.[b]	a. Giuffrida A, Torgerson DJ. Should we pay the patient? Review if financial incentives to enhance patient compliance. BMJ 1997;315:703-7. b. **Gosden T, Forland F, Kristiansen I, Sutton M, Pedersen L, Leese B, Giuffrida A, Sergison M, Oxman A. Capitation, salary, fee for service and mixed systems of payment: effects on the behaviour of primary care physicians [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.** **Giuffrida A, Leese B, Forland F, Gosden T, Kristiansen I, Sergison M, Pedersen L, Sutton M, Oxman A. Target payments in primary care: effects on professional practice and health care outcomes [Protocol for a Cochrane Review. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.**
M46	Audit all suicides and learn the lessons for prevention (the Confidential Inquiry into Suicide and Homicide) *(cont)*	To date very few interventions have been shown to have any impact on suicide rates.[a] For those who harm themselves, problem solving techniques appear to be less cost-effective than alternative and less time consuming interventions.[b]	a. Gunnel D, Frankel S. Prevention of suicide: Aspirations and evidence. BMJ 1994;308:1227-33. **Hawton K, Townsend E, Arensman E, Gunnell D, Hazell P, House A, van Heeringen K. Psychosocial versus pharmacological treatments for deliberate self harm. [Cochrane Review] In: The Cochrane Library,**

MENTAL HEALTH: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M46	*(cont)* Audit all suicides and learn the lessons for prevention (the Confidential Inquiry into Suicide and Homicide)	Suicide prevention programmes for adolescents can be used to improve knowledge and understanding about suicide, but they have not been shown to induce any behavioural change or improvement in levels of depression or coping skills.[c] Curriculum-based suicide prevention programmes may improve suicide-related knowledge and attitudes as well as increased self-esteem but may also have negative effects, especially for males, who may be at a higher risk of suicide (eg socially isolated, multiple family problems, past history of self harm).[c]	**Issue 1, 2000, Oxford: Update Software.** b. **NHS Centre for Reviews and Dissemination. Deliberate self-harm. Effective Health Care 1998;4(6):1-12.** c. Gunnel D, Frankel S. Prevention of suicide: aspirations and evidence. BMJ 1994;308:1227-33. **Hawton K, Townsend E, Arensman E, Gunnell D, Hazell P, House A, van Heeringen K. Psychosocial versus pharmacological treatments for deliberate self harm In: [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** Ploeg J, Ciliska D, Brunton G, MacDonnell J, O'Brien M. The effectiveness of school-based curriculum suicide prevention programs for adolescents. Prepared by the Effective Public Health Practice Project for the Public Health Branch, Ontario Ministry of Health. 1999.
	Local Players and Communities can:		
M47	Provide advice and practical help on financial, housing, day care, and work problems	No systematic reviews were identified in this area.	
M48	Implement the *National Service Framework for Mental Health (cont)*	Audit and feedback can be effective in improving the practice of health care professionals, in particular in prescribing and diagnostic test ordering. However, it should not be relied on to improve practice.[a] A significant proportion of cases classifiable as major depression are currently unrecognised. Educational programmes for GPs can be used to improve the diagnosis of depression in primary care.[b] Mental health care can be improved by making physicians aware of the problem of diagnostic overshadowing (failure to recognise the presence of multiple disorders because one disorder is prominent) in the assessment of patients showing both mental retardation and further psychiatric complications.[c] If it is possible to identify local opinion leaders, they may be important change agents for some problems. However, the evidence is not strong.[d]	a. **Thompson MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Audit and feedback: effects on professional practice and health care outcomes. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. **NHS Centre for Reviews and Dissemination. The treatment of depression in primary care. Effective Health Care 1993:1(5).** c. White MJ, Nichols CN, Cook RS, Spengler PM, Walker BS, Look KK. Diagnostic overshadowing and mental retardation: a meta-analysis. American Journal on Mental Retardation 1995;100:293-8. d. **Thompson MA, Oxman AD, Davis DA, Haynes RB, Freemantle N, Harvey EL. Local opinion leaders: effects on professional practice and health care outcomes [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

MENTAL HEALTH: Services interventions

POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*	Interventions designed to improve provider recognition and management of mental disorder in primary care may be effective in improving diagnosis, treatment and clinical outcome in psychiatric symptoms and functional status.[e]	e. Kroenke D, Taylor-Vaissey A, Dietrich AJ, Oxman TE. Interventions to improve provider diagnosis and treatment of mental disorders in primary care A critical review of the literature. Psychosomatic 2000;41:29-52.
	Children - hyperactivity The results of the large, as yet unpublished, Multisite Multimodal trial may effect all conclusions related to the use of stimulant drugs.[a] **Currently available evidence suggests:** Studies with longer follow-up show a trend to general improvement over time regardless of treatment.[a] Stimulant drugs decrease the symptoms of attention deficit disorder in children in the short and medium term. Methylphenidate reduces behavioural disturbance among attention-deficit hyperactivity disorder children as long as it is taken but many children discontinue medication.[a] There are few short term differences in effectiveness of methylphenidate (MPH), dextroamphetamine and pemoline. Stimulants (particularly MPH) are more effective than non-pharmacological interventions. There is a not evidence to support the superiority of combination therapy.[b] Many of the adverse effects associated with stimulant use are mild, of short duration, and respond to dosing or timing adjustments. Long-term data are inadequate.[a] Tricyclic antidepressants are only effective in the short term. Tricyclic antidepressant drugs (desipramine) are more effective than placebo and lithium does not appear to be an effective alternative for children that do not respond to stimulants.[a] Carbemazepine may offer an alternative to stimulants.[c] Both social skills training and health visitor home visits are also effective	a. Jadad A, Atkins D. McMaster University Evidence-based Practice Center http://www.ahcpr.gov/clinic/adhdsum.htm. b. **Treatment for children diagnosed with attention deficit hyperactivity disorder. Health Technology Assessment Brief No 1, 2000.** c. Silva RR et al. Carbamazepine use in children and adolescents with features of attention-deficit hyperactivity disorder: a meta-analysis. Journal of the American Academy of Child and Adolescent Psychiatry 1996;35:352-8. d. Wilens TE, McDermott SP, Biederman J, Abrantes A, Hahesy A, Spencer TJ. Cognitive therapy in the treatment of adults with ADHD: A systematic chart review of 26 cases. Journal of Cognitive Psychotherapy 1999;13:215-26.

MENTAL HEALTH: Services interventions

POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*	(single trial only).[b] The effects of psychotherapeutic interventions for adults with attention-deficit hyperactivity disorder are unknown but there is some evidence of the positive effects of medication in combination with cognitive therapy.[d] **Dementia** Although screening tests for dementia are available, their use needs to take into account that there are currently no known effective treatments for dementia.[a] There is insufficient evidence to support the use of validation therapy,[b] reminiscence therapy,[c] music therapy,[d] oestrogen therapy,[e] dehydroepiandrosterone,[f] lecithin,[g] nicotine,[h] piracetam,[i] nimodipine,[j] and aspirin.[k] Reality orientation and memory training has promise in improving both cognition and behaviour.[l] High dose rivastigmine may have a modest effect on cognition and activities of daily living, but not on clinical global impression for patients with mild to moderate Alzheimer's disease, but the drug has significant side effects.[m] Donepezil may provide modest improvements in cognitive function and study clinicians rated global clinical state more positively in treated patients.[n] Gingko may improve cognition but its clinical value is not proven.[o] Cytidinediphosphocholine (CDP choline) may have a short term effect on memory and behaviour.[p] Selegiline[q] and hydergine[r] may have benefit, but the evidence remains inconclusive. Very limited data are available to support the use of thioridazine in the treatment of dementia and if it were not currently in widespread clinical use, there would be inadequate evidence to support its introduction.[s]	a. **Arrieta J, Lewington S, Szeto S. Tacrine for Alzheimer's disease. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Birks JS, Melzer D. Donepezil for mild and moderate Alzheimer's Disease [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Birks J, Grimley Evans J, Hermans D. Gingko biloba for dementia. [Protocol for a Cochrane Review] Forthcoming in: The Cochrane Library, Issue 3, 2000. Oxford: Update Software.** **Birks J, Flicker L. Selegiline for Alzheimer's disease. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Flicker L, Grimley Evans J. Piracetam for dementia or cognitive impairment. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Higgins J, Flicker L. Lecithin for dementia and cognitive impairment. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Huppert FA, Van Niekerk JK, Herbert J. Dehydroepiandrosterone (DHEA) supplementation for cognition and well-being [Cochrane Review] In: The Cochrane Library, Issue 1, 2000 Oxford: Update Software.** **Kirchner V, Harvey R, Kelly C. Thioridazine for dementia. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Koger SM, Brotons M. Music therapy for dementia symptoms [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **Lopez Arrieta J, Birks J. Nimodipine in the treatment of primary degenerative, mixed and vascular dementia. [Cochrane Review] In: The Cochrane Library, Issue 1,**

MENTAL HEALTH: Services interventions

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M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

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M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*

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POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*		**Oxford: Update Software**. p. **Fioravanti M, Yanagi M. Cytidinediphosphocholine (CDP choline) for cognitive and behavioural disturbances associated with chronic cerebral disorders in the elderly [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** q. **Birks J, Flicker L. Selegiline for Alzheimer's disease [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** r. **Olin J, Schneider L, Novit A, Luczak S. Hydergine for Dementia. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** s. **Kirchner, V, Kelly, CA, Harvey, RJ. Thioridazine for dementia. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**.
	Depression **Non-drug treatments** There is some evidence that home visiting before and after childbirth can, among other benefits, improve the mental well-being of mothers and their children.[a] Cognitive therapy has been shown to be as useful as more standard primary care treatments in the management of depression,[b] and may also reduce relapse rates in primary[c] and secondary care,[d] and in adolescents.[e] Cognitive, cognitive behavioural and behavioural therapy are probably of similar effectiveness, are cost effective compared to no treatment, and are superior to psychodynamic psychotherapy.[b] There is no evidence supporting the effectiveness of counselling alone in the treatment of depression or related problems.[c] Psychosocial interventions can be effective in treating primary care patients with depression or anxiety.[f] Individual psychological therapy for depression is superior to group therapy.[b] Outreach programmmes designed to make available help to depressed elderly	a. Blondel B, Breart G. Home visits during pregnancy; consequences on pregnancy outcome, use of health services, and womens' situations. Seminars in Perinataology 1995;19:263-71. Ciliska D, Hayward S, Thomas H, Mitchell A, Dobbins M,. Underwood J, Rafael A, Martin E. The effectiveness of home visiting as a delivery strategy for public health nursing interventions: a systematic overview. Canadian Journal of Public Health 1996;May:193. **Hodnett ED. Support during pregnancy for women at increased risk [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** **NHS Centre for Reviews and Dissemination. Mental health promotion in high risk groups. Effective Health Care 1997:3(3).** b. **Hunot V, Churchill R, Corney R, Tylee A, McGuire H, Wessely S. A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. Health Technology Assessment. 2000 (in press).** c. **NHS Centre for Reviews and Dissemination. The treatment of depression in primary care. Effective Health Care 1993:1(5).** **Hunot V, Churchill R,Corney R, Tylee A, McGuire H, Wessely S. A systematic review of controlled trials of the effectiveness and cost-effectiveness of brief psychological treatments for depression. Health**

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M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

people living in the community are effective in increasing their access to mental health care.[g] Psychological treatments offered to depressed elderly in the community are effective, and cognitive behavioural therapies are more effective than other psychological therapies.[g]

Drug treatments

Antidepressant drugs are effective treatments for depression.[h]

Refractory depression is usefully treated with tricyclic antidepressants augmented by triiodothyronine.[i]

Selective serotonin re-uptake inhibitors (SSRIs) have not been shown to be more effective than tricyclic antidepressants.[j]

Compliance is better with the newer drugs, but extrapolating from the secondary care data, one needs to transfer[i] patients from the older to the new drugs to prevent one treatment discontinuation.

There is no evidence that progestogens help in postnatal depression.[k]

Extracts of hypericum (St John's Wort) are more effective than placebo for short-term treatment of mild to moderately severe depression. Current evidence is inadequate to establish whether hypericum is as effective as other anti-depressants.[l]

Continued treatment with an antidepressant for at least 6 months decreases the risk of relapse by 70%.[m]

Other

A forthcoming review will assess the relative merits of psychological versus pharmacological interventions in the elderly.[n]

A forthcoming review will determine whether or not drugs and psychological treatments should, or should not, be used together.[o]

Electroconvulsive therapy can be effective in treating the depressed phase of bipolar depression.[p]

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MENTAL HEALTH: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M48	*(cont)* Implement the *National Service Framework for Mental Health (cont)*		Agency for Health Care Policy and Research. Treatment of Depression—Newer Pharmacotherapies. Summary Evidence Report/Technology Assessment. Agency for Health Care Policy and Research, Rockville, MD. http://www.ahrq.gov/clinic/deprsumm.htm. 1999;7. k. **Lawrie T, Herxheimer A, Dalton, K. Oestrogens and progestogens for preventing and treating postnal depression. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** l. **Linde K, Mulrow CD. St John's Wort for Depression. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. m. Agency for Health Care Policy and Research. Treatment of Depression—Newer Pharmacotherapies. Summary Evidence Report/Technology Assessment. Agency for Health Care Policy and Research, Rockville, MD. http://www.ahrq.gov/clinic/deprsumm.htm. 1999;7. n. **Wilson K, Mottram P, Nicholson M. Long-term pharmacotherapy versus psychotherapy for elderly people with depression. [Cochrane Review] In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.** o. **Churchill R, Wessely S, Lewis G. Effects of combining pharmacotherapy and psychotherapy for the treatment of depression. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. p. Zornberg GL, Pope HG. Treatment of depression in bipolar disorder: New directions for research. Journal of Clinical Psychopharmacology 1993;13:397-408.
		Eating disorders There is provisional evidence that cognitive behavioural psychotherapy reduces binge eating in bulimia.[a]	a. **Hay PJ, Bacaltchuk J. Psychotherapy for bulimia nervosa and binging [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. Whittal MC, Agras WS, Gould RA. Bulimia Nervosa: A meta-analysis of psychosocial and pharmacological treatments.Behavior Therapy 1999;30(1):117-35. Wilson GT. Cognitive behavior research for eating disorders: progress and problems. Behaviour Research and Therapy 1999;37(suppl. l)1:S79-95.

MENTAL HEALTH: Services interventions

POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*	**Learning disability** Functional analysis/behavioural assessment reduces problem behaviours in individuals with mental impairment.[a] Antipsychotic medication is commonly used for people with both learning disability and challenging behaviour, but there is no reliable evidence to support or refute their value.[b] Antipsychotic medication is also used to help those with both learning disability and schizophrenia, but this is a poorly researched area and relevant data have not been found.[c]	a. Didden R, Duker PC, Korzilius H. Meta-analytic study on treatment effectiveness for problem behaviors with individuals who have mental retardation. American Journal of Mental Retardation 1997;101:387-99. b. **Brylewski J, Duggan L. Antipsychotic medication for challenging behaviour in people with learning disability [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. **Duggan L, Brylewski J. Antipsychotic medication for people with both schizophrenia and learning disability [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**
	Schizophrenia Family intervention is effective in improving relapse rates but present evidence does not show that it reduces suicide in those with schizophrenia.[a] Interventions providing support but no additional resources for non-professional carers in families with a member with schizophrenia have not been shown to be effective in reducing perceived care-giver burden or expressed anger/frustration within families.[a] 'Assertive community treatment' - a community care package for those with serious mental illnesses - has been shown to have a range of beneficial effects on outcome.[b] On the other hand, case management approaches to severe mental illness increase the rate of hospital re-admission and do not appear to improve mental state outcomes.[c] There is some evidence that the use of community mental health teams can reduce the risk of suicide in people with severe mental illness in comparison to hospital based care.[d] Co-ordinating the input from psychiatric, psychological and social services is known to improve outcomes in schizophrenia and may have a similar impact on other mental illnesses.[e]	a. **Pharoah F, Mari JJ, Streiner D. Family intervention for schizophrenia [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** b. **Marshall M, Lockwood A. Assertive community treatment for people with severe mental illness. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** c. **Marshall M, Gray A, Lockwood A, Green R. Case management for people with severe mental disorders. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** d. Brooker C, Repper J, Booth A. The effectiveness of community mental health nursing: a review. Journal of Clinical Effectiveness 1996;1:44-50. **Tyrer P, Coid J, Simmonds S, Joseph P, Marriott S. Community mental health teams (CHMTs) for people with severe mental illnesses and disordered personality. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**. e. Danish Medical Research Council and the Danish Hospital Institute. Schizophrenia, Consensus statement (Skizofreni, Konsensus-konference) Copenhagen: Danish Hospital Institute, 1993. f. **Johnstone P, Zolese G. Length of hospitalisation for people with severe mental illness. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.** g. **Ahonen J, Cheine M, Wahlbeck K. Beta blocker**

POLICY

M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

There is some evidence that implementing a policy of short stays for those needing admission to hospital may improve both care and outcomes.[f]

A range of drug regimens are already well known to relieve the symptoms of schizophrenia, albeit with attendant side effects. Evidence on the effectiveness and cost effectiveness of novel regimens is rapidly becoming available.[g]

The new generation of antipsychotic drugs are an improvement but not a revolution in the management of those with schizophrenia.[h]

Older, inexpensive, poorly publicised drugs may have similar benefits as novel expensive atypicals.[i]

Supplementing drug treatment with other drugs such as beta-blockers or carbemazepine has not been shown to be helpful.[j]

Fish oil derivatives may have antipsychotic effects but more will be known when ongoing studies are completed.[k]

Cognitive therapy may have benefits for those with depression but is not widely accessible at present.[l]

Electroconvulsive therapy can provide short term palliative care in schizophrenia.[m]

The use of life skills training as a component of rehabilitation programmes for people with schizophrenia is not supported by evidence.[n]

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Wahlbeck K, Cheine M, Essali MA, Rezk E. Clozapine versus 'typical' neuroleptic medication for schizophrenia. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

h. **Ahonen J, Cheine M, Wahlbeck K. Beta blocker supplementation of standard drug treatment for schizophrenia. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

Bagnall A-M, Lewis RA, Leitner ML, Kleijnen J. Ziprasidone for schizophrenia and severe mental illness [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

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Kennedy E, Song F, Hunter R, Gilbody S. Risperidone versus typical antipsychotic medication for schizophrenia [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

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MENTAL HEALTH: Services interventions

POLICY

M48 *(cont)* Implement the *National Service Framework for Mental Health (cont)*

SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE

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Wahlbeck K, Cheine M, Essali MA, Rezk E. Clozapine versus 'typical' neuroleptic medication for schizophrenia. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

i. **Murphy B, Fenton M, Wood J, Bagnall AM, Chue P. Loxapine for schizophrenia [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

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Sultana A, McMonagle T. Pimozide for schizophrenia or related psychoses [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

j. **Cheine M, Ahonen J, Wahlbeck K. Beta-blocker supplementation of standard drug treatment for schizophrenia [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

Leucht S, McGrath J, White P, Kissling W. Carbamazepine for schizophrenia and schizoaffective psychoses [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.

k. **Joy CB, Mumby-Croft R, Joy LA. Polyunsaturated fatty acid (fish or evening primrose oil) for schizophrenia [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software**.

l. **Jones C, Cormac I, Mota J, Campbell C. Cognitive behaviour therapy for schizophrenia [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

m. **Tharyan P. Electroconvulsive therapy for schizophrenia. [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.**

n. **Nicol MM, Robertson L, Connaughton, JA. Life Skills programmes for chronic mental illness [Cochrane Review] In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software**.

MENTAL HEALTH: Services interventions

	POLICY	*SYSTEMATIC REVIEWS OF RELEVANT EVIDENCE*	*REFERENCES*
M49	Develop range of comprehensive and culturally sensitive mental health services in accordance with *Modernising Mental Health Services*	Specialist training for primary care teams could usefully emphasise psychological services for ethnic minorities since these are presently under-utilised as a treatment option in this context.[a] Presently a disproportionate number of ethnic minority referrals to mental health care come through the Criminal Justice System.[a]	a. **NHS Centre for Reviews and Dissemination. Ethnicity and health: Reviews of literature and guidance for purchasers in the areas of cardiovascular disease, mental health and haemoglobinopathies. University of York: NHS Centre for Reviews and Dissemination 1996:5.**
	People can:		
M50	Contribute information to service planners and get involved	No systematic reviews were identified in this area.	
M51	Contact services quickly when difficulties start	Community crisis intervention teams, for those with acute relapse of serious mental illnesses, may find it difficult to avoid hospital admission during their treatment period.[a] Crisis home care may reduce loss to follow-up at 6 and 12 months and family burden, and is a more satisfactory form of care for both patients and families.[a]	a. **Joy CB, Adams CE, Rice K. Crisis intervention for severe mental illnesses. [Cochrane Review] In: The Cochrane Library , Issue 2, 2000. Oxford: Update Software**.
M52	Increase knowledge about self-help	No systematic reviews were identified in this area.	

Education

Chapter 9 of the White Paper identified a number of wider public health issues on which it calls for further action, including sexual health, tackling drugs, diet and nutrition, food safety, and work-based health promotion. This section of the report summarises the findings of systematic reviews of the effects of educational interventions, including both the form and content of health education and health promotion programmes.

Health Promotion – General effectiveness of health education / health promotion

CITATION	*REVIEW DETAILS*	*FINDINGS*
Harden A, Weston R, Oakely A. A review of the effectiveness and appropriateness of peer-delivered health promotion interventions for young people. EPI-Centre, London, Social Science Research Unit, Institute of Education 1999.	A systematic review of peer-delivered health promotion for young people found some evidence to support its effectiveness. There were more sound outcome evaluations which demonstrated peer-delivered health promotion to be effective than ineffective. More than half of the sound studies showed a positive effect on at least one behavioural outcome. The studies reviewed in this report are not encouraging on the issue of peer-delivered health promotion reaching young people at enhanced risk of adverse health behaviours. Also young men are notably more reluctant to take on the role of peer educator. The current evidence for peer-delivered health promotion is therefore limited.	A systematic review of peer-delivered interventions aimed at primary prevention of disease or health promotion among young people aged 11-24 years. The review was restricted to studies in the English language and excluded peer counselling or mediation interventions as well as those where the principle medium of the intervention was video, theatre or newsletters. The searches produced 5124 citations of which 523 met the inclusion criteria. 49 outcome and 15 process evaluations were included in the review the most common focus for the outcome evaluations was drugs (including alcohol and smoking – 53%) and for process evaluations sexual health (56%) 12 of the 49 outcome evaluation studies were assessed as methodologically sound. The authors note that “as in previous systematic reviews in health promotion methodologically sound studies were disappointingly scarce”.

EDUCATION: Health Promotion – General effectiveness of health education / health promotion

CITATION	*REVIEW DETAILS*	*FINDINGS*
Kok G, Van Den Borne B, Dolan P. Effectiveness of health education and health promotion: meta-analysis of effect studies and determinants of effectiveness. Patient Education and Counseling 1997;30(1):19-27.	Systematic review of MW Lipsey and DB Wilson 1993. Health education and promotion may be effective, but they are not always found effective. Characteristics of effective interventions are reviewed.	A systematic review based on the work of Lipsey and Wilson 1993 and of Mullen 1988 on primary studies in the areas of psychological, psycho-therapeutic, behavioural and educational interventions. The work of Lipsey and Wilson should be noted for its findings that meta-analyses tend to find moderate effect sizes with negative findings and strong effect sizes being fairly uncommon.
Krishna S, Balas A, Spencer DC, Griffin JZ et al. Clinical trials of interactive computerized patient education: implications for family practice. Journal of Family Practice 1997;45(1):25-33.	A systematic review of computerized patient education interventions found positive results for interactive educational intervention. The one exception to this was the treatment of alcoholism. Computerized educational interventions can lead to improved health status in several major areas of care, and are a supplement to, but not a substitute for, face-to-face time with physicians.	A systematic review of 22 randomized clinical trials of computerized patient education interventions identified 13 studies that used instructional programmes, 5 that used information support networks and 4 that evaluated systems for health assessment and history taking. The exception of alcoholism treatment to the findings of positive results of such interventions should be noted.
Harrison JA, Mullen PD, Green LW. A meta-analysis of studies of health belief model with adults. Health Education Research 1992;7(1):107-16.	A systematic review found a generally weak effect of the health belief model (HBM) on health promotion. It concluded that it is premature to draw conclusions about the predictive validity of the HBM as operationalized in these studies.	A systematic review of 16 studies identified 24 mean effect sizes. 22 were positive and statistically significant. The lack of homogeneity amongst the studies identified, and the limitations this puts upon the available evidence should be noted.
Baker SB, Swisher JD, Nadenichek PE, Popowicz CL. Measured effects of primary prevention strategies. Personnel and Guidance Journal 1984;62(8):459-64.	A systematic review of primary prevention strategies in schools concluded that the results are encouraging and that there is evidence of their measured effectiveness. Some limits to the generalizability of these findings are noted. Also a lack of clarity in terms of the content and goals of some primary prevention programmes was noted.	A systematic review of 40 primary prevention studies that used intervention and control groups some problems of inconsistent data reporting within and across professional journals should be noted as should some problems in measuring the dependent variable in different primary studies.

EDUCATION: Sexual Education – Preventing teenage pregnancy

CITATION	*REVIEW DETAILS*	*FINDINGS*
Dienso A, Guyatt G, Willan A. A systematic review of the effectiveness of adolescent pregnancy primary prevention programmes. Hamilton, Ontario. Effective Public Health Practice Project. March 1999.	A systematic review of studies of primary prevention programmes in preventing adolescent pregnancy found that there are no simple approaches that will markedly reduce adolescent pregnancy. The evidence demonstrates that programmes that focus on sexuality, including school, community, and clinic based interventions, do not increase sexual activity. There does not exist any evidence the abstinence-only programmes delay the onset of intercourse or pregnancy. These programmes were substantial in duration and focused on behaviours. They were theory based, actively involved participants, shared facts, focused on social pressures, modeling and skill rehearsal, and they included trained adult or peer leaders.	This review was based on 11 electronic databases from 1970 to November 1998, The Cochrane Library, handsearching of key journals between January 1993 and 1998, and reference lists from retrieved articles. Each reviewed article was independently reviewed for relevance and validity by two reviewers. 20 randomized controlled trials were identified for inclusion in this review. The trials were assessed for quality using a four point scales and only two studies scored higher than two. Neither study found any significant difference in outcomes between groups. The three behavioural outcomes of interest were: initiation of intercourse, birth control use and pregnancy. In total the 20 studies examined these outcomes 40 times. Of these there were five significant findings. These need to be interpreted cautiously because, out of 40 outcomes, one would expect to find two significantly significant findings by chance ($P<0.05$) and all these studies were rated as poor when assessed for quality.
Zoritch,B, Roberts I,Oakley A. The health and welfare effects of day care: a systematic review of randomised controlled trials. Social Science and Medicine 1998;47(3):317-727.	Day-care for pre-school children has a number of positive educational and health outcomes, one of which is lower teenage pregnancy rates. There are also positive effects on mothers education, employment and interaction with children. This systematic review by UK researchers is of US trials, some of which had methodological weaknesses. The need for well designed research of the effects of day-care in the British context is noted.	Good quality systematic review with cautious notes about some methodological weaknesses of some primary studies
NHS Centre for Reviews and Dissemination. Effective health care preventing and reducing the adverse effects of unintended teenage pregnancies 1997;3(1):1-12.	A factor strongly associated with deferring pregnancy is a good general education. School-based sex education can be effective in reducing teenage pregnancy especially when linked to access to contraceptive services. The most reliable evidence shows that is does not increase sexual activity or pregnancy rates. Increasing the availability of contraception clinic services for young people is associated with reduced pregnancy rates.	A systematic review of 45 reviews of research in the area of teenage pregnancy, of which 5 were considered to be relevant and of high quality. A total of 42 evaluations of educational approaches to preventing teenage pregnancy was identified. The sample sizes of most studies was small and statistical power was therefore weak. No pooling or aggregation of samples was attempted.

EDUCATION: Sexual Education – Preventing teenage pregnancy

CITATION	*REVIEW DETAILS*	*FINDINGS*
De Ridder LM. Teenage pregnancy: etiology and educational interventions. Educational Psychology Review 1993; 5(1):87-107.	Educational interventions to reduce and/or prevent teenage pregnancy have been evaluated and found to be generally ineffective. However, two programmes (in Minnesota and Maryland USA) have demonstrated significant reductions in teenage pregnancy (details of which are vague).	A systematic review of a number of educational interventions in the U.S. to reduce teenage pregnancy
Stout J, Rivara F. Schools sex education: does it work. Pediatrics 1989;83:375-89.	A narrative literature review of the effects of school-based sex education on sexual behaviour, contraception and adolescent pregnancy found that there is little or no effect of these programmes.	A narrative literature review which identified 5 studies of the effect of sex education on the outcomes mentioned.

EDUCATION: Sexual Education – Providing better understanding about sex and relationships

CITATION	*REVIEW DETAILS*	*FINDINGS*
Denman , Gillies , Wilson , Wijewardene . Sex education in schools: an overview with recommendations. Public-Health 1994;108(4):251-6.	A number of key principles which are essential for effective sex education within schools. Planning and teaching of the topic, in-service training of teachers, and the established links between schools and parents. The wide variations in quality and quantity of provision of sex education in schools, does not appear to be consistently supportive. Practical recommendations are included.	An overview (not a systematic review) of a number of key policies on sex education in England and Wales including those related to the 1983 Education Act. The limitations of overviews (as opposed to systematic reviews) should be noted.
Schlaefli A, Rest JR, Thoma SJ. Does moral education improve moral judgement? A meta-analysis of intervention studies using the defining issues test. The Review of Educational Research 1985;55(3):319-52.	A systematic review of education interventions designed to stimulate development in moral judgement found that the dilemma discussion and psychological development programmes produce modest overall effect sizes. Interventions of 3-22 weeks are optimal. Programmes with adults (24+ years) produce larger effect sizes than with younger people. However significant effect sizes were obtained with all groups.	A systematic review of 55 primary studies of educational interventions that used the Defining Issues Test. Various groups of students were involved at the primary, secondary and tertiary level (including adult learners). Various types of programmes were considered and the duration of interventions varied from a few hours to a whole year.
Koepke ALW. Meta-analysis: educational strategies to promote value development. Indiana School of Nursing. Manuscript (250 pages).	A systematic review of 111 studies of the most effective methods of promoting value developments found case studies to be the most effective educational strategy. 6 to 12 hours of intervention were found to be the most effective strategy and interventions that lasted from 3-6 weeks yielded the greatest value development. Students in pre-school and in high school were the most receptive to these interventions. This systematic review concluded that value development can be promoted through educational methods advocated by Bandura's Social Learning Theory.	A systematic review of 111 published and unpublished studies including an analysis that removed 21 hetreogeneous studies. Unpublished studies generated the highest effect size, a finding that is in contradiction to much of the systematic review literature. The overwhelming majority of studies were conducted during the 1970s and these studies produced the most value development.

EDUCATION: Sexual Education – Improving public understanding about Sexually Transmitted Infections (STIs) and how to prevent them

CITATION	*REVIEW DETAILS*	*FINDINGS*
Macke BA, Maher JE. Partner notification in the United States – an evidence-based review. American Journal of Preventive Medicine 1999; 17(3):230-42.	A systematic review concluded that there is good evidence that partner notification is an effective means of detecting sexually transmitted infections. Also there is "fair evidence" that provider referral generally ensures that more partners are notified and medically evaluated than does self referral.	A systematic review of a number of databases yielded 212 English language articles on partner notification 13 of which met the inclusion criteria of this review. More research is needed to improve elicitation and notification procedures and tailor them to specific populations. Research to assess the research of new testing techniques on partner notification, and to understand the consequences of partner notification for infected persons and their partners is also indicated.
Yamada J, DiCenso A, Feldman L, Cormillott P, Wade K, Wignall R, Thomas H. A systematic review of the effectiveness of primary prevention programs to prevent sexually transmitted diseases in adolescents. Hamilton, Ontario, Effective Public Health Practice Project. March 1999.	A systematic review of primary preventions programmes aimed at preventing STDs in adolescents aged 10-19 years found that it is possible to improve the behaviour of adolescents in ways which protect against STDs. Effective education interventions are theory-based, provide facts, and skill-building exercises, use trained facilitators, and last the minimum of eight hours. The review also found that such programmes do not lead to an increase in the number of adolescents who choose to become sexually active, or in the frequency of sexual intercourse. Those studies in the review which were stronger in design and had positive findings were conducted on high risk populations or female under graduates in the United States. This may limit the generalizability of the review's findings.	A total of 584 articles were identified using 11 electronic databases from September 1998 to as far back as they were referenced, except for EMBASE which was searched from 1998 back to 1993. Key journals were handsearched from 1993 to October 1998. Reference lists from retrieved articles were searched and experts were contacted for unpublished studies. Each retrieved article was independently reviewed for quality and relevance by two reviewers. From these 584 articles 24 met the reviews inclusions criteria including being randomized or other types of controlled trials. Of these 24 none was rated `strong' for methodology, 4 were rated `moderate' and 20 were rated as `weak'. The 24 studies examined at least one of the six behavioural outcomes: improved condom use, number of sexual partners, frequency of sexual intercourse, frequency of unprotected sexual intercourse, and the number of diagnosed cases of STDs.
Cook RL, Rosenberg MJ. Do spermicides containing nonoxynol-9 prevent sexually transmitted infections? A meta-analysis. Sexually Transmitted Diseases 1998;25(3):144-50.	Nonoxynol-9- containing spermicides have an appreciable protective effect against both gonorrhea and chlamydial infection, and a wider use of spermicides might substantially reduce the incidence of these diseases. However, insufficient data exist to judge their effect on HIV transmission, and further research on the effect of nonoxynol-9 on HIV transmission is urgently needed to make evidence-based clinical decisions and public health recommendations in the future.	Fairly good evidence for preventing gonorrhea and chlamydial infections. Insufficient evidence for preventing HIV transmission.

EDUCATION: Sexual Education – Improving public understanding about Sexually Transmitted Infections (STIs) and how to prevent them

CITATION	*REVIEW DETAILS*	*FINDINGS*
Patrick MA. The control of sexually transmitted diseases in Canada: a cautiously optimistic overview. Canadian Journal of Human Sexuality 1997;6(2):79-87.	Successful interventions aimed at curable STDs include screening, curative therapy, and partner notification and treatment. With proper planning and implementation, STD control and prevention programmes can dramatically reduce STD morbidity.	Good quality overview with justified caution about the methodological quality of some primary studies.
Kirby D, Short L, Collins J et al. School-based programmes to reduce sexual risk behaviours: A review of effectiveness. Public Health Reports 1994;109:339-60.	A review of 23 studies of school-based programmes to reduce sexual risk behaviours. Some specific programmes delayed the initiation of intercourse, reduced the frequency of intercourse, reduced the number of sexual partners or increased the use of condoms and other contraceptives. These effective programmes were reported to have had the potential to reduce exposure to unintended pregnancies and sexually transmitted diseases including HIV infection.	A review commissioned by the Division of Adolescent and School Health within the Centres for Disease Control and Prevention, Public Health Service (USA). 23 studies that were published in professional journals and that measured the impact of programmes on behaviour were included. Additional research is needed to clarify the most important characteristics of effective programmes.

EDUCATION: Sexual Education – Improving public understanding about HIV/AIDS and how to prevent them

CITATION	*REVIEW DETAILS*	*FINDINGS*
Juarez O, Diez E. AIDS prevention among adolescents in school: a systematic review of the efficacy of interventions. Gaceta Sanitaria 1999;13(2): 150-62.	A systematic review of school AIDs prevention interventions. Amongst students aged 13 to 19 found that all the primary studies reviewed reported modified knowledge and attitudes. However the effect on intentions and behaviour of students was small (less than 10%).	A systematic review of 29 primary studies of which only 38% were considered of high or intermediate quality. The cautious conclusions of this systematic review seem warranted.
Weinhardt LS, Carey MP, Johnson BT, Bickham NL, Effects of HIV counselling and testing on sexual risk behaviour: a meta-analytic review of published research. American Journal of Public Health 1999;89(9):1397-1405.	HIV counselling and testing appears to provide an effective means of secondary prevention for HIV positive individuals but is not an effective *primary* prevention strategy for uninfected patients. HIV counselling as an education initiative seems justified for secondary prevention.	Good quality systematic review with carefully distinguished conclusions about primary (not effective) and secondary (effective) intervention.
Cook RL, Rosenberg MJ. Do spermicides containing nonoxynol-9 prevent sexually transmitted infections? A meta-analysis. Sexually Transmitted Diseases 1998;25(3):144-50.	Nonoxynol-9- containing spermicides have an appreciable protective effect against both gonorrhea and chlamydial infection, and a wider use of spermicides might substantially reduce the incidence of these diseases. However, insufficient data exist to judge their effect on HIV transmission, and further research on the effect of nonoxynol-9 on HIV transmission is urgently needed to make evidence-based clinical decisions and public health recommendations in the future.	Fairly good evidence for preventing gonorrhea and chlamydial infections. Insufficient evidence for preventing HIV transmission.
Kim N, Stanton B, Dickersin K, Galbraith J. Effectiveness of the forty adolescent AIDs risk reduction interventions: a quantitative review. Journal of Adolescent Health 1997;20: 204-15.	A systematic review of AIDs risk reduction interventions in the USA found that these interventions can be effective in improving knowledge (88%), attitudes (58%) and behavioural intentions (60%) and in reducing risk practices (73% change in condom use and 64% in decreasing number of sexual partners).	A systematic review of 5 electronic databases and hand searches of 11 journals published from January 1983 to November 1995 identified 40 studies that met pre-established inclusion criteria.

EDUCATION: Sexual Education – Improving public understanding about HIV/AIDS and how to prevent them

CITATION	*REVIEW DETAILS*	*FINDINGS*
Wolitski RJ, MacGowan RJ, Higgins DL, Jorgensen CM. The effects of HIV counseling and testing on risk-related practices and help-seeking behaviour AIDS Education and Prevention 1997;9(3):52-67.	A systematic review of 35 U.S. and international studies found that the evidence of the ability of HIV counselling and testing (HIV CT) to motivate changes in risk-related practices, and to promote help-seeking behaviour, was generally mixed. Many studies provided at least some evidence supporting the ability of HIV CT to motivate risk-reducing and help-seeking behaviour, but others did not. The pattern of results varied substantially across, and within, study populations and were often limited by considerable methodological weaknesses.	A systematic review of 35 U.S. and international studies published since 1991 grouped the studies that were identified into four categories according to subject population: (1) men who have sex with men, (2) injection and other drug users, (3) women and heterosexual couples, and (4) mixed samples recruited from sexually transmitted disease (STD) clinics and other settings. Considerable methodological weaknesses were identified in many of the primary studies. Consequently, the cautious conclusions of the systematic review seem warranted.
Peersman G, Oakley A, Oliver S, Thomas J. Review of effectiveness of sexual health promotion interventions for young people. London: EPI-Centre, 1996.	A systematic review of 122 evaluations of sexual health promotion interventions for young people aged 12-16 years, the majority of which were carried out in educational settings, identified 21 studies that were judged to be methodologically sound. Only 4 soundly designed evaluations described interventions that were effective in changing young peoples reported behaviour. The authors note that investing in health promotion interventions that have not been shown to work is not an effective or cost-effective strategy.	Only 21 outcome evaluations out of 122 that were identified in the literature were found to be methodologically sound. The authors note that evaluation design in the field of HIV/AIDS risk reduction, and general sexual health in young people, needs to be improved. The need for more randomized controlled trials is noted. Particular attention needs to be paid to the design of effective interventions for high risk young people including gay/bi-sexual young men, injecting drug users, homeless young people and those who are inconsistent school attenders.
Wingood GM, DiClemente RJ. HIV sexual risk reduction interventions for women: a review. American Journal of Preventive Medicine 1996;6:209-17.	A systematic review of HIV prevention interventions targeted toward women found that some interventions are efficacious at increasing condom use during sexual intercourse. Effective interventions emphasised gender-related influences, were peer led and used multiple intervention sessions.	A systematic review of MEDLINE, ERIC and PSYCLIT. Some methodological limitations of the primary studies that were identified are noted. The need for rigorous methodological research designs to evaluate intervention programmes was also noted.
Booth RE, Watters JK. How effective are risk reduction interventions targeting injecting drug users? AIDS, 1994;8(11):1515-24.	A systematic review of published HIV/AIDS risk-reduction interventions targeting IV drug users found that only two out of 66 studies reported consistent and significant differences between groups.	A systematic review of 66 published studies which focussed on research design issues and the ability of these studies to attribute interventions to outcomes. Several major weaknesses that cross cut many of the studies were identified. Only studies using 1-group pretest-post test (PTPT) control group designs were able to control for historical trends that might impact risk behaviours.

EDUCATION: Sexual Education – Improving public understanding about HIV/AIDS and how to prevent them

CITATION	*REVIEW DETAILS*	*FINDINGS*
Oakley A, Fullerton D. Risk, knowledge and behaviour: HIV/AIDS education programmes and young people. London SSRU 1994.	A systematic review of 12 sound evaluation studies of HIV/AIDS prevention found that 11 studies were judged to be effective, or partially effective. Only two studies demonstrated any impact on risk taking behaviours. The most effective approach to HIV/AIDS risk reduction among young people would appear to be ones that provide practical information and support in a non-didactic way, and that is based on a accurate qualitative assessment of young people's needs.	A total of 1300 studies in the area of sexual health promotion were identified using electronic and hand searches. 378 of these studies had a focus on young people, and 81 described evaluation of different approaches. Of these 36 were evaluations of outcomes relevant to HIV/AIDS prevention. Only 12 of these 36 studies were judged to be methodologically adequate in terms of using a control group, providing pre and post intervention data, and reporting on all relevant outcomes. Only 3 outcome evaluations were carried out in the UK, and none of these were considered methodologically sound. The need for higher quality evaluation studies of HIV/AIDS risk reduction, including the greater use of randomized controlled trials, is noted by the authors.
Oakley A, Fullerton D, Holland J et al. Review of effectiveness: HIV prevention and sexual health education interventions: SSRU Database Project Number 1. London SSRU 1994.	A systematic review of 15 sound evaluations of HIV/AIDS prevention found that the most effective interventions were skill-based, and used interviews or role play facilitated by peers or clinical psychologists in community settings to target behavioural or combined knowledge and behavioural outcomes.	A total of 1210 studies of sexual health interventions were identified using electronic and hand searches. A 114 of these were evaluations of interventions with a specific focus on HIV/AIDS. A methodological review of these 114 studies found that only 15 of the outcome evaluations were judged to be methodologically adequate in terms of using a comparison group, providing pre and post intervention data, and reporting on all relevant outcomes. Only 3 outcome evaluation studies were carried out in the UK and none of these were considered methodologically sound. The need for higher quality evaluation studies of HIV/AIDS prevention, including the greater use of randomized controlled trials, is noted by the authors.
Weller SC. A meta-analysis of condom effectiveness in reducing sexually transmitted HIV. Social Science and Medicine 1993;36:(12):1635-44.	Condoms are 87% effective in preventing pregnancy, but may reduce the risk of HIV infection by only about 69%. Thus, the efficacy of condom use in preventing HIV infection may be much lower than commonly assumed. Some caution in using the results of this systematic review is advised given the design limitations of the original studies.	Systematic review suggesting some caution is required in accepting the findings on the efficacy of condom use given the design limitations of some primary studies.

EDUCATION: Helping teenage parents complete education and learn parenting skills

CITATION	*REVIEW DETAILS*	*FINDINGS*
Barlow J. Systematic review of the effectiveness of parent-training programmes in improving behaviour problems in children aged 3-10 years. Oxford, Health Services Research Unit, Institute of Health Sciences. ISBN: 1874551251.	A systematic review found that group based parent-training programmes have a positive effect on the behaviour of children aged 3 to 10 years. This finding was consistent across parent-report outcome measures and, to a lesser extent, independent observations of children's behaviour. One study indicated that community group-based parent-training programmes produced greater change in children's behaviour than individual clinic-based programmes. There was also some evidence to suggest that group-based programmes may be up to six times as cost effective and more acceptable to many parents. While the behavioural programmes appeared to be more effective in changing children's behaviour than Parent Effectiveness Training (PET), and Adlerian programmes, there is currently insufficient research on the effectiveness of the 'relationship' programmes	255 studies of parent-training programmes were identified of which 16 met the inclusion criteria of the review. All 16 studies were randomized controlled trials, and critical appraisal showed that they were of variable quality. The author notes that there is currently insufficient research to demonstrate which aspects of group parent-training programmes are the decisive factor in bringing about change. The only study using a placebo control group in which parents presented and discussed their concerns about parenting with other group members, and in which no set parent-training curriculum was used, showed that there were no significant differences in the results in placebo and treatment groups. The author also notes the need for further research on which parents benefit from the different types of programme available.
Hodnett ED, Roberts I. Home-based social support for socially disadvantaged mothers. [Cochrane Review]. In: The Cochrane Library Issue 1, 2000 Oxford: Update Software.	A systematic review concluded that postnatal home based support programmes appear to have no risks and may have benefits for socially disadvantaged mothers and their children, possibly including reduced rates of child injury.	Systematic review of randomized and quasi-randomized trials of one or more postnatal home visits with the aim of providing additional home based support for socially disadvantaged women who had recently given birth (compared to usual care) identified 11 studies involving 2992 families. Most of the trials had important methodological limitations consequently some caution is advised when considering the findings of this review.
Das-Eiden R, Reifman A. Effects of Brazelton demonstrations on later parenting: a meta-analysis. Journal of Pediatric Psychology 1996;21(6):857-68.	Indicating that Brazelton-based interventions during the neonatal period have a small-moderate beneficial effect on the quality of later parenting.	Only published studies (n=13) were included in this analysis, with one effect size entered for each study. Analyses were conducted by weighting each study equally (unit weighting) and also by sample size. The possibility of bias from using only published studies should be noted.
Van Ijzendoorn MH, Juffer F, Duyvesteyn MG. Breaking the intergenerational cycle of insecure attachment: a review of the effects of attachment-based interventions on maternal sensitivity and infant security. Journal of Child Psychology and Psychiatry and Allied Disciplines 1995;36(2):225-48.	A systematic review of preventive or therapeutic interventions aiming at enhancing parental sensitivity and children's attachment security is addressed. Results show that interventions are more effective in changing parental insensitivity (d=58) than in changing children's attachment insecurity (d=17). Longer more intensive, and therapeutic interventions appear to be less effective than short-term preventive interventions.	Sixteen pertinent studies have been reviewed and 12 studies have been included in a quantitative systematic review (N=869)

EDUCATION: Helping teenage parents complete education and learn parenting skills

CITATION	*REVIEW DETAILS*	*FINDINGS*
Jones LC. A meta-analytic study of the effect of childbirth education on the parent infant relationship. Healthcare Women International 1986;7:357-70.	A systematic review found that childbirth education is beneficial to the parent infant relationship. A greater magnitude of effect was found for middle income parents as compared with parents with low income. Moderate effects were found in both the behavioural and attitudinal components of the parent infant relationship.	A systematic review of 27 studies published between 1960 and 1981. Several methodological floors in the primary studies were found including researcher allegiance to childbirth education, unblinded procedures and the use of instruments without reliability or validity testing. Caution is advised in using or interpreting this review.

EDUCATION: Tackling drugs – alcohol

CITATION	*REVIEW DETAILS*	*FINDINGS*
McArthur DL, Kraus JF. The specific deterrence of administrative per se laws in reducing drunk driving recidivism. American Journal of Preventive Medicine 1999;16(1):68-75.	A systematic review of the effects of administrative per se laws in reducing drunk driving recidivism, traffic accidents and other alcohol related driving offences by drivers with suspended licenses found these interventions to be effective in some states (of the USA) but not others.	A systematic review of studies with comparison groups and providing relevant data that lead to an objective assessment of recidivism. Types of studies included were randomized controlled trials, non randomized controlled trials, other specialised cohort studies and case control studies. Only 3 studies met the inclusion criteria. The small number of studies, and the evidence of differential effectiveness in different states, suggests that caution should be exercised in interpreting or using this review.
Murphy-Brennan MG, Oei TP. Is there evidence to show that fetal alcohol syndrome can be prevented? Journal of Drug Education 1999;29(1):5-24.	A review (of uncertain nature) of prevention programmes aimed at preventing fetal alcohol syndrome suggest that they have been successful in raising awareness of FAS across the groups examined but not successful in changing drinking behaviour in high risk groups. It concludes that prevention programmes have had minimal or no impact of lowering the incidence of FAS and that "urgent steps must now be taken to fully test prevention programmes, and find new strategies involving both sexes, to reduce and ultimately eliminate the incidence of FAS.	A narrative review of articles on the effectiveness of prevention programmes aimed at fetal alcohol syndrome. The possibility of selection and publication bias should be noted and caution exercised in using the evidence provided by this review.
Black DR, Tobler NS and Sciacca JP. Peer helping/involvement: an efficacious way to meet the challenge of reducing alcohol, tobacco and other drug use among youth: a meta-analysis. Journal of School Health 1998;68(3):87-93.	Peer-led drug prevention programs for middle school students are reviewed for their effectiveness in minimising the use of alcohol, tobacco, and other drugs (ATOD). The authors conclude that peer interventions for middle school students are statistically superior to non-interactive didactic, lecture programs led by teachers/researchers.	A systematic review of 120 primary studies of school-based drug prevention programs
Foxcroft DR, Lister-Sharpe D, Lowe G. Alcohol misuse prevention for young people: a systematic review reveals methodological concerns and lack of reliable evidence of effectiveness, Addiction 1997;97(5)531-7.	A systematic review of 33 studies of alcohol misuse prevention found that there was a lack of reliable evidence and that no one type of prevention programme can be recommended. The need to carry out well designed scientific evaluations of the effectiveness of current or new prevention efforts which target young people's alcohol misuse is indicated.	A good systematic review with cautious notes about the reliability of evidence on alcohol prevention programmes for young people.

EDUCATION: Tackling drugs - alcohol

CITATION	*REVIEW DETAILS*	*FINDINGS*
Wells-Parker E, Bangert-Drowns R, McMillen R, Williams M. Final results from a meta-analysis of remedial interventions with drink/drive offenders. Addiction 1995;90:907-26.	A systematic review of the efficacy of remediation with drinking/driving offenders found that combinations of interventions, in particular those including education, psychotherapy/counselling and follow up contact/probation were more effective than other evaluated modes for reducing drinking/driving recidivism. The average effect of remediation on drinking/driving recidivism was an 8-9% reduction over no remediation.	A systematic review of 215 primary studies controlled for methodological quality found that better quality studies were associated with smaller effect size and less variation in effect size. Treatment effects are probably under estimated in the literature due to over emphasise on education as a treatment for all offenders and drinks/driving recidivism as the most frequent measure of outcome. The limitation of primary studies is discussed.
Rundell TG, Bruvold WH. A meta-analysis of school-based smoking and alcohol use prevention programs 1988; 15(3):317-34.	A systematic review of school-based intervention programs for smoking and alcohol found equally modest effects on immediate behavioural outcomes. Smoking interventions, however, have been more successful than alcohol interventions in altering students' long-term behaviour. Social reinforcement, social norms and developmental behaviour models are more effective than traditional awareness programs designed to inform adolescents about the health risks associated with tobacco and alcohol use.	A systematic review of 47 smoking and 29 alcohol school-based intervention programs published after 1970. 29 out of 33 smoking studies, and 19 out of 31 alcohol studies successful changes students attitudes.

EDUCATION: Tackling drugs – smoking/tobacco

CITATION	*REVIEW DETAILS*	*FINDINGS*
Hughes JR, Stead LF, Lancaster T. Anxiolytics and antidepressants for smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	A systematic review of the use anxiolytics and antidepressants for smoking cessation concluded that there is little evidence that anxiolytics are effective for this purpose but that some antidepressants (bupropion and nortriptyline) may be effective. It is unclear whether these effects are specific for individual drugs, or a class effect.	A systematic review of randomized controlled trials comparing anxiolytics or antidepressant to placebo or an alternative therapeutic control for smoking cessation identified 6 trials of anxiolytics and 8 trials of antidepressants. Trials with less than 6 months follow up were excluded.
Sowden AJ, Arblaster L. Community intervention for preventing smoking in young people. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	A systematic review of the effectiveness of community interventions for preventing smoking in young people found that there is some limited support for such programmes. The importance of building upon elements of existing programmes that had shown to be effective was noted. Programmes need to be flexible to the variability between communities and responsive to different target groups. Programme messages and activities should be guided by theoretical constructs about how behaviours are acquired and maintained (eg social learning theory). Community activities must reach the intended audience if they are to stand any chance of success.	A systematic review of MEDLINE and 21 other electronic databases, plus the Cochrane Tobacco Addiction Groups specialised register. Bibliographies of identified studies were checked and contact was made with content area specialists. 13 studies were included in the review. 44 studies did not meet all the inclusion criteria. All studies used a control trial design with 4 using random allocation of schools or communities. The need for more rigorous methodological procedures in primary studies was noted.
White AR, Rampes H, Ernst E. Acupuncture for smoking cessation. . [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	A systematic review of acupuncture for smoking cessation found no clear evidence for its effectiveness. Acupuncture was not superior to sham acupuncture in smoking cessation at any time point when compared with other anti smoking interventions there was no differences in outcome at any time point. Acupuncture appeared to be superior to no intervention in the early results but this difference was not sustained.	A systematic review of randomized controlled trials comparing a form of acupuncture with either sham acupuncture, another intervention or no intervention for smoking cessation. 20 comparisons were identified in 18 publications. Odds ratio and confidence intervals are presented.
Black DR, Tobler NS, Sciacca JP. Peer helping/involvement: an efficacious way to meet the challenge of reducing alcohol, tobacco and other drug use among youth: a meta-analysis. Journal of School Health 1998;68(3):87-93.	Peer-led drug prevention programs for middle school students are reviewed for their effectiveness in minimising the use of alcohol, tobacco, and other drugs (ATOD). The authors conclude that peer interventions for middle school students are statistically superior to non-interactive didactic, lecture programs led by teachers/researchers	A systematic review of 120 primary studies of school-based drug prevention programs

EDUCATION: Tackling drugs – smoking/tobacco

CITATION	*REVIEW DETAILS*	*FINDINGS*
Gourlay SG, Stead LF, Benowitz NL. Clonidine for smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	Clonidine is an anti hypertensive agent which acts on the central nervous system and may reduce withdrawal symptoms in various addictive behaviours including tobacco use. This systematic review, based on a small number of trials found that Clonidine is effective in promoting smoking cessation. However prominent side effects limits its usefulness for smoking cessation.	A systematic review of randomized trials of Clonidine vs placebo with a smoking cessation end point of at least 12 weeks following treatment. Identified 6 trials which met the inclusion criteria. 3 trials were or oral use of Clonidine and 3 were of transdermal use ie patch. Pooled odds ratio and confidence intervals are presented. Some potential sources of bias in the trials identified is noted.
Sowden AJ, Arblaster L. Mass media interventions for preventing smoking in young people. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	A systematic review of the effectiveness of mass media campaigns in preventing the uptake of smoking in young people concluded that such programmes can be effective but overall the evidence is not strong. Important characteristics of effective mass media campaigns include developing media messages that are appropriate to the target groups, using theoretical concepts about how behaviours are required and maintained, having sufficient intensity, frequency and duration of campaigns so as to have a reasonable chance of being effective and using radio and TV according to the age of the target group.	A systematic review of MEDLINE and 28 other electronic databases, plus handsearching of key journals, bibliographic checks and contact with content area specialists. Only 6 out of 63 studies met all the inclusion criteria which included using a controlled trial design. Two of these 6 studies concluded that mass media were effective in influencing the smoking behaviour in young people. Rigorous evaluation of mass media campaigns seems to be lacking and needs to be improved for the future.
Hajek P, Stead LF. Aversive smoking for smoking cessation. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	A systematic review of the efficacy of rapid smoking and other aversive therapy methods for smoking cessation found insufficient evidence to determine its effectiveness or whether there is a dose-response relationship to aversive stimulation.	A systematic review of randomized controlled trials which compared aversion treatments with `inactive' procedures or which compared aversion treatments of different intensity for smoking cessation identified 24 trials which met inclusion criteria. A funnel plot of included studies was asymmetric due to the relative absence of small studies with negative results. Most trials had a number of serious methodological problems likely to lead to spurious positive results. The only trial using biochemical validation of all self reported cessation gave a non significant result.

EDUCATION: Tackling drugs – smoking/tobacco

CITATION	*REVIEW DETAILS*	*FINDINGS*
Lichtenstein E, Glasgow RE, Lando HA, Ossip-Klein DJ et al. Telephone counseling for smoking cessation: rationales and meta-analytic review of evidence. Health Education Research 1996;11(2):243-57.	A systematic review of telephone counseling.for smoking cessation suggested that reactive approaches attract only a small percentage of smokers but are sensitive to promotional campaigns. They appear to be efficacious and useful as a public intervention for large populations. Proactive phone counseling showed significant short-term (3-6 mo) effects. 4 found substantial long-term differences. A significant increase in smoking cessation rates was found when compared with control groups. Proactive phone counseling appeared most effective when used as the sole intervention modality or when augmenting programs initiated in hospital settings.	A systematic review of 13 randomized trials using Slavin's best evidence synthesis.
Reid D. Tobacco control – overview. British Medical Bulletin 1996;52(1): 108-20.	An overview of the principle components of an effective tobacco control programme found that national targets for the reduction of smoking prevalence are more likely to be achieved through the use of high reach interventions such as fiscal policy and mass communications. Restrictions on smoking at work may contribute to declines in consumption. Advice from health professionals, though effective, has limited impact owing to low reach. Measures aimed primarily at youth can delay but not prevent recruitment to smoking. Media publicity not only reduces smoking but also creates a climate of opinion in favour of effective measures such as fiscal policy.	An overview of the literature on tobacco control which does not appear to met the standards of a systematic review consequently the potential for bias should be noted as should its limitations from the point of view of effective policy and practice.
Rooney BL, Murray DM. A meta-analysis of smoking prevention programs after adjustment for errors in the use of analysis. Health Education Quarterly 1996;23(1):48-64.	A systematic review of school-based smoking prevention programs based on peer or social-type programs suggests that the average effect is limited in magnitude. The reduction in smoking may be only only 5%. Even under optimal conditions, the reduction in smoking may be only 20-30%.	A systematic review of 90 primary studies published 1974-1991. Treatment characteristics were used to predict an effect size after adjustment for study design and population characteristics, and in particular after a post hoc correction for errors in the original unit of analysis.

EDUCATION: Tackling drugs – smoking/tobacco

CITATION	*REVIEW DETAILS*	*FINDINGS*
Stead, M. Hastings G, Tudor-Smith C. Preventing adolescent smoking: a review of options. Health Education Journal. 1996;5531-54.	Adolescent smoking remains a major health promotion challenge in Wales. Between 1986 and 1994, the Welsh Youth Health Surveys have indicated that prevalence of regular smoking among 15-year olds has increased from 16 per cent to 18 per cent for males and from 20 per cent to 26 per cent for females, and that females in Wales have one of the highest levels of adolescent smoking in Europe. The Health for All in Wales targets call for regular smoking among 15-year-olds to be reduced. This review was commissioned by Health Promotion Wales to inform and guide a new programme of work aimed at reducing adolescent smoking prevalence, particularly among females. A review was conducted of recent published research data and recommendations on adolescent smoking from the UK, North America, Australasia and Europe.	A systematic review of published research data and recommendations on adolescent smoking from the UK, USA, Australasia and Europe. Databases searched included MEDLINE, SSCI, ASSIA, CINAHL and The Health Promotion Library, Scotland. Papers in the English language published between 1989 and 1995 were included. The bulk of the papers comprised original research using quantitative samples large enough to yield statistically significant results. Other types of paper included were discussion articles from expert tobacco control committees/groups, pilot studies, and studies using qualitative methods.
Law M, Tang JL. An analysis of the effectiveness of interventions intended to help people stop smoking. The Archives of International Medicine 1995;1(55):1933-41.	A systematic review of the efficacy of interventions to help people stop smoking found that personal advice and encouragement given by physicians during a single routine consultation has a modest (2%) but cost effective effect on smoking cesssation. Follow up letters or visits have an additional effect. Advice and encouragement are particularly effective for smokers at special risk such as pregnant women (efficacy equals 8% and patients with ischemic heart disease). Behaviour modification techniques are also effective but no more so than simple advice giving by a physician (they are also several times more expensive). Nictotine replacement therapy is effective in an estimated 13% of smokers seeking cessation. The effect of hypnosis, acupuncture and other pharmacological treatments are not proven.	A systematic review of 188 randomized controlled trials of the efficacy of interventions intended to stop people smoking.
Dolan-Mullen P, Ramirez G and Groff JY. A meta-analysis of randomized trials of prenatal smoking cessation interventions. American Journal of Obstetrics and Gynecology 1994;1328-34.	A systematic review of prenatal smoking cessation interventions found that these were effective in terms of smoking cessation during pregnancy and reducing the incidence of low birth weight.	A systematic review of 11 randomized controlled trials with objective validation of smoking status, 4 of which also measured rates of low birth weight. Risk ratios consistently favoured experimental groups for smoking cessation, and for two of the four studies which measured low birth weight.

EDUCATION: Tackling drugs – smoking/tobacco

CITATION	*REVIEW DETAILS*	*FINDINGS*
Fiore MC, Smith SS, Jorenby DE , Baker TB. The effectiveness of the nicotine patch for smoking cessation. Journal of the American Medical Association 1994;271:1940-7.	A systematic review found that nicotine patch is an effective aid to stopping smoking across the range of strategies of patch-use. Active patch subjects were more than twice as likely to quit smoking as individuals wearing a placebo patch and this effect was present at both high and low intensity of counselling. The nicotine patch has the potential to improve public health significantly.	A systematic review of nicotine patch efficacy studies published up until September 1993 and identified using MEDLINE, PSYCLIT and the Food and Drug Administration new drug applications. Only double-blind, placebo-controlled nicotine patch studies of four weeks or longer with random assignment of subjects, biochemical confirmation of abstinence and subjects not selected on the basis of specific diseases (eg coronary heart disease were included). This yielded 17 primary studies with an N of 598 patients.
Silagy C, Mant D, Fowler G, Lodge M. Meta-analysis on efficacy on nicotine replacement therapies in smoking cessation. Lancet 1994;343:139-42.	A systematic review of nicotine replacement therapy (NRT) by chewing gum, transdermal patch, intranasal spray or inhalation found that all the currently available forms of NRT are effective therapies to aid smoking cessation.	A systematic review of published and unpublished randomized controlled trials of NRT that have assessed abstinence at least 6 months after the start of NRT were identified and 53 trials (42 gum, 9 patch, 1 intranasal spray, 1 inhaler) with data from 17703 subjects were included in the analyses. Odds ratio consistently favoured use of NRT.
Wisborg K, Obel C, Henriksen TB, Hedegaard M, Secher NJ. Strategies for smoking cessation among pregnant women. Ugeskrift for Laeger 1994;156: 4119-24.	A systematic review of intervention studies directed towards smoking cessation during pregnancy found that it is possible to reduce smoking during pregnancy only by an efficient and personal effort performed by a committed person towards each pregnant woman.	A systematic review of Scandinavian and English randomized controlled intervention studies. The intervention studies included anti-smoking advice, self help manuals, measurements of smoking dependent chemical factors, and multi factorial methods.
Matson DM,. Lee JW, Hopp JW. The impact of incentives and competitions on participation and quit rates in worksite smoking cessation programmes. American Journal of Health Promotion, 7(4):270-80.	A systematic review of incentives and competitions on participation and quit rates in worksite smoking cessation programmes found that incentives positively influenced participation rates, and had some effect on smoking reduction. No study, however, showed that incentives and/or competition enhanced smoking cessation past 6 months.	A systematic review identified 15 evaluations of smoking cessation programmes that had a quasi-experimental or experimental design and were published between 1966 and 1992. Only 8 of these 15 studies had an appropriate comparison group that allowed separation of the effects of incentives and competitions from other programme elements. Only 1 study separated the effects of competition from incentives with competition. Consequently, the evidence from these studies is weak.
Walsh R, Redman S. Smoking cessation in pregnancy: do effective programmes exist? Health Promotion International 1993;8:111-27.	A systematic review of controlled evaluations of smoking cessation interventions during pregnancy found that cognitive behavioural smoking cessation programmes in pregnancy are effective and that there was insufficient evidence to determine whether advice feedback or nurse home visitation programmes improved smoking cessation during pregnancy.	A systematic review of smoking cessation programmes during pregnancy identified 20 controlled evaluations of which 12 were judged to be methodologically inadequate and were excluded from the review.

EDUCATION: Tackling drugs – smoking/tobacco

CITATION	*REVIEW DETAILS*	*FINDINGS*
Fisher KJ, Glasgow RE, Terborg JR. Worksite smoking cessation: A meta-analysis of long-term quit rates from controlled studies. Journal of Occupational Medicine 1990;32(5),429-39.	A systematic review of 20 controlled studies of work site smoking cessation interventions found a modest but significant overall effect. Interventions conducted in smaller work sites, which lasted 2-6 hours, and which contained heavy smokers, were associated with the largest effect sizes. Quit rates were also associated with these factors plus programmes that included a cessation group, were not overly complicated, and that shared company and employee time.	A systematic review of 20 controlled studies of work site smoking cessation interventions yielding a total of 34 comparisons of long-term (average = 12 months) quit rate. An overall mean effect size of .21 +/- .07 ($p<.01$) was found. The weighted average follow up quit rate from all interventions was 13%.
Kottke TE, Battista RN, DeFriese GH, Brekke ML. Attributes of successful smoking cessation interventions in medical practice. A meta-analysis of 39 controlled trials. Journal of the American Medical Association 1988;259(19)2883-9.	A systematic review of 39 controlled smoking cessation trials found that success six months after the initiation of intervention was related to the type of intervention (face-to-face advice being better than all others), type of intervener (both physician and non-physician counsellors were better than either alone and the number and duration of reinforcing sessions. The number of modalities used by the intervention was also predictive of success, and was of borderline statistical significance.	A systematic review of 108 intervention comparisions in 39 controlled trials of smoking cessation.
Rundell TG, Bruvold WH. A meta-analysis of school-based smoking and alcohol use prevention programs 1988; 15(3):317-34.	A systematic review of school-based intervention programs for smoking and alcohol found equally modest effects on immediate behavioural outcomes. Smoking interventions, however, have been more successful than alcohol interventions in altering students' long-term behaviour. Social reinforcement, social norms and developmental behaviour models are more effective than traditional awareness programs designed to inform adolescents about the health risks associated with tobacco and alcohol use.	A systematic review of 47 smoking and 29 alcohol school-based intervention programs published after 1970. 29 out of 33 smoking studies, and 19 out of 31 alcohol studies successful changes students attitudes.
Lam W, Sze PC, Sacks HS, Chalmers TC. Meta-analysis of randomised controlled trials of nicotine chewing gum. The Lancet 1987;4(2):27-30.	The proper use of nicotine chewing gum in specialised clinics will increase the rate of stopping patients smoking, but the use of the gum in general medical practice is questionable.	Systematic review indicating nicotine chewing gum is more effective in specialised clinics than in general practice. (See also Stapleton 1998 above).

EDUCATION: Tackling drugs – other substances

CITATION	*REVIEW DETAILS*	*FINDINGS*
Tobler NS, Lessard T, Marshall D, Ochshorn P, Roona M. Effectiveness of school-based drug prevention programmes for marijuana use. a meta-analysis. School Psychology International 1999;20(1):105-37.	Non-interactive lecture-oriented prevention programmes that stressed knowledge about drugs affecting development of students showed minimal reductions in marijuana use. Interactive programmes that fostered the development of social competencies showed greater reductions in marijuana use. The primary finding for prevention programme planners is that interactive cultivation of social skills reduces marijuana use.	A good systematic review of X studies supporting interactive education methods as being more effective than non-interactive. This systematic review confirms findings of other meta-analyses.
Black DR, Tobler NS, Sciacca JP. Peer helping/involvement: an efficacious way to meet the challenge of reducing alcohol, tobacco and other drug use among youth: a meta-analysis. Journal of School Health 1998;68(3):87-93.	Peer-led drug prevention programs for middle school students are reviewed for their effectiveness in minimising the use of alcohol, tobacco, and other drugs (ATOD). The authors conclude that interactive peer interventions for middle school students are statistically superior to non-interactive didactic, lecture programs led by teachers/researchers	A systematic review of 120 primary studies of school-based drug prevention programs
White D, Pitts M. Educating young people about drugs: A systematic review. Addiction 1998;93(10):1475-87.	Systematic review showed that the impact of evaluated interventions was small and that gains were dissipated over time. Interventions targeting hard to reach groups have not been adequately evaluated.	A systematic review which noted that evaluations of school-based interventions against drug misuse tend to target alcohol, tobacco and marijuana, and are methodologically stronger than studies of interventions targeted at other drugs and taking place outside of schools.
Dusenbury L, Falco M, Lake A. A review of the evaluation of 47 drug abuse prevention curricula available nationally. J-Sch-Health. 1997;67(4): 127-32.	A vote counting review which found that only 10 of 47 primary prevention curricula for alcohol and other drugs. Amongst P-12 grades met acceptable evaluation standards. Generally favourable outcomes (8 out of the 10 studies) were reported in terms of preventing alcohol and other drug abuse.	A vote counting systematic review with inclusion and exclusion criteria that resulted in only 10/47 curricula being included in the review.

EDUCATION: Tackling drugs – other substances

CITATION	*REVIEW DETAILS*	*FINDINGS*
Ennett ST, Tobler NS, Ringwalt CL, Flewelling RL. How effective is drug abuse resistance education? A meta-analysis. American Journal of Public Health 1994;85(6)873-74.	The Drug Abuse Resistance Education (DARE) programme is the most widely used school-based drug prevention programme in the United States. DARE's effect sizes were substantially smaller than those of programmes emphasising social and general competencies and using interactive teaching strategies.	A systematic review of eight methodologically rigorous DARE evaluations. Weighted effect size means for several short-term outcomes were compared with means reported for other drug use prevention programs.
Hansen WB. School-based substance abuse prevention – a review of the state of the art in curriculum, 1980-1990. Health Education Research 1992;7:403-30.	A review of substance use prevention studies classified primary studies in terms of 12 content areas and identified 6 groups of programmes (information/values clarification, affective education, social influence, comprehensive, alternatives, and incomplete programmes. The review concluded that comprehensive and social influence programmes are the most successful in preventing the onset of substance abuse.	A review of substance use prevention studies published between 1980 and 1990 reports are analysed for two major threats to validity, selection bias and statistical power. Programme groups generally have similar selection biases, but have important differences in statistical power.
Bruvold WH. A meta-analysis of the California school-based risk reduction programme. Journal of Drug Education 1990;20(2):139-52.	Information-focused interventions on drug use have more impact upon knowledge, but less upon attitudes and behaviour, whereas alternative interventions have less impact upon knowledge but more upon attitudes and behaviour.	A systematic review performed upon eight risk-reduction programs meeting six standard methodological requirements for evaluation research.
Bangert Drowns RL. The effects of school-based substance abuse education--a meta-analysis. Journal of Drug Education. 1988;18(3):243-64.	Typical substance abuse education had most positive effects on knowledge and attitudes, but was unsuccessful in changing drug-using behaviours of students. Attitudinal effects were significantly higher when peers were instructional leaders and when group discussion was part of instructional mode. Students who volunteered for substance abuse education reported lower drug use after treatment than did students who were required to participate in such programmes	A high quality systematic review of 33 evaluations of school-based alcohol and drug education programs.
Tobler NS. Meta-analysis of 143 adolescent drug prevention programs - Quantitative outcome results of program participants compared to a control or comparison group. Journal of Drug Issues. 1986;16:537-67.	Peer programmes were significantly different from the combined results of all comparison/control groups. Peer programmes maintained high effect size for alcohol, soft drugs and hard drugs, as well as for cigarette use	A high quality systematic review of 143 adolescent drug prevention programmes

EDUCATION: Tackling drugs – other substances

CITATION	*REVIEW DETAILS*	*FINDINGS*
Schaps E, Churgin S, Palley CS, Takata B. Primary prevention research: a preliminary review of programme outcome studies. International Journal of Addiction 1980;15:657-76.	A review of 35 drug abuse prevention programme evaluation studies found that the "new generation" prevention strategies (ie affective, peer-oriented, and multi dimensional) approaches may produce more positive and fewer negative outcomes than older drug information approaches. Caution is advised due to the methodological inadequacy of some primary studies.	A review of 35 drug abuse prevention programme evaluation studies of which the scientific rigor of the research was found to be frequently inadequate. The rigor of research was negatively correlated with the intensity and duration of programme services. The authors advise that the findings of this review must be approached with great caution.

EDUCATION: Diet and nutrition

CITATION	*REVIEW DETAILS*	*FINDINGS*
Brug J, Campbell M, van Assema P. The application and impact of computer generated personalised nutrition education: a review of the literature. Patient Education and Counselling 1999; 36(2):145-56.	A literature review of computer generated nutrition education found that this is more likely to be read, remembered and experienced as personally relevant than our standard educational materials. Computer tailored nutrition education also appears to have a greater impact in motivating people to change their diet and their fat intake in particular. At present no definite conclusions can be drawn.	A review of 8 published studies that have assessed the impact of comprehensive computer generated nutrition interventions based on behaviour change theory. The selective nature of the review due to its theoretical focus, and the authors acknowledgement that no definite conclusions can be drawn should be noted.
McArthur DB. Heart healthy eating behaviors of children following a school-based intervention: a meta-analysis. Issues in Comprehensive Pediatric Nursing. 1998;21(1):35-48.	A systematic review of the effects of school-based interventions on heart healthy eating behaviours of fourth and fifth grade students found that these interventions had a significant effect on the student participants.	A systematic review identified 12 studies of school-based interventions on 4th and 5th grades students. The overall effect size (d value) across 12 studies was 24. The 95% confidence interval ranged from .174 to .301.
Hursti UK, Sjoden P. Changing food habits in children and adolescents: experiences from intervention studies. Scandinavian Journal of Nutrition 1997; 41:102-10.	A systematic review of school or community based studies using experimental or quasi experimental design reported only modest changes in the outcome measures (changes in eating habits) and only 3 report maintenance of the effects of interventions. Even moderate changes in dietary risk factors for cardiovascular disease may be beneficial if maintained over long periods.	A systematic review of experimental and quasi experimental studies during the 1980s and the 1990s.
Levy SR, Iverson BK, Walberg HJ. Nutrition-education research: An interdisciplinary evaluation and review. Health Education Quarterly 1980;7:107-26.	The more interdisciplinary criteria a study fulfils, the more likely it is to influence knowledge, behaviour, and attitudes with respect to nutrition	An interdisciplinary review which compared school nutrition education programs systematically 6 out of 22 studies met inclusion criteria for the review and effect sizes were reported.

EDUCATION: Work based health promotion

CITATION	*REVIEW DETAILS*	*FINDINGS*
Landbergis PA, Cahill J, Schnall P. The impact of lean production and related new systems of work organisation on worker health. Journal of Occupational Health Psychology 1999;4(2):108-30.	A review (nature uncertain) of studies of the impact of different work practices on injuries and illness found little evidence to support the hypothesis that lean production empowers auto workers in fact auto industry studies suggest that lean production creates intensified work pace and demands. Increases in decision authority and skill levels are modest, or temporary whereas decision latitude typically remain low thus lean production and new systems of work organisation can be considered to have job strain and possibly poor effects on health.	A review of studies on different work practices. The nature of this review is unclear and seems not to meet the standards of a systematic review. Some degree of selection and publication bias is suggested. Consequently caution should exercised when interpreting the findings of this review.
Peersman G, Harden A, Oliver S. Effectiveness of health promotion interventions in the workplace: a review. London, Health Education Authority 1998.	A systematic review on workplace health promotion programmes, most of which were undertaken in the United States of America, identified a number of studies from which general pointers to potential success of such interventions can be derived. However the author's note that most of the evaluations of these programmes were methodologically flawed due to the absence of a control or comparison group. Consequently, little can be concluded about these studies that is valid and reliable. The effectiveness of different approaches to workplace health promotion is likely to be influenced by different organizational cultures. The enormous potential for the workplace as a setting for improving the health of the adult population is noted.	The evidence concerning the effectiveness of workplace health promotion is generally weak due to a number of methodological flaws in the design and execution of programme evaluations. The absence of comparison or control groups is particularly troublesome. The inclusion criteria for this review were developed with the aim of including studies based on participatory methods, as these were considered more likely to be relevant and acceptable in the workplace. Other criteria included studies that gathered both process and outcome measures as these presented a better picture of whether, and how, the intervention has worked.
Innes E. Education and training programmes for the prevention of work injuries: do they work? Journal of Prevention, Assessment and Rehabilitation 1997;9(3):221-32.	A narrative literature review of education and training programmes to deal with the prevention of occupational injuries and diseases suggested that they can be effective in reducing risk and injury when used in combination with other controlled systems. They seem to be particularly effective in preventing back injuries.	A narrative review of the format structure and content of programmes applied to a model addressing behaviour change (the health belief model). The uncertain nature of the search procedures, and of their comprehensiveness, suggests the possibility of both selection and publication bias consequently the conclusions of this review should be used with caution.

EDUCATION: Work based health promotion

CITATION	*REVIEW DETAILS*	*FINDINGS*
Lusk SL. Health promotion and disease prevention in the worksite. Annual Review of Nursing Research 1997;15: 187-13.	A review of 73 US and Canadian studies on health promotion/disease prevention programmes in the worksite found that nearly all (68 out of 73) of the published studies obtained positive results in terms of benefiting health or reducing costs. The Johnson and Johnson "Live for Life" Programme is presented as an exemplar of a comprehensive, multi faceted, worksite health promotion disease prevention programme whose effects are consistently assessed.	A systematic review of published studies on health promotion/disease prevention programmes in the worksite between 1990 and 1994.
Sparks K, Cooper C, Yitzhak F, Shirom A. The effects of hours of work on health: a meta-analytic review. Journal of Occupational and Organisational Psychology 1997;70(4):391-408.	A quantitative and qualitative review of existing literature on working hours and health including a systematic review on 21 study samples concluded that there is a link between the hours worked and ill health. A small but significant positive mean correlation between overall health symptoms, physiological and psychological health symptoms and hours of work was found. The implications are that limiting the hours people work has a beneficial effect on their health.	A quantitative and qualitative review and a meta analysis of 21 studies. The qualitative analysis of 12 other studies supported that findings of the meta analysis of a positive relationship between hours or work and ill health.
Verhoeven C, Johanna M. Wellness effects of a worksite health promotion program. Leiden University Press 1997; 255.	A systematic review of the effectiveness of European Worksite Health Promotion Programmes found that the total wellness-health promotion programme was effective in establishing improvements in working conditions and decreases in sick leave related absenteeism. The programme aimed at avoiding stress situations at work and increasing latitude in employees decision making.	A systematic review in the form of a book publication which noted that there were few experimental or quasi-experimental studies of worksite health promotion programmes and that those which do exist differ substantially in terms of the interventions applied and the outcome measures used. Consequently the accumulative evidence of worksite health promotion programmes is weak.
Wilson MG, Jorgensen C, Cole G. The health effects of worksite HIV/AIDS intervention: A reviews of the research literature, American Journal of Health Promotion 1996;11(2):150-7.	A systematic (vote counting) review of the individual and organisational health effects of HIV/AIDS interventions conducted at the worksite concluded that 10 of the 12 studies reviewed reported positive effects of employee education programmes on knowledge and attitudes. Methodological weaknesses should be noted.	A vote counting review of 12 studies on worksite HIV/AIDS educational interventions, of which 9 studies lacked a comparison or control group. Consequently, the evidence on the effectiveness of these interventions is weak.

EDUCATION: Work based health promotion

CITATION	*REVIEW DETAILS*	*FINDINGS*
Matson DM, Lee JW, Hopp JW. The impact of incentives and competitions on participation and quit rates in worksite smoking cessation programmes. American Journal of Health Promotion, 7(4):270-80.	A systematic review of incentives and competitions on participation and quit rates in worksite smoking cessation programmes found that incentives positively influenced participation rates, and had some effect on smoking reduction. No study, however, showed that incentives and/or competition enhanced smoking cessation past 6 months.	A systematic review identified 15 evaluations of smoking cessation,programmes that had a quasi-experimental or experimental design and were published between 1966 and 1992. Only 8 of these 15 studies had an appropriate comparison group that allowed separation of the effects of incentives and competitions from other programme elements. Only 1 study separated the effects of competition from incentives with competition. Consequently, the evidence from these studies is weak.
Fisher KJ, Glasgow RE, Terborg JR. Worksite smoking cessation: A meta-analysis of long-term quit rates from controlled studies. Journal of Occupational Medicine 1990;32(5):429-39.	A systematic review of 20 controlled studies of work site smoking cessation interventions found a modest but significant overall effect. Interventions conducted in smaller work sites, which lasted 2-6 hours, and which contained heavy smokers, were associated with the largest effect sizes. Quit rates were also associated with these factors plus programmes that included a cessation group, were not overly complicated, and that shared company and employee time.	A systematic review of 20 controlled studies of work site smoking cessation interventions yielding a total of 34 comparisons of long-term (average = 12 months) quit rate. An overall mean effect size of .21 +/- .07 ($p<.01$) was found. The weighted average follow up quit rate from all interventions was 13%.

EDUCATION: Food safety

CITATION	*REVIEW DETAILS*	*FINDINGS*
Campbell ME, Gardner CE, Dwyer JJ, Isaacs SM, Krueger PD, Ying JY. Effectiveness of public health interventions in food safety: a systematic review. Canadian Journal of Public Health 1988;89(3):197-202.	A systematic review of the effectiveness of public health interventions regarding food safety at restaurants, institutions, homes and other community based settings found that routine inspection (at least once per year) of food service premises is effective in reducing the risk of food borne illnesses. Food handler training can improve the knowledge and practices of food handlers. Selected community based education programmes can increase public knowledge of food safety. There is some evidence for the effectiveness of multiple public health interventions on food safety.	A systematic review of published and unpublished studies using comprehensive literature searches and screening for relevance and quality of studies identified. 15 primary studies were included in this review and were grouped into three categories: inspections, food handler training, and community based education.

Social Care and Social Welfare

This section of the report summarises the findings of systematic reviews of the effects of interventions in the fields of social work and social welfare, encompassing social, public and fiscal policies, models of service delivery and interventions with individuals, groups and communities.

Fiscal policies

CITATION	*REVIEW DETAILS*	*FINDINGS*
Connors J, Rodgers A, Priest P. Randomised studies of income supplementation: a lost opportunity to assess health outcomes. Journal of Epidemiological Community Health. 1999;53:725-30.	A systematic review of randomised studies of income supplementation, with particular reference to health outcomes.	Ten relevant studies were identified, all conducted in North America, mostly in the late 1960s and 1970s. Five trials were designed to assess the effects of income supplementation on workforce participation and randomised a total of 10,000 families to 3-5 years of various combinations of minimum income guarantees and reduced tax rates. Two trials were designed to assess re-offending rates in recently released prisoners and randomised a total of 2400 people to 3-6 months of benefits. One trial was designed to assess housing allowances and randomised 3500 families to three years of income supplements. One trial assessed the health effects of 12 months of income supplementation in 54 people with severe mental illness. Finally, one study compared three groups of people who won different amounts of money in a state lottery. In all these studies the interventions resulted in increases in income of at least one fifth. However, no reliable analyses of health outcome data are available. Extensive opportunities to reliably assess the effects of increases in income on health outcomes have been missed. Such evidence might have increased the consideration of potential health effects during deliberations about policies that have major implications for income, such as taxation rates, benefit policies, and minimum wage levels. Randomised evidence could still be obtained with innovative new studies, such as trials of full benefit uptake or prospective studies of lottery winners in which different sized winnings are paid in monthly instalments over many years.
Burgess S, Metcalfe P. Incentives in Organisation. http://www.bris.ac.uk/Depts/CMPO Document 99/016. 1999	A selective overview of a sizeable economic literature relating to the provision of incentives within firms and discusses the suitability of this programme in light of the evidence. The paper related to the reform and extension of variable pay incentives in the public sector. For other excellent recent surveys with a more general ambition, See Prendergast (1999), Malcolmson (1999), Murphy (1999) and Gibbons and Waldman (1999).	Employees do respond to incentives, often in sophisticated ways that may or may not be to the benefit of the organisation as a whole. The design of the scheme is hence extremely important. The pattern of existence of schemes is broadly in line with theory: where a worker has many tasks to perform or where output is difficult to measure, objectively assessed performance related pay is observed less frequently and subjectively assessed bonus payments are observed more frequently. Public sector workers are motivated by more than just their own income. We do not know if the same result holds for workers in the private sector. Differences in the pattern of existence of incentive schemes between the public and private sectors are not easy to interpret but may indicate that there are inefficiently few schemes in the public sector. Other aspects of organisation design such as promotion systems and hierarchical reward structures also provide incentives although there is less evidence on this. This survey reveals several gaps in the empirical literature. We have very little evidence relating to incentives for those whose pay is determined subjectively by their superiors; we do not know how incentive schemes interact with the need for proper behaviour by public servants and we do not have a full understanding of the provision of and response to incentives for teams.

SOCIAL CARE AND SOCIAL WELFARE: Public policies relating to health

CITATION	*REVIEW DETAILS*	*FINDINGS*
Kossek EE, Ozeki C. Bridging the work family policy and productivity gap: A literature review. Community-Work and Family. 1999;2(1):7-32.	Reviews the relationship between work-family conflict and 6 work outcomes: (1) performance, (2) turnover, (3) absenteeism, (4) organizational commitment, (5) job involvement, and (6) burnout in a meta-analysis.	Also reviewed are studies on the effects of employer (work-family) policies aimed at reducing such conflict. Policies to aid employees in managing work and family roles can be expensive, and studies show that they are often marginally effective. The review shows that relationships between work-family policies and organizational effectiveness is mixed and their connection to work-family conflict often under-examined. Work-family conflict is a critical link that may shed light on policy impacts. Suggestions on how future studies can build bridges between practitioners and academics and more clearly examine organizational effectiveness links are provided. An appendix of the studies included in the meta-analysis is provided.
Guterman NB. Enrolment strategies in early home visitation to prevent physical child abuse and neglect and the "universal versus targeted" debate: a meta-analysis of population-based and screening-based programs. Child Abuse and Neglect. 1999:23(9):863-90.	A meta-analysis comparing effect sizes from 19 controlled outcome studies across screening-based and population-based enrollment strategies. Effect sizes were calculated on protective services data and on child maltreatment related measures of parenting.	On protective services report data, population-based studies reported a weighted mean effect size attributable to early home visitation of +3.72%, in comparison to -.07% for screening-based studies. On child maltreatment related measures of parenting, population-based studies reported a weighted mean effect size (r) attributable to early home visitation of +.092, in comparison to +.020 for screening-based studies. CONCLUSIONS: The findings indicate that population-based enrolment strategies appear favourable to screening-based ones in early home visitation programs seeking to prevent physical child abuse and neglect. It may be that psychosocial risk screens serve to enrol higher proportions of families for which early home visitation services are less likely to leverage change, and to exacerbate a mismatch between early home visitation service aims and family needs.
Hodnett ED, Roberts I. Home-based social support for socially disadvantaged mothers. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	A systematic review of 11 randomised controlled trials of home visiting programmes.	Eight trials examined the effectiveness of home visiting in the prevention of childhood injury. The pooled odds ratio for the eight trials was 0.74 (95% confidence interval 0.60 to 0.92). Four studies examined the effect of home visiting on injury in the first year of life. The pooled odds ratio was 0.98 (0.62 to 1.53). Nine trials examined the effect of home visiting on the occurrence of suspected abuse, reported abuse, or out of home placement for child abuse. Because of the potential for bias in outcome reporting in these studies, pooled effect estimates were not calculated. Home visiting programmes have the potential to reduce significantly the rates of childhood injury. The problem of differential surveillance for child abuse between intervention and control groups precludes the use of reported abuse as a valid outcome measure in controlled trials of home visiting.
Posavac EJ, Kattapong KR, Dew DE. Peer-based interventions to influence health-related behaviours and attitudes: a meta-analysis. Psychological Reports 1999; 85:1179-94.	A meta-analysis of the effects of 47 peer-based health education programmes described in 36 published studies.	The overall effect size was small: the mean d was .190 when controls received no programme and .020 when controls received an alternative programme. Differences between the studies suggested several biases likely to have influenced the effect sizes. Preventive interventions which produce only small effects can be valuable because many participants would not have developed the problem without the programme. This review suggested that, when health education programmes are studies: (a) detailed statistical information should be provided to facilitate using the research findings in meta-analyses

Grossman DC, Varcia CC. Effectiveness of health promotion programs to increase motor vehicle occupant restraint use among young children. American Journal of Preventive Medicine 1999;16(1)12-22.	A systematic review of the effectiveness of non-legislative community and clinical programmes to increase the rate of child motor vehicle occupant restraint use among children under the age of 5.	Programmes to increase the rate of child restraining use among child occupants of motor vehicles appear to have overall moderate short-term effectiveness There is a substantial 'wash-out' of the magnitude of the positive effects one or more months after interventions end. There is a need for high quality randomised controlled trials to determine the long-term effectiveness of child restraint prevention programmes.
Stanton MD, Shadish WR. Outcome, attrition, and family-couples treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. Psychological-	A meta-anlysis of drug abuse outcome studies that included a family-couples therapy treatment condition.	The meta-analytic evidence, across 1,571 cases involving an estimated 3,500 patients and family members, favours family therapy over (a) individual counselling or therapy, (b) peer group therapy, and (c) family psycho-education. Family therapy is as effective for adults as for adolescents and appears to be a cost-effective adjunct to methadone maintenance. Because family therapy frequently had

CITATION	*REVIEW DETAILS*	*FINDINGS*
Bulletin. 1997;122:(2)170-91.		higher treatment retention rates than did non-family therapy modalities, it was modestly penalised in studies that excluded treatment dropouts from their analyses, as family therapy apparently had retained a higher proportion of poorer prognosis cases. Re-analysis, with dropouts regarded as failures, generally offset this artefact. Two statistical effect size measures to contend with attrition (dropout d and total attrition d) are offered for future researchers and policy makers.
Durlak JA, Wells AM. Primary prevention mental health programs for children and adolescents: A meta-analytic review. American Journal of Community Psychology. 1997;25:(2):115-52.	A meta-analysis of 177 primary prevention programs designed to prevent behavioral and social problems in children and adolescents.	Findings provide empirical support for further research and practice in primary prevention. Most categories of programs produced outcomes similar to or higher in magnitude than those obtained by many other established preventive and treatment interventions in the social sciences and medicine. Programs modifying the school environment, individually focused mental health promotion efforts, and attempts to help children negotiate stressful transitions yield significant mean effects ranging from 0.24 to 0.93. In practical terms, the average participant in a primary prevention program surpasses the performance of between 59% to 82% of those in a control group, and outcomes reflect an 8% to 46% difference in success rates favoring prevention groups. Most categories of programs had the dual benefit of significantly reducing programs and significantly increasing competencies. Priorities for future research include clearer specification of intervention procedures and program goals, assessment of program implementation, more follow-up studies, and determining how characteristics of the intervention and participants relate to different outcomes.
Mullen PD, Simons-Morton DG, Ramirez G, Frankowski RF, Green LW, Mains DA. A meta-analysis of trials evaluating patient education and counselling for three groups of preventive health behaviours. Patient Education and Counselling 1997; 32(3):157-73.	A meta-analysis of the effectiveness of patient education and counselling on preventive health behaviours. Inclusion criteria: Randomised and non-randomised controlled trials measuring behaviour in clinical settings with patients without diagnosed disease. Behaviours were grouped based on whether the behaviour is addictive and whether the desired change required subtraction of existing behaviours or adding new behaviours.	The weighted average effect size from a random effects model for smoking/alcohol studies was 0.61 (CI = 0.45, 0.77), for nutrition/weight, 0.51 (CI = 8.20, 0.82) and for other behaviours, 0.56 (CI = 0.34, 0.77) indicating that the behavioral outcomes for these subgroups were significantly different from zero. Multiple regression models for the three groups indicated that using behavioral techniques, particularly self-monitoring, and using several communication channels, e.g., media plus personal communication, produces larger effects for the smoking/alcohol and nutrition/weight groups. Conclusions: Patient education and counselling contribute to behaviour change for primary prevention of disease. Some techniques are more effective than others in changing specific behaviours.
Barker M, Bridgeman C. Preventing vandalism: what works? Crime Detection and Prevention Series Paper 56 London, UK: Home Office Police Research Group. 1994	A review of what works in vandalism prevention in the UK.	Subtle approaches aimed at building up social responsibility by showing children the consequences of their vandalism may be helpful in reducing damage caused inadvertently. Making targets less vulnerable, particularly through surveillance, appears to have measurable effects. This may, however, displace vandalism to softer targets elsewhere. Other successful efforts include: instituting packages of measures rather than individual attempts, and creating single-, rather than multi-agency initiatives.
Lester D. Controlling crime	A review of research conducted by the	Results provide evidence that limiting access to a preferred method of committing

CITATION	*REVIEW DETAILS*	*FINDINGS*
facilitators: evidence from research on homicide and suicide. R.V. Clarke (ed) Crime Prevention Studies, Monsey NY: Criminal Justice Press. 1993;1:35-54.	author and his colleagues over a ten year period which examined the effects of limited access to lethal methods for suicide and for homicide.	suicide and homicide has a preventive effect, more clearly for suicide than for homicide. However, some evidence of some switching of method may take place after limiting access to one method, again more so for suicide than for homicide.
Holbrook AM, Crowther R, Lotter A, Cheng C, King D, Applegate, Brooks A. Meta-Analysis of the Effects of Day Care on Development: Preliminary Findings. 1986;25 ED280613.	A meta-analysis of eleven randomised controlled trials assessing the benefits of benzodiazepines compared with other therapies in the treatment of acute alcohol withdrawal. Benefit was defined as therapeutic success within two days.	Benzodiazepines were superior to placebo (common odds ratio {OR} 3.28, 95% confidence internal [CI] 1.30-8.28). Data on other drugs could not be pooled but none of the alternative drugs was found to be clearly more beneficial than the benzodiazepines. The benzodiazepines should remain the drugs of choice for the treatment of acute alcohol withdrawal.

SOCIAL CARE AND SOCIAL WELFARE: Public policies relating to education and day care

CITATION	*REVIEW DETAILS*	*FINDINGS*
Zoritch B, Roberts I, Oakley A. Day care for pre-school children. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	A systematic review of randomised controlled trials of day-care for pre-school children. A total of 8 trials were identified, all conducted in the U.S.A.	Results showed that day-care promotes children's intelligence, development and school achievement. Long-term follow up demonstrates increased employment, lower teenage pregnancy rates, higher socio-economic status and decreased criminal behaviour. There are positive effects on mothers' education, employment and interaction with children. Effects on fathers have not been examined. Few studies look at a range of outcomes spanning the health, education and welfare domains. Most of the trials combined non-parental day-care with some element of parent training or education (mostly targeted at mothers); they did not disentangle the possible effects of these two interventions. The trials had other significant methodological weaknesses, pointing to the importance of improving on study design in this field. There is a need for well designed research on day-care to provide an evidence-base for British social policy.
Roth J, Brooks-Gunn J, Murray L, Foster W. Promoting healthy adolescents: synthesis of youth development program evaluations. Journal of Research on Adolescence 1998;8(4):423-59.	A review of the usefulness of the youth development framework based on 15 program evaluations.	The results of the evaluations are discussed and 3 general themes emerge. First, programs incorporating more elements of the youth development framework seem to show more positive outcomes. Second, the evaluations support the importance of a caring adult-adolescent relationship, although these relationships need not be limited to 1-on-1 mentoring. Third, longer-term programs that engage youth throughout adolescence appear to be the most effective. The policy and programmatic implications of these findings are discussed.
Wheeler JA, Gorey KM, Greenblatt B. The beneficial effects of volunteering for older volunteers and the people they serve: A meta-analysis. International Journal of Aging and Human Development 1998; 47(1):69-79.	A meta-analysis of thirty-seven independent studies examining the effects of volunteering amongst older people, both on themselves and the people they serve.	Relatively healthy older volunteers' sense of well-being seems to be significantly bolstered through volunteering. Such relatively healthy older people represent a significant adjunct resource for meeting some of the service needs of more vulnerable elders, as well as those of other similarly vulnerable groups such as disabled children. Averaging across studies, 85 percent of the "clients" who received service from an older volunteer (e.g., peer-counseling of nursing home residents) scored better on dependent measures (e.g., diminished depression) than the average person in comparison conditions did (U3 = .847 [Cohen, 1988], combined $p < .001$). The policy implications of such beneficial effects among both older volunteers and the people they serve are discussed.
Ploeg J, Ciliska D, Dobbins M, Hayward S, Thomas H, Underwood J. A systematic overview of the effectiveness of public health nursing interventions: an overview of adolescent suicide prevention programs. University of Toronto, McMaster University. Quality of Nursing Worklife Research Unit. 1996.	A systematic overview summarizing the evidence about the effectiveness of adolescent suicide prevention curricula programs.	There is currently insufficient evidence to support curriculum-based suicide prevention programs. The evidence suggests that there may be both beneficial and harmful effects of the programs on students. In most studies, knowledge related to suicide improved as a result of the programs. However, studies found both beneficial and harmful effects on attitudes related to suicide. One study found an increase in hopelessness and maladaptive coping for males following the intervention. The literature suggests that more broadly based comprehensive school health programs should be evaluated for their effectiveness in addressing the determinants of adolescent risk behaviour.
Schweinhart LJ. 'Lasting Benefits of	This digest reviews various longitudinal	Concerning program effects on school performance, all studies that collected data on

SOCIAL CARE AND SOCIAL WELFARE: Public policies relating to education and day care

CITATION	*REVIEW DETAILS*	*FINDINGS*
Preschool Programs'. ERIC Digest. 1994.	studies that examined the long-term effects of programs that served young children living in poverty and at risk of school failure.	children's intellectual performance found that their program groups had better intellectual performance than their no-program groups during the program and for a year or two thereafter. Results of various studies indicated that, compared to the no-program group, program group members were less likely to be placed in special education classes and to be retained in grade, and had higher high school graduation rates. Concerning the programs' effects on community behavior, one study found that, compared to the no-program group, program group members: (1) had fewer criminal arrests; (2) spent less time on probation; (3) reported higher monthly earnings; (4) were more likely to own a home and a second car; and (5) received less welfare assistance or other social services as adults. One study that analyzed the costs and benefits of a preschool program found significant returns to taxpayers from savings in later schooling costs, higher taxes paid by program participants because of their later higher earnings, savings in welfare assistance, and savings to the criminal justice system and to potential victims of crimes. These studies suggest that high-quality programs for young children produce long-term benefits because they empower young children to carry out their own learning activities; parents to work with teachers in supporting children's development; and teachers to engage in practices that support children and parents.

SOCIAL CARE AND SOCIAL WELFARE: Public policies relating to crime and substance abuse

CITATION	*REVIEW DETAILS*	*FINDINGS*
Pease K. A review of street lighting evaluations: crime reduction effects. In K. Painter and N. Tilley (eds) Surveillance of Public Space: CCTV, Street Lighting and Crime Prevention. Crime Prevention Studies, Monsey, NY: Criminal Justice Press. 1999;10.	A review of the effectiveness of street lighting in preventing crime.	Precisely targeted street lighting generally have crime reduction effects. More general increases in street lighting sometimes have crime prevention effects. In the most recent and sophisticated studies, street lighting improvements have been associated with crime reductions in the daytime as well as during hours of darkness.
Philips C. A review of CCTV evaluations: crime reduction effects and attitudes towards its use. In K. Painter and N. Tilley (eds) Surveillance of Public Space: CCTV, Street Lighting and Crime Prevention. Crime Prevention Studies, Monsey, NY: Criminal Justice Press 1999;10.	A systematic review of the effectiveness of CCTV in reducing rime, disorder and fear of crime.	CCTV can be effective in deterring property crime, but the findings are more mixed in relation to personal crime, public order offences and fear of crime.
Rawlings BA et al. Systematic International Review of Therapeutic Community Treatment for People with Personality Disorders and Mentally Disordered Offenders. Report 17. University of York: NHS Centre for Reviews and Dissemination 1999.	This review covers the democratic therapeutic communities for personality-disordered offenders, found mainly in British and European prisons and hierarchical therapeutic communities for drug users, found mainly in the US.	Evaluative research has looked either at changes in behaviour and reported feelings during treatment, or at changes in behaviour after treatment has finished. Post-treatment follow-up research largely takes the form of reconviction studies. The main body of research finds that therapeutic communities have a positive effect on reconviction and re-offending, and a positive effect on behaviour whilst in prison.
Hollin CR. Treatment programs for offenders: Meta-analysis, 'what works', and beyond. International Journal of Law and Psychiatry 1999;22(3):361-72.	A reviews of meta-analytic studies in the field of offender treatment while concluding that offender treatment is clearly back on the agenda of administrators, practitioners, and researchers.	The meta-analyses have pointed the way toward "what works" in offender treatment, as opposed to the "nothing works" message of the early 1970's. Two main consequences have emerged from this shift. First, there is an overall positive net gain to be seen when treated offenders are compared to nontreatment groups. The second conclusion, and perhaps the more significant, is that not all interventions have the same effect on recidivism: the meta-analyses have shown that some interventions have a significantly higher effect than others. Clearly, treatment will never eliminate crime, but if effective work with offenders can reduce the human and financial costs of victimization then the effort is surely worthwhile.
Kar SB, Pascual CA, Chickering KL. Empowerment of women for health promotion: A meta-analysis. Social	The objective of this paper was to identify conditions, factors and methods, which empower women and mothers (WAM)	Content analysis extracted data from all cases on six dimensions: (1) problem, (2) impetus/leadership, (3) macro-environment, (4) methods used, (5) partners/opponents and (6) impact. Analysis identified seven methods frequently used to EMPOWER

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Science and Medicine. 1999;49(11):1431-60.	for social action and health promotion movements. WAM are the primary caregivers in almost all cultures; they have demonstrated bold leadership under extreme adversity. Consequently, when empowered and involved, WAM can be effective partners in health promotion programs. The methodology includes a meta-analysis of 40 exemplary case studies from across the world, which meet predetermined criteria, to draw implications for social action and health promotion. Cases were selected from industrialized and less-industrialized nations and from four problem domains affecting quality of life and health: (1) human rights, (2) women's equal rights, (3) economic enhancement and (4) health promotion.	(acronym): empowerment education and training, media use and advocacy, public education and participation, organizing associations and unions, work training and micro-enterprise, enabling services and support, and rights protection and promotion. Cochran's Q test confirmed significant differences in the frequencies of methods used. The seven EMPOWER methods were used in this order: enabling services, rights protection/promotion, public education, media use/advocacy, and organizing associations/unions, empowerment education, and work training and micro-enterprise. Media and public education were more frequently used by industrialised than non-industrialised societies (X2 tests). While frequencies of methods used varied in all other comparisons, these differences were not statistically significant, suggesting the importance of these methods across problem domains and levels of industrialisation.
Farrell G. A global empirical review of drug crop eradication and United Nations' drug crop substitution and alternative development strategies. Journal of Drug Issues 1998;28(2):395-436.	A review of twenty years of United Nations' programmes in eleven countries to reduce illicit cultivation of coca bush, opium poppy and cannabis.	Such programmes have little if any significant impact on illicit cultivation at national and regional levels, and less still at global level.
Williams D, McBride AJ. The drug treatment of alcohol withdrawal symptoms: a symptomatic review. Alcohol and Alcoholism 1998;33(2):103-15.	A review of 14 randomised controlled trials of the effects of therapy for alcohol withdrawal symptoms.	All 12 compounds investigated were reported to be superior to placebo, but this has only been replicated for benzodiazepines and chlormethiazole. Further research using better methods is required to allow comparison of different drugs in the treatment of alcohol withdrawal. On the evidence available, a long-acting benzodiazepine should be the drug of first choice. However, the quality of methodological design, even in this highly selected group of studies. Was often poor. Study populations were generally ill-defined, most excluded severely ill patients, control groups were poorly matched and the use of additional medication may have confounded results in some studies.12 different rating scales were used to assess severity of symptoms across 14 studies
Marsch LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta-	A meta-analysis of studies examining the effectiveness of methadone maintenance treatment (MMT) on illicit opiate use (11 studies), HIV-risk behaviours (8 studies)	There was a consistent and statistically significant relationship between MMT and the reduction of illicit opiate use, HIV-risk behaviours and drug and property-related criminal behaviours. The effectiveness of MMT was most apparent in its ability to reduce drug-related criminal behaviours. MMT had a moderate effect in relation to reducing

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analysis. Addiction 1998;4:515-32.	ad criminal activities (24 studies).	illicit opiate use and drug and property related criminal behaviours, and a small to moderate effect in reducing HIV-risk behaviours. MMT's effectiveness was evident across a variety of contexts, cultural and ethnic groups and study designs.
Smart RG, Goodstadt MS. Effects of reducing the legal alcohol-purchasing age on drinking and drinking problems: a review of empirical studies. Journal of Studies on Alcohol 1997;38(7):1313-23.	A review of studies on the effects of reducing the legal age for drinking and purchasing alcoholic beverages.	Suggests there are public health reasons for not introducing such changes in jurisdictions which have not already done so. Both self-report and sales studies indicate that substantial increases in youthful drinking occurred in Canada following the reduction of the legal age for purchasing alcoholic beverages. There are usually greater increases in alcohol-related motor accidents where the purchasing age has been reduced than in comparison areas. No information is available which shows conclusively that reducing the purchasing age has caused increased in educational, family, or public-order problems.
Glanz M, Klawansky D, McAullife W, Chalmers T. Methadone vs L-alphaacetylmethadol (LAAM) in the treatment of opiate addiction: a meta-analysis of the randomised controlled trials. American Journal of Addiction 1997;6(4):339-49.	A meta-analysis of studies published between 1966 and 1996 and indexed in MEDLINE of the comparative effectiveness of Methadone and L-alpha-acetylmethadol (LAAM). All studies were conducted in standard outpatient opiate addiction treatment clinics. Most participants were men from lower socio-economic classes.	Results revealed a statistically significant risk difference that favoured methadone for retention in treatment and for discontinuation of treatment because of side effects. The risk difference for illicit drug use favoured LAAM, but the difference was not significant. A small treatment difference in favour of methadone was also noted. Findings indicated that LAAM is a relatively effective alternative in the treatment of opiate addiction, given its potential practical and operational benefits in comparison to methadone in certain situations.
Dusenbury L, Falco M, Lake A. A review of the evaluation of 47 drug abuse prevention curricula available nationally. Journal of School Health 1997;67(4):127-32.	Review of the number of available drug prevention curricula which had been tested in rigorous evaluation. 47 curricula were included.	Only 10 had been subjected to rigorous evaluation. 8 of these had shown some positive effect at least some of the time.
Mayo-Smith MF. Pharmacological management of alcohol withdrawal: A meta-analysis and evidence-based practice guideline. JAMA 1997;278 (2):144-51.	A meta-analysis of studies pertaining to the pharmacological management of alcohol withdrawal designed to provide an evidence-based practice guideline. Meta-analysis is based on English language articles published before July 1, 1995, identified through MEDLINE.	Benzodiazepines reduce withdrawal severity, reduce incidence of delirium (- 4.9 cases per 100 patients; 95% confidence interval, -9.0 to -0.7; P=.04), and reduce seizures (-7.7 seizures per 100 patients; 95% confidence interval, -12.0 to -3.5; P=.003). Individualizing therapy with withdrawal scales results in administration of significantly less medication and shorter treatment (P<.001). beta-Blockers, clonidine, and carbamazepine ameliorate withdrawal severity, but evidence is inadequate to determine their effect on delirium and seizures. Phenothiazines ameliorate withdrawal but are less effective than benzodiazepines in reducing delirium (P=.002) or seizures (P<.001). Conclusions.-Benzodiazepines are suitable agents for alcohol withdrawal, with choice among different agents guided by duration of action, rapidity of onset, and cost. Dosage should be individualized, based on withdrawal severity measured by withdrawal scales, comorbid illness, and history of withdrawal seizures. beta-Blockers, clonidine, carbamazepine, and neuroleptics may be used as adjunctive therapy but are not recommended as monotherapy.

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Elvik R. A meta-analysis of studies concerning the safety of daytime running lights on cars. Accident Analysis and Prevention, 1996;28(6):685-94.	A meta-analysis of 17 studies. Distinguishes between those examining the relationship between DRL and traffic safety, and studies examining the effect of mandatory DRL on safety.	Use of DRL reduces accidents by 3-12% and multi-party accidents by 10-15%.
Allen M, Burrell N. Comparing the impact of homosexual and heterosexual parents on children: meta-analysis of existing research. Journal of Homosexuality 1996;32 (2):19-35.	A meta-analysis of the available quantitative literature comparing the impact of heterosexual and homosexual parents, using a variety of measures, on the child(ren).	The analyses examine parenting practices, the emotional well-being of the child, and the sexual orientation of the child. The results demonstrate no differences on any measures between the heterosexual and homosexual parents regarding parenting styles, emotional adjustment, and sexual orientation of the child(ren). In other words, the data fail to support the continuation of a bias against homosexual parents by any court.
Wells-Parker E, Bangert-Drowns R, McMillen R, Williams M. Final results from a meta-analysis of remedial interventions with drink/drive offenders. Addiction 1995;90:907-26.	A meta-analysis of the efficacy of remediation with drinking/driving offenders included 215 independent evaluations identified through a comprehensive literature search.	Study characteristics, including dimensions of methodological quality were coded using scales and protocols developed by expert panels. Better methodological quality (as indicated by group equivalence) was associated with smaller effect size and less variation in effect size. Among studies with adequate methods (as determined empirically through examination of effect size variation with quality), the average effect of remediation on drinking/driving recidivism was an 8-9% reduction over no remediation. A similar effect size was found for alcohol involved crashes. However, licensing actions tended to be associated with reduction in occurrence of non-alcohol events (e.g. non-alcohol crashes). Exploratory regression analysis and confirmatory within study analysis suggested that combinations of modalities--in particular those including education, psychotherapy/counseling and follow-up contact/probation--were more effective than other evaluated modes for reducing drinking/driving recidivism. Treatment effects are probably underestimated in the literature due to overemphasis on education as a treatment for all offenders and drinking/driving recidivism as the most frequent measure of outcome. Limitations of the primary literature and future research needs are discussed
Wagenaar AC, Zobeck TS, Williams GD, Hingson R. Methods used in studies of drink-drive control efforts: a meta-analysis of the literature from 1960 to 1991. Accident Analysis and Prevention 1995;27(3):307-16.	A meta-analysis of 125 (out of a possible 6000) which met the authors inclusion criteria containing 664 analysis which formed the basis of the meta-analysis. DWI policies and enforcement efforts included: administrative license suspension, illegal per se, implied consent, mandatory jail sentence, limits on plea bargaining, mandatory fines, selective enforcement patrols, regular police patrols, and sobriety checkpoints.	All DWI control efforts were associated with reductions in drink-driving and traffic crashes. The DWI control literature is limited by the preponderance of weak study designs and reports that often fail to include basic data required for meta-analysis.
Agosti V. The efficacy of treatments	Meta-analysis was used to assess the	In the short-term and 1-year follow-up studies, patients in the experimental group drank

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in reducing alcohol consumption: A meta-analysis. International Journal of the Addictions 1995;3(8):1067-77.	relative efficacy of various treatments in reducing alcohol consumption over the short-term, 6 months, and 12 months. All the treatments were administered in well-controlled studies.	much less than the control group. However, between group consumption differences were negligible in the 6-month studies. When the studies were pooled, regardless of the follow-up assessment periods, the experimental group drank significantly less than the control group. These results suggest that, in general, patients who received experimental treatments consumed much less alcohol than patients in the control groups.
Agosti V. The efficacy of controlled trials of alcohol misuse treatments in maintaining abstinence: A meta-analysis .International Journal of the Addictions 1994;29(6):759-69.	Meta-analysis was used to establish the efficacy of various controlled alcohol misuse treatments in maintaining abstinence over short-term, 6- month, and 12-month follow-ups. Effect sizes were measured by odds ratio.	Aggregate effect size differences between experimental and control groups were negligible. Only three of 15 studies found a clinically significant difference between treatment abstinence outcomes.
Poyner B. What works in crime prevention: an overview of evaluations. In R.V. Clarke (ed) Crim Prevention Studies, Volume 1, Monsey, NY: Criminal Justice Press. 1993:3-34.	A review of 122 evaluations of crime prevention projects. Prevention measures are grouped into six general categories: campaigns and publicity, policing and other surveillance; environmental design or improvement; social and community services; security devices and target removal or modification.	Using objective indices of crime, about half of the measures evaluated were found to be effective. Successes were documented in all categories, but target removal or modification enjoyed the most successes, and social and community services the least.
Foxcroft DR, Lister-Sharp D. Lowe G. Alcohol misuse prevention for young people: A systematic review reveals methodological concerns and lack of reliable evidence of effectiveness. Addiction 92(5):531-7.	A systematic review of the methodological quality of evaluations of alcohol misuse prevention programmes for young people, and recorded evidence of effectiveness.	After pre-screening over 500 papers which reported prevention programmes, information was systematically abstracted from 155 papers. Only 33 studies merited inclusion in the review, and most of these had some methodological shortcomings. Twenty-one studies reported some significant short- and medium-term reductions in drinking behaviour. Of two studies which carried out longer-term evaluations, only one reported a significant longer-term effect, with small effect sizes. No factors clearly distinguished partially effective from ineffective or harmful prevention programmes. In conclusion, the lack of reliable evidence means that no one type of prevention programme can be recommended. In particular there is a need to carry out well-designed scientific evaluations of the effectiveness of current or new prevention efforts which target young people's alcohol misuse.
Evans WN, Neville D, Graham, JD. General deterrence of drunk driving; evaluation of recent American policies: 1991.	A review of research and of national and state-level data, 1975-1986.	No evidence that any specific form of punitive legislation is having a measurable effect on motor vehicle fatalities. Mandatory seat belt laws and alcohol taxes are reducing drunk driving fatalities.
Rundall TG, Bruvold WH. A meta-analysis of school-based smoking and alcohol use prevention programs. Health Education Quarterly	A meta-analysis of 47 smoking and 29 alcohol school-based intervention programs published after 1970.	In general, smoking and alcohol interventions have equally modest effects on immediate behavioural outcomes. Smoking interventions, however, have been more successful than alcohol interventions at altering students' long term behavior. All of the alcohol programs and all but one of the smoking programs reviewed successfully increased knowledge

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1988;15(3)317-34.		regarding the risks of these behaviors. Attitude change appears to be more difficult to achieve. The data indicate that for immediate smoking outcomes and long-term alcohol outcomes innovative interventions relying upon social reinforcement, social norms, and developmental behavioral models are more effective than traditional "awareness" programs designed to inform adolescents about the health risks associated with tobacco and alcohol use.
Rosenbaum DP. Community crime prevention: a review and synthesis of the literature. Justice Quarterly 1988;5(3):323-95.	A review of outcome research.	There is a paucity of evidence that such interventions can alter the behaviour and local environments of individuals who are not already predisposed to crime prevention.
Sherman LW. Police crackdowns: initial and residual deterrance. In M. Tonry and N. Morris (eds) Crime and Justice: A Review of Research Chicago and London: University of Chicago Press. 1988;12:1-48.	A review of the effectiveness of police crackdowns covering 18 case studies of various target problems that illustrate the extent and limits of knowledge about crackdowns.	15 of the 18 case studies suggest evidence of initial deterrent effects, including 2 examples of long term effects. In most cases, however, initial deterrent effects 'washed out', sometimes despite continued dosage of police presence and sanctions. Crackdowns might be more effective if limited in duration and rotated across targets.
US General Accounting Office Drinking-Age Laws: an evaluation synthesis of their impact on highway safety. Washington, DC: US GAO. 1987.	Analysis of 49 evaluations of laws raising the legal drinking age.	Raising the drinking age has a direct effect on reducing alcohol related traffic accidents amongst youths affected by the laws. A higher legal drinking age also reduced the number of traffic accidents. It also results in less alcohol consumption and less driving after drinking by the age group affected by the law. Only limited evidence exists for assessing whether a higher drinking age protects youth younger than the minimum age from traffic accidents.
Tobler NS. Meta-analysis of 143 adolescent drug prevention programs: quantitative outcome results of program participants compared to a control or comparison group. Journal of Drug Issues 1986; 16(4):537-67.	A meta-analysis of the outcome results for 143 adolescent drug prevention programs. Five major modalities were identified and their effect sizes computed for 5 outcomes: knowledge, attitudes, use, skills, and behaviour measures.	The magnitude of the effect size depended on the outcome measure employed and the rigor of the experimental design. On the ultimate criteria of drug use, peer programs were significantly different from the combined results of all remaining programs. Peer programs (combining positive peer influence with specific skill training) maintained high effect size for alcohol, soft drugs, and hard drugs, as well as for cigarette use.
Larson RC, Cahn MF. Synthesizing and extending the results of policy patrol studies. Washington DC, US Government Printing Office. 1985	A meta-evaluation of research.	Studies of preventive patrol have not confirmed the presence of absence of any relationship between patrol and crime deterrence, but foot patrol (in contrast to motor patrol) is directly related to increased citizen satisfaction. Response time studies demonstrate that the difference between anticipated and actual response time is a major determinant of citizen satisfaction; the relationship between response time and apprehension rate is ambiguous. Evaluations of team policing are hampered by methodological problems. Theoretical and empirical results favour 1-officer cars over 2-officer cars. Analyses of difference in officer safety are inconclusive.
Susskind EC, Bond RN. The potency of primary prevention: a meta-	A meta-analysis of 47 primary prevention studies, of which 13 provided enough	Wide variability in the effects of prevention programmes. Average effect was an improvement of 8% in outcomes.

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analysis of effect size 1981.	data to calculate an effect size.	
Rubenstein H, American Institutes for Research et al. The link between crime and the built environment: the current state of knowledge. Washington, DC: US National Institute for Justice. 1980;1.	A review of studies examining the link between crime and the built environment. Inclusion criteria were (i) study had an empirical base, (ii) study used the built environment as the independent variable, and (iii) the dependent variable included occurrence of stranger-to-stranger-crimes or fear of crime.	Evidence from 15 studies which met inclusion criteria suggests that changes in the physical environment of reduce crime and the fear of crime. However, findings are inconsistent and do not indicate what are the 'active ingredients'. Because of the lack of cause-effect information the present knowledge base cannot be used to prescribe strategies. Changes in the physical environment are probably the fastest way of reducing fear of crime. Primary mechanisms thought to account for crime reduction and fear reduction are: increasing difficulty of access and creating a social ambience that is mutually protective.
Lundman RJ, Scarpitti FR. Delinquency prevention: Recommendations for future projects. Crime and Delinquency 1978;24(2):207-20.	A review of 40 completed or continuing attempts at the prevention of juvenile delinquency.	Little evidence found for the effectiveness of (then) contemporary or previous delinquency prevention programmes. Recommendations for future projects include separation of implementation and evaluation, enrichment or abandonment of the individual treatment approach, diversification of evaluative measures, and greater sensitivity to the rights of the juveniles involved in future projects
Chaiken JM. What's known about deterrent effects of police activities. Santa Monica, CA: Rand Corporation. 1977.	A review of cross-sectional, longitudinal and experimental studies of the effects of police activities on crime rates.	Studies are consistent with the view that a substantial increase in police activity will reduce crime for a time, but, in the real world, increases in police manpower tend to follow increases in crime. The magnitude and duration of deterrence effects are essentially unknown.
Smart RG. Effects of legal restraint on the use of drugs: a review of empirical studies. Bulletin on Narcotics 1976;28(1):55-65.	A review of empirical studies.	Little can be concluded with any certainly from the data. It appears that successful attempts to reduce the supply of heroin by means of seizures and crop reductions have produced reductions, sometimes small, in illicit heroin availability, heroin addiction, and deaths from heroin. Large reductions in cannabis availability can probably reduce cannabis consumption, at least temporarily, but provably with the substitution other drugs. In general, it appears that legal restraints work best where legal drug distribution is being controlled by bringing pressure to bear on ethically motivated and well-regulated agencies e.g. the pharmaceutical industry and physicians.
Dixon MC, Wright WE. Juvenile delinquency prevention programs: an evaluation of policy related research on the effectiveness of prevention programs. Nashville, TN. Peabody College for Teachers. 1975.	A survey was made of approximately 6,600 abstracts published over a ten year period that describe delinquency prevention services that do not remove youth from their home community. 350 articles, pamphlets and reports were collected.	The overview revealed that certain types of prevention and treatment projects, recreational programmes, guided group interaction, social casework, and detached worker/gang worker projects have failed to show evidence of effectiveness and should be abandoned. Evidence which suggests that community treatment, the use of volunteers, diversion programmes, youth service bureaux, and special school projects hold some promise of success has begun to accumulate.

SOCIAL CARE AND SOCIAL WELFARE: Psychiatric social work

CITATION	*REVIEW DETAILS*	*FINDINGS*
Abel EM. Psychosocial treatments for battered women: A review of empirical research. Research on Social Work Practice 2000;10(1):55-77	Despite the high incidence of domestic violence, information about the effectiveness of social work practice with battered women is scant. The purpose of this article is to critically review the research on practice effectiveness with abused women. One article published in 1986 and 8 articles published between 1991 and 1996 are analysed. The author examines the outcomes of practice research with battered women in terms of its conceptual adequacy, methodology, and findings.	
Dato PM, Mann R. A synthesis of psychological interventions for the bereaved. Clinical Psychology Review 1999;19(3):275-96.	This review summarizes four major theories of bereavement, presents a qualitative review of bereavement intervention studies, including individual, family, and group therapy, and assesses the overall effectiveness of bereavement intervention studies in a quantitative meta-analysis. Summaries of the theories are drawn from published theoretical works.	Overall, the interventions were largely methodologically flawed, rarely specified what theory of bereavement they were testing, and showed surprisingly weak effect sizes. Possible interpretations for the small effect sizes are discussed, and future directions are outlined. (c) 1999 APA/PsycINFO, all rights reserved) KP: theories of bereavement and effectiveness of individual and family and group therapy in bereavement intervention, therapists and bereaved individuals
Gorey KM, Thyer BA,Pawluck, DE. Differential effectiveness of prevalent social work practice models: A meta-analysis. Social Work 1998;43:3: 269-78.	A meta-analysis of 45 published (1990-1994) independent studies of social work's differential effectiveness by prevalent practice models builds on the more general findings of related meta-analyses that have estimated that three-quarters of the clients who participate in social work interventions do better than the average client who does not.	It found that the effectiveness of interventions based on different practice models--personal versus systemic-structural--was moderated by their primary focus for change. When the focus for change was clients themselves, personal orientations seemed more effective, whereas systemic-structural models were found to be more effective in supporting the change of other targets, such as environmental factors (structural change) rather than personal adaptation to environmental challenges.
Videka-Sherman L. Metaanalysis of Research on Social Work Practice in Mental Health. Social Work 1998;33(4):325-38.	A meta-analysis of 38 research studies on the effectiveness of social work practice in mental health, focusing on (1) relationships between intervention techniques and treatment efficacy and (2) services delivered by social workers to	Findings of Part 1, practice in outpatient settings, show that methodological and theoretical differences in effectiveness were small; however, certain practice techniques were associated with effectiveness. Findings of Part 2 indicate that successful practice involves considerable practitioner activity to engage and maintain clients in treatment, interventions to improve clients' living environments, and creation and support of clients' social networks.

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	the chronically mentally ill.	
Baucom DH, Mueser KT, Daiuto AD, Stickle TR. Empirically supported couple and family interventions for marital distress and adult mental health problems. Journal of Consulting and Clinical Psychology 1998;66(1):53-88.	A review of the efficacy, effectiveness, and clinical significance of empirically supported couple and family interventions for treating marital distress and individual adult disorders, including anxiety disorders, depression, sexual dysfunctions, alcoholism and problem drinking, and schizophrenia.	
Pinquart M. Effects of psychosocial and psychotherapeutic interventions on well-being and self concept in late adulthood: meta-analytical outcomes. Zeitschrift fur Gerontologie 1998;31(2):120-6 (abstract).	The analysis of research on self-concept of the elderly shows a need for more complex methods that measure not only self-esteem and subjective age identity, but also those that reflect the specificity of life in the elderly. The self-concept of 140 elderly living in one community (65-93 years) was analyzed by an age-specific, self-concept interview.	Factor-analysis resulted in a 10-factor assessment with the main factor being "bodily competency and purpose of life". Other factors were subjective age identity, composure, social integration, resignation, etc.. The subjects were cluster-analyzed. The first cluster contained almost 50% of the elderly who had a positive self-concept of competency, social integration, mood, and self-esteem; they were younger, often married, and in good health. Some clusters identified elderly with a moderate self-concept and some problems regarding health and activities of daily life. A very negative self-concept was shown by two groups of socially isolated (7.14%) and strongly physically and/or psychologically handicapped (5.71%) elderly, who had a generally negative self-concept and needed psychosocial therapy. Implications for further research are discussed.
Cornah DK, Stein K, Stevens A. The therapeutic community method of treatment for borderline personality disorder. Southampton, Wessex Institute for Health Research and Development 1997.	A review of the effects of therapeutic communities for people with borderline personality disorders.	Treatment effects are difficult to summarise given the heterogeneity of the client group and methodological problems. Clinically significant improvements have been reported in up to 40% of clients including changes in psychometric test performance, reductions in deliberate self harms fewer hospital admissions (but increased outpatient service use) and reduced criminal behaviour. There have been no randomised controlled trials of the approach. Observational studies show potentially important clinical effects which may be associated with some cost savings to secondary care and prison services, although the validity of these findings remains open to some doubt. Importantly, it remains impossible to conclude which people would be expected to benefit. The treatment's validity is not proven.
Allen M, Burrell N. Comparing the impact of homosexual and heterosexual parents on children: meta-analysis of existing research. Journal of Homosexuality 1996;32 (2):19-35.	A meta-analysis summarising the available quantitative literature comparing the impact of heterosexual and homosexual parents, using a variety of measures, on the child(ren).	The analyses examine parenting practices, the emotional well-being of the child, and the sexual orientation of the child. The results demonstrate no differences on any measures between the heterosexual and homosexual parents regarding parenting styles, emotional adjustment, and sexual orientation of the child(ren). In other words, the data fail to support the continuation of a bias against homosexual parents by any court.
Feldman MA. Parenting education for parents with intellectual	This review of parenting education interventions for such parents identified	Overall, initial training, follow-up, and social validity results are encouraging. Generalization and child outcome data are weak. Further research is needed to (a)

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disabilities: a review of outcome studies. Research in Developmental Disabilities 1994;15(4):299-332.	20 published studies with adequate outcome data. A total of 190 such parents (188 mothers, 2 fathers), with IQs ranging from 50 to 79 were involved. Parenting skills trained included basic child-care, safety, nutrition, problem solving, positive parent-child interactions, and child behavior management. The most common instructional approach was behavioral (e.g., task analysis, modeling, feedback, reinforcement).	identify variables associated with responsiveness to intervention, and (b) develop and compare innovative programs that teach parents with cognitive disabilities the necessary generalized skills to demonstrate long-term beneficial effects on their children.
Corrigan PW. Social skills training adult psychiatric populations: a meta-analysis. Journal of Behavior Therapy and Experimental Psychiatry 1991;22(3):203-10.	A meta-analysis of 73 studies of social skills training in four adult psychiatric populations: developmentally disabled, psychotic, nonpsychotic and legal offenders	Patients participating in social skills training programs broadened their repertoire of skills. Changes were maintained at several months follow-up. Patients showed reductions in psychiatric symptoms relating to social dysfunctions. Although results from ANOCVA comparing effect sizes across the four populations (with design quality as a covariate) were non-significant, consistent trends suggested that social skills training had the greatest effect on developmentally disabled groups and the least effect on offender groups. Social skills training was relatively more effective in outpatient than inpatient settings.

SOCIAL CARE AND SOCIAL WELFARE: Delinquency

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Wilson SJ, Lipsey MW. Wilderness challenge programs for delinquency youth; a meta-analysis of outcome evaluations. Evaluation and Program Planning 2000;2(3):1-12.	A systematic review of studies from 1950 of the effects of Wilderness programmes on delinquency.	The overall effect size was .18, equivalent to a recidivism rate of 29% for programme e participants, and 37% for controls. Programmes with the most intensive activities or included a therapeutic component showed the greatest reductions in delinquency.
Petrosino A, Petrosino C, Finchenouer JO. Our well-meaning programs can have harmful effects! Lessons from the Scared Straight experiments. Crime and Delinquency. (in press).	A systematic review of 9 randomised experiments testing the effects of Scared Straight programmes.	Scared-Straight like programmes, including confrontational and interactive sessions with inmates, tours and orientations in prisons, and educational sessions in prisons, not only are ineffective but likely increase crime and delinquency.
Woolfenden S, Williams K. Family and parenting interventions for conduct disorder and delinquency in children aged 10-17 [Cochrane Review currently undergoing editorial process]. In: The Cochrane Library, Issue 2, 2000.Oxford: Update Software.	A meta-analysis of the effects of family and parenting interventions for conduct disorders and delinquency in children aged 10-17.	The evidence suggests that family and parenting interventions for juvenile delinquencies for juvenile delinquents have beneficial effects on reducing criminal activity. This is of major importance to young people, their families and society as a whole. *NOT TO BE QUOTED UNTIL REVIEW IS PUBLISHED.*
Redondo S, Sanchex-Meca J, Garrido V. The influence of treatment programmes on the recidivism of juvenile and adult offenders: a European meta-analytic review. Psychology, Crime and Law 1999;5 (3):251-78.	A meta-analysis of European studies between 1980 and 1991 (published and unpublished) of treatments aimed at reducing recidivism.	The studies which evaluated recidivism during an average follow-up period of 2 years obtained a global effect size equivalent ot a 12% reduction in recidivism. Behavioural and cognitive-behavioural techniques were the most beneficial techniques in reducing recidivism.
Lipsey MW. Juvenile delinquency treatment: a meta-analytic inquiry into the variability of effects. In T.A. Cook et al (eds) Meta-analysis for explanation: A casebook New York, NY: Russell Sage Foundation. 1992:83-127.	A meta-analysis examining the variability in delinquency intervention effects. Covers 443 studies conducted since 1050 in English speaking countries.	Overall treatment programmes effects were positive but there was a larger than expected degree of variability in outcomes. More structured and focused treatments, such as behavioural and skill-oriented approaches, as well as multimodal treatments were most effective. Subject characteristics were unrelated to treatment effects. From his detailed analysis the author concludes that the wide variability in treatment effects implies that whether delinquency treatment is deemed effective depends upon which areas of the research literature are examined.
Roberts AR, Camasso MJ. The effect of juvenile offender treatment programs on recidivism: a meta-analysis of 46 studies. Notre Dame Journal of Law, Ethics and Public	A meta-analysis of evaluations of juvenile offender interventions.	Juvenile offender interventions typically have small, positive effects. The largest effects are for family therapy (ES-.55) and group treatment strategies (ES=.81) The authors note that the evaluations. The authors question the accuracy of group treatment results. Effect sizes decrease dramatically with length of follow up. They emphasise the need to recommend to juvenile justice administrators that they replicate family counselling

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CITATION	*REVIEW DETAILS*	*FINDINGS*
Policy 1991;5(2)421-41.		programs.
Izzo RL, Ross RR. Meta-analysis of rehabilitation programs for juvenile delinquents: A brief report. Criminal Justice and Behavior 1990;17(1):134-42	A meta-analysis of 46 studies of intervention programs for juvenile delinquents revealed a significant difference between programs that included a cognitive component and those that did not.	Cognitive programs were more than twice as effective as non-cognitive programs. These results are consistent with previous qualitative analyses (R. R. Ross, 1980) and provide support for a cognitive model of offender rehabilitation.
Whitehead JT, Lab SP. A meta-analysis of juvenile correctional treatment. Journal of Research in Crime and Delinquency 1989;26(3) 276-95.	A meta-analysis of research reports published from 1975 to 1984.	The results show that interventions have little positive impact on recidivism and many appear to exacerbate the problem. Indeed, the analysis in this article could be considered overly lenient in its interpretation of the results. It appears that the earlier evaluations that claim that 'nothing works' are close to the conclusion to be drawn from more recent evaluations of juvenile treatments.
Breunlin DC, Breunlin C, Kearns DL, Russell WP. A review of the literature on family therapy with adolescents 1979-1987. Journal of Adolescence. 1988;11(4):309-34.	A review updates a 1979 analysis of the literature on the effects of family therapy with adolescents.	Results of outcome studies indicate that family therapy with families of adolescents with problems is viable, and is often superior to more traditional treatments.
Basta JM, Davidson WS II. Treatment of juvenile offenders: Study outcomes since 1980. Behavioral Sciences and the Law. 1988;6(3)355-84.	This review examined the effectiveness of the treatment of adjudicated juvenile offenders, based on a computer-data-based search of the literature published from 1980 to 1987.	The conclusions are that treatment outcomes were positive, but that serious methodological weaknesses still exist in the literature. Improvements still need to be made in sample sizes, use of appropriate and multiple measures of recidivism, random assignment and/or use of appropriate control groups, and long-term follow-up assessment.
Gottschalk R, Davidson WS. Community based interventions. In Gensheimer L K, Mayer, JP.BK: Quay, H. C. (Ed) Handbook of juvenile delinquency. Wiley series on personality processes. New York, NY, USA: John Wiley and Sons. 1987: 266-289.	A meta-analysis of the research literature on community-based interventions with juvenile offenders, post-1975. 90 studies involving over 11,000 participants were examined.	Treatment in community settings did not have a large effect on outcomes. If a strong intervention is used and care is taken during intervention to ensure that it is actually being implemented as designed, then more positive effects may emerge.
Mayer JP et al. Social learning treatment within juvenile justice: a meta-analysis of impact in the natural environment. In J: Apter and P Arnold (Eds) Youth Violence: Programs and Prospects. Elmsford, NY: Pergamon Press 1986;24-38.	A meta-analysis of 39 studies reporting behavioural interventions within the juvenile justice system. Typical study involved an adjudicated male sample in a residential setting. Treatment involved token economies, modelling, contracting, or some other application of social learning theory. Both 'vote count' and	The 'vote count' results agreed with past reviews suggesting that behavioural approaches were for the most part highly effective. The 'effect size' method presented a more mixed picture. The literature suffered from serious methodological shortcomings and findings must therefore be strictly scrutinised.

SOCIAL CARE AND SOCIAL WELFARE: Delinquency

CITATION	*REVIEW DETAILS*	*FINDINGS*
	'effect size' methods of research accumulation were employed in assessing recidivism, behavioral and attitudinal outcomes	
Gensheimer LK, Mayer JP, Quay HC. Diverting youth from the juvenile justice system: a meta-analysis of intervention efficacy. In J. Apter and P Arnold (Eds) Youth Violence: Programs and Prospects. Elmsford, NY: Pergamon Press 1986.	A meta-analysis of diversion interventions with juvenile delinquents.	Overall, findings did not provide substantial evidence for the efficacy of diversion programmes. However, it was not possible to determine how far into the system those youths went before they were diverted. The older the subject the less likely for intervention have a positive effect. The data substantiate the ambiguity and diversity of diversion programmes.
Garrett CJ. Effects of residential treatment on adjudicated delinquents: A meta-analysis. Journal of Research in Crime and Delinquency 1985;22(4) 287-308.	A meta-analysis of the primary research literature produced since 1960 was undertaken to assess the amount of change associated with various treatments of adjudicated delinquents. 111 studies identified that used a comparison group of pre-post design.	Results indicated that treatment of adjudicated delinquents resulted in a positive change of .37 standard deviations. No consistent evidence on the relative efficacy of behavioral versus psychodynamic approaches was found. Recidivism was modestly reduced; institutional adjustment, psychological adjustment, and academic performance were all improved following treatment. The results of the meta-analysis suggest that treatment of adjudicated delinquents in an institutional or community residential setting does 'work'.
McMurty SL. Secondary prevention of child maltreatment: A review. Social Work 1985;30(1):42-8	Reviews research on the secondary prevention of child maltreatment, which involves identifying potential child abusers and treating them before the abuse takes place.	Research on attempts to identify parents at risk of maltreating their children shows that, although accurate identification of such parents may eventually be possible, identifying criteria and effective means of intervention to prevent abuse need to be developed. Issues in secondary prevention of child abuse that must be considered include individual screening, applicability of research results, and the accuracy of screening measures. The current feasibility of secondary prevention programs is discussed.
Kaufman P. Meta-analysis of Juvenile Delinquency Prevention Programs. Unpublished paper, Claremont Graduate School, Claremont, California 1985.	A review of 20 studies available up until 1983 which examined the effects of delinquency prevention with preadjudicated youths.	Participants in early interventions programmes appeared to perform better on a wide range of dependent measures compared with controls. Larger effect sizes were associated with pre-experimental designs and with studies in which the internal validity was rated as poor. Several other design factors were associated with study outcome. Author concludes that an accurate interpretation of the early intervention research literature cannot be made without consideration of specific design variables and study characteristics.
Goldstein AP, Pentz M. Psychological Skill Training and the Aggressive Adolescent. School Psychology Review 1984;13(3):311-23.	A review of 30 evaluation-oriented studies of skills training with aggressive adolescents.	Authors conclude there is evidence of the effectiveness of social skills training with different settings, types of youth and target skills.
Winterdyk MA, Griffiths C. Wilderness experience programs: reforming delinquents or beating	A review of the effectiveness of Wilderness experience programmes.	Those studies which used a control group provide mixed support for the efficacy of wilderness experiences in relation to changes on psychological measures and recidivism. Studies had limited follow-up data.

SOCIAL CARE AND SOCIAL WELFARE: Delinquency

CITATION	*REVIEW DETAILS*	*FINDINGS*
around the bush? Juvenile and Family Court Journal 1984;35(3):35-44.		
Dixon MC, Wright WE. Juvenile delinquency prevention programs: an evaluation of policy related research on the effectiveness of prevention programs. Nashville, TN. Peabody College for Teachers 1975.	A survey was made of approximately 6,600 abstracts published over a ten year period that describe delinquency prevention services that do not remove youth from their home community. 350 articles, pamphlets and reports were collected.	The overview revealed that certain types of prevention and treatment projects, recreational programmes, guided group interaction, social casework, and detached worker/gang worker projects have failed to show evidence of effectiveness and should be abandoned. Evidence which suggests that community treatment, the use of volunteers, diversion programmes, youth service bureaux, and special school projects hold some promise of success has begun to accumulate.
Berleman WC, Steinburn TW. Crime and Delinquency 1969;15(4):471-8	Not a systematic review. A narrative review discussing five experiments in eastern American cities attempting to prevent delinquency. These involved division of non-delinquents into experimental and control groups with the former receiving contact to prevent delinquency.	Authors conclude that the treatments under review involved insufficient contacts to produce results and that the conditions of the experiments are not adequately reported. (NB: Interventions aimed at delinquency prevention were primarily oriented towards counselling and differ from more recent interventions)
Henderson M, Hollin C. A critical review of social skills training with young offenders. Criminal Justice and Behavior 1983;10(3):316-41	A review of 15 studies in which social skills training (SST) was used with delinquent populations.	The authors concluded at the time that the findings do not provide unequivocal support for the usefulness of SST in reducing criminal behavior of delinquents, and failure to show consistent generalization and durability of training effects must be taken into account when discussing the efficacy of such treatment with young offenders. (31/2 p ref)

SOCIAL CARE AND SOCIAL WELFARE: Child and family support

CITATION	*REVIEW DETAILS*	*FINDINGS*
Barlow J, Coren E. Parent-training programmes for improving maternal psychosocial health [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 2, 2000.Oxford: Update Software.	A systematic review of parent training interventions with a focus on maternal psychosocial health.	
Mentore JL. The effectiveness of early interventions with young children 'at risk': a decade in review. PhD. Dissertation, Fordham University, DAI-B 60/07, Jan 2000.	A meta-analysis of studies examining the effects of early intervention programs with children at risk. 86 studies from 1986 through 1998 were examined and a total of 319 effect sizes were yielded from the total sample, with 185 these being from studies of high quality.	Early intervention programmes appear to be efficacious for at risk children. No differences were identified between types of early intervention programmes e.g educational, psychological, medical or mixed. Efficacious programmes were structured and utilised trained intervenors. Programmes were more beneficial for children biologically at risk e.g. low birthweight, premature, than for economically or socially disadvantaged children. Duration, intensity, location and degree of parental involvement did not appear to influence outcome.
Gray E. Early Parenting Intervention to Prevent Child Abuse: A Meta-Analysis. Final Report. National Council of Jewish Women, New York, NY, Center for the Child. No date.	An attempted meta-analysis of 48 studies examining the effects of early parenting interventions. The methodology appeared premature given the great variance in theoretical base and methods of intervention.	Home-visiting programmes produced the greatest and most consistent effects, and more frequently served people at risk for poor parenting.
Comer EW, Fraser MW. Evaluation of six family-support programs: are they effective? Families in Society 1998:79(2):134-48.	Rigorous programme evaluations for six family support programmes	Programme families demonstrated enhanced child, parent and family functioning, as well as gains in both immediate and long term effects on housing and income.
Durlak JA, Wells AM. Evaluation of indicated preventive intervention (secondary prevention) mental health programs for children and adolescents. American Journal of Community Psychology 1998;26 (5):775-802.	Evaluated the outcomes of 130 indicated preventive interventions (secondary prevention) mental health programs for children and adolescents that seek to identify early signs of maladjustment and to intervene before full-blown disorders develop.	Results indicate such programs significantly reduce problems and significantly increase competencies. In particular, behavioral and cognitive-behavior programs for children with subclinical disorders (mean ESs in the 0.50s) appear as effective as psychotherapy for children with established problems and more effective than attempts to prevent adolescent smoking alcohol use, and delinquency. In practical terms, the average participant receiving behavioral or cognitive-behaviour intervention surpasses the performance of approximately 70% of those in a control group. Of particular interest was the high mean effect (0.72) achieved by programs targeting incipient externalizing problems which are customarily the least amenable to change via traditional psychotherapeutic efforts when they reach clinical levels. Priorities for future research include greater specification of intervention procedures, assessment of treatment implementation, more follow-up studies, and identifying how different participants respond to early intervention.
Kazdin AE. Psychosocial treatments for conduct disorder in children. In	This chapter reviews research for 4 psychosocial treatments that have shown	The chapter describes and evaluates the underpinnings, techniques, and evidence on behalf of these treatments. Critical issues that are raised in providing treatment to

CITATION	*REVIEW DETAILS*	*FINDINGS*
Nathan, Peter E. (Ed); Gorman Jack M. (Ed); et-al. A guide to treatments that work. New York, NY, USA: Oxford University Press. 1998:65-89.	considerable promise in the treatment of conduct disorder in children and adolescents: cognitive problem-solving skills training, parent management training, functional family therapy, and multisystemic therapy. The treatments were selected because they have been carefully evaluated in controlled clinical trials.	children with conduct disorder and their families also are examined.
Magee Quinn M, Kavale KA, Mathur SR, Rutherford RB Jr, Forness SR. A meta-analysis of social skill interventions for students with emotional or behavioral disorders. Journal of Emotional and Behavioral Disorders 1999;7(1):54-64. See also: Kavale KA, Mathur SR, Forness SR, Rutherford RB Jr, Quinn MM. Effectiveness of social skills training for students with behavior disorders: a meta-analysis. Advances in Learning and Behavioral Disabilities 1997;11:1-26	A meta-analysis of social skill interventions for students with emotional or behavioral disorders.	
Tucker S. Gross D. Behavioral Parent Training: an intervention strategy for guiding parents of young children. Journal of Perinatal Education 1997;6(2):35-44.	A review of the effectiveness of Behavioral Parent Training (BPT) as an early intervention strategy for families with young children.	BPT teaches parents how to manage child behavior effectively and to promote parent-child interactions. Studies that have examined the effectiveness of BPT for families with young children are reviewed. Findings largely suggest BPT to be an effective early intervention strategy for families with young children.
Serketich WJ, Dumas JE. The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. Behavior Therapy 1996;27(2):171-86.	A meta-analysis of 26 controlled studies on the outcome of behavioral parent training (BPT) for the modification of antisocial behavior in preschool and/or elementary school age children.	Results support the short-term effectiveness of BPT to modify child antisocial behavior at home and school, and to improve parental personal adjustment. However, research still needs to examine if positive changes as a function of BPT are maintained over time, are comparable to changes resulting from other interventions for child antisocial behavior, and are related to important methodological and contextual variables. Findings and directions for future research are discussed in light of the limitations of the current literature on antisocial child behavior.
Roy R, Frankel H. How Good Is Family Therapy? A Reassessment. Toronto, Canada: University of	Summarises and assesses outcome studies pertaining to the effectiveness of family therapy according to life stages and	Overall, the reviewers conclude that family therapy is an effective treatment. However, many studies are limited by methodological flaws such as lack of control groups, small samples, unclear outcome measures, lack of attention to certain variables, and

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Toronto Press 1995.	specific problems	inappropriate data analysis. For example, evaluations of placement prevention programs in child welfare practice have yielded disappointing results because they are conducted too early in the development of the programme or overemphasised placement rates as an outcome measures. Other problems with family preservation research are attributed to demands on staff and lack of standards for selection criteria and case documentation.
Erwin PG. Social problem solving, social behavior, and children's peer popularity. Journal of Psychology 1994;128(3):299-306.	A review of the relative effectiveness of 3 methods of social skills training with socially isolated children: coaching, interpersonal cognitive problem solving, and modeling. A search of the published literature in the area produced a total of 43 studies that met criteria for inclusion in the subsequent analysis.	Social skills training produced significant improvements in children's levels of social interaction, sociometric status, and cognitive problem-solving abilities. No training technique produced a significantly greater improvement than either of the others. Isolated children showed larger increases in their levels of social interaction and sociometric status than non-isolated children. Multi-modal training programs were recommended to capitalise on the independent therapeutic effects which derive from a number of different social skills training techniques.
Weiss HB. Home visits: necessary but not sufficient. Future of Children 1993;3(3)113-28.	A review of experimental and quasi-experimental studies that examine the role of home visiting in successful programmes for children and families.	The most effective programmes will be comprehensive, continuous and family focused. Programme effectiveness rests, in part, on the availability ad quality within the community of other services for families as well as on the capacity of the families to connect with such services.
Kazdin AE, Mazurick JL, Bass D. Risk for attrition in treatment of antisocial children and families. Journal of Clinical Child Psychology 1993;22(1):2-16.	160 5-23 year old children referred to treatment because of antisocial behaviour and their families were studied for differences between those who completed outpatient treatment and those who terminated prematurely.	Premature termination was greater for younger mothers, single parents, and minority-group families; for families with socio-economic disadvantages, high stress and more adverse life events, adverse family child-rearing practices; and for mothers with a history of antisocial behaviour in their childhood. Child characteristics associated with premature termination included severity, breadth, and history of antisocial behaviour; academic and educational dysfunction; current contacts with antisocial peers; and multiple (co-morbid) diagnoses. The accumulation of multiple factors placed families at increased risk for dropping out of treatment prematurely.
Berrick JD, Barth RP. Child sexual abuse prevention: Research review and recommendations. Social Work Research and Abstracts 1992; 28(4):6-15.	Reviews 30 research studies on child sexual abuse prevention. Nine studies (published 1981-1990) deal with preschool-age children; 20 studies (published 1984-1991) deal with elementary school-age children; and 1 study (1990) deals with high school-age children.	References and a summary of results are presented in table form, although diversity of research design and instrumentation has allowed for little replication or verification of results. A meta-analysis of 13 of the studies demonstrates that children at all ages can improve their scores on child abuse knowledge measures but does not inform whether type or amount of knowledge sufficiently protects them from abuse. Recommended directions for future research include school and community-based interventions, targeted services, teacher training, and integration of prevention efforts with the total community.
Grossman PB, Hughes JN. Self-control interventions with internalizing disorders: A review and analysis. School Psychology Review 1992;21(2):229-45. .	A meta-nalytic review of self-control therapies (SCTs) for children or adolescents (less than 18 years of age) with internalising disorders with symptoms of clinically significant	SCT was found to be effective with internalizing disorders in general, but to be more effective with disorders primarily affecting mood than with somatic disorders. SCT appeared to result in lasting, socially significant changes in behaviour and was relatively inexpensive to administer. Factors that may affect the effectiveness of SCT are (1) use of more than one self-control treatment per intervention, (2) group therapy as opposed to

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	severity. Studies testing self-control interventions (problem solving training, cognitive restructuring, coping skills training, and self-reinforcement) were reviewed.	individual therapy, and (3) older vs younger children.
Kazdin AE. Psychotherapy for children and adolescents. Annual Review of Psychology. 1990;41:21-54	Reviews treatment outcome research in child and adolescent psychotherapy (PT), including an evaluation of treatment effects, exemplary individual studies, and research programs.	Discussion focuses on current deficiencies in treatment evaluation, improving the yield from treatment outcome studies, and methodological features that warrant increased attention. Specific types of treatment facilities and alternative interventions (e.g., foster care placement) are directed toward many of the same ends as PT. PT is one facet of the effort to controvert dysfunction and to improve adjustment of children and adolescents.
Markus E, Lange A, Pettigrew TF. Effectiveness of family therapy: A meta-analysis. Journal of Family Therapy 1990;12(3):205-21.	Meta-analysis, a quantitative literature review technique, is used to evaluate the effectiveness of family therapy (FT) in 19 studies. Patients participating in FT are shown to be better off than 76% of patients with an alternative treatment, a minimal treatment, or no treatment.	Preliminary data suggest that the effect of FT increased during the 1st yr after treatment but then decreased sharply after 18 months. Results are compared to a previous meta-analysis of FT by M. D. Hazelrigg et al.
Cedar B, Levant RF, River C. A meta-analysis of the effects of parent effectiveness training. American-Journal of Family Therapy 1990;18(4):373-84.	A meta-analysis of 26 studies of parent effectiveness training (PET).	PET had an overall effect size of 0.33 standard deviation units, which was significantly greater than the effect size of a group representing alternative treatments. PET had effects on parents' knowledge, attitudes, and behaviour and on children's self-esteem, and these effects endured (up to 26 weeks) after the programs were completed. A trend was found suggesting that the effect on child behaviour may have had a latency period. Better designed studies had significantly greater effect sizes (.45) than less well-designed studies (.26).

SOCIAL CARE AND SOCIAL WELFARE: Child abuse and neglect - prevention

CITATION	*REVIEW DETAILS*	*FINDINGS*
Barlow J. Systematic Review of the Effectiveness of Parent-Training Programmes in Improving Behaviour Problems in Children Aged 3-10. (2nd Edition) Oxford: Health Services Research Unit, Department of Public Health, University of Oxford 1999.	A systematic review of randomised controlled trials of group based parent-training programmes designed to ameliorate child behaviour problems. Inclusion criteria: group-based interventions Parent Effectiveness Training (PET), Adlerian Programmes and Behavioural programmes.	All group-based programmes produced changes in children's behaviour. The more behavioural programmes in which the parent was trained to use reinforcement techniques effectively, appeared to produce the best results compared with PET and Adlerian programmes.
Kaplan SJ, Pelcovitz D, Labruna V. Child and adolescent abuse and neglect research: A review of the past 10 years. Part I: Physical and emotional abuse and neglect. Journal of the American Academy of Child and Adolescent Psychiatry 1999;38(10): 1214-22.	A review of the clinically relevant literature on the physical and emotional abuse and neglect of children and adolescents published during the past 10 years.	During the last decade there has been substantial progress in understanding the symptomatology associated with maltreatment. However, prevention and intervention research studies are relatively rare and frequently have important methodological limitations. Child maltreatment research in the next decade needs to focus on understanding factors leading to resilient outcomes and on assessing the effectiveness of psychotherapeutic and psychopharmacological treatment strategies. Increased resources are needed to support child maltreatment research studies and investigators.
West MM. Meta-analysis of studies assessing the efficacy of projective techniques in discriminating child sexual abuse. Child Abuse and Neglect. 1998;22(11):1151-66.	A meta-analysis of 12 studies assessing the efficacy of projective techniques to discriminate between sexually abused children and non-sexually abused children.	It is possible to discriminate between sexually abused children and non-sexually abused children using projective techniques.
Holmes WC, Slap GB. Sexual abuse of boys: definition, prevalence, correlates, sequelae, and management 1998.	Studies from 1985 to 1997 were included for review if they appeared in peer-reviewed journals; had clear research designs and reported results for at least 20 male subjects. Preference was given to studies with large samples with case-control or cohort designs, and/or with adjustment for effect modifiers or confounders.	166 studies representing 149 sexual abuse sample were identified. Studies were methodologically limited and definitions of sexual abuse varied widely. Evaluation of management strategies was limited. Reviewers conclude that sexual abuse of boys appears to be common, underreported, underrecognized, undertreated, and little is known about effective management.
Fryer GE. The efficacy of hospitalization of non-organic failure-to-thrive children: A meta-analysis. Child Abuse and Neglect 1988;12 (3):375-81.	A meta-analysis of previously published research findings which met certain inclusion criteria. Two categories of outcome measures, physical growth pattern and psychosocial development, were quantitatively synthesized separately using standard meta-analytic techniques.	Hospitalization was found to significantly enhance the probability of sustained catch-up physical growth among non-organic failure-to-thrive (NOFTT) children, but only a comparatively small effect size for hospitalization on their psychosocial development was documented. There remains need for prospective longitudinal study of effectiveness in treating NOFTT children.
Reeker J, Ensing D, Elliott R. A	A review of 15 studies of the	The overall mean effect size across studies was .79. Effect size comparisons based on

SOCIAL CARE AND SOCIAL WELFARE: Child abuse and neglect - prevention

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meta-analytic investigation of group treatment outcomes for sexually abused children. Child Abuse and Neglect 1997;21(7):669-80.	effectiveness of group treatment for sexually abused children or adolescents was investigated, based on studies using empirical measures, and sufficient statistical information was reported to calculate effect size.:	response perspective and outcome variable groupings yielded no significant differences. While statistically insignificant, a trend of larger effect sizes for groups comprised exclusively of females was found. CONCLUSIONS: Results from the current meta-analysis support the conclusion that effective group treatments for sexually abused children and adolescents exist and that the current meta-analysis can function as a comparison group for future researchers studying treatment outcome for this population. Suggestions for research are discussed.
Wurtele SK, Owens JS. Teaching personal safety skills to young children: an investigation of age and gender across five studies. Child Abuse and Neglect 1997;21(8):805-14.	A review of the extent to which preschool-aged boys and girls can benefit from instruction in personal safety. Four hundred and six preschoolers were pretested and participated in either the Behavioral Skills Training program (BST; Wurtele, 1986) or a control program. Children were posttested on skill and knowledge gains.	Preschoolers who had participated in the BST program demonstrated greater knowledge and higher levels of personal safety skills compared with controls. Boys and girls reacted similarly to the program, as did children from younger and older age groups. Results provide support for the assertion that most preschool-aged children can benefit from participating in a developmentally appropriate personal safety program. Suggestions for expanding the efforts to prevent child sexual abuse are offered, so that children do not shoulder the full responsibility for prevention.
Rispens J, Aleman A, Goudena PP. Prevention of child sexual abuse victimization: a meta-analysis of school programs. Child Abuse and Neglect 1997;21(10):975-87.	A meta-analytic approach was used to calculate post-test and follow-up effect sizes of 16 evaluation studies of school programs aimed at the prevention of child sexual abuse victimization. Tests of categorical models were used in the analysis of moderator variables.	Significant and considerable mean post-intervention (d = .71) and follow-up (d = .62) effect sizes were found, indicating that victimisation prevention programs are successful in teaching children sexual abuse concepts and self-protection skills. Intervention characteristics such as duration and content of the program, and child characteristics such as age and SES were important moderators of effect size. Findings corroborate and refine the positive conclusions of traditional narrative reviews. Programs that focus on skill training, allowing sufficient time for children to integrate self-protection skills into their cognitive repertoire, are to be preferred. Future evaluation research should focus on transfer of training.
Finkelhor D, Berliner L. Research on the treatment of sexually abused children: a review and recommendations. Journal of the American Academy of Child and Adolescent Psychiatry 1995;34(11): 1408-23.	29 studies that used quantitative outcome measures to evaluate the effectiveness of various therapeutic alternatives for sexually abused children.	The studies document improvements in sexually abused children consistent with the belief that therapy facilitates recovery. Only five of the studies reviewed provide evidence that recovery is not simply due to the passage of time or some factor outside therapy. Studies suggest the need to target aggressiveness and sexualised behaviour.
MacMillan HL, MacMillan JH, Offord DR, Griffith L, MacMillan A. Primary prevention of child physical abuse and neglect: a critical review. Part I. Journal of Child Psychology and Psychiatry and Allied Disciplines	A review of the effectiveness of interventions aimed at the primary prevention of child physical abuse and neglect. Interventions aimed at the prevention of physical abuse and neglect were classified into six main categories	While many of these programs did not show a reduction in physical abuse or neglect, there is evidence that extended home visitation can prevent physical abuse and neglect among disadvantaged families.

SOCIAL CARE AND SOCIAL WELFARE: Child abuse and neglect - prevention

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1994;35(5):835-56.	within the broad group of perinatal and early childhood programs.	
MacMillan HL; MacMillan JH, Offord DR, Griffith L, MacMillan A. Primary prevention of child sexual abuse: a critical review. Part II. Journal of Child Psychology and Psychiatry and Allied Disciplines 1994; 35(5): 857-76.	A review of the effectiveness of interventions aimed at the primary prevention of child sexual abuse. Interventions aimed at the prevention of sexual abuse were classified into eight main categories based on the method of intervention. All programs had education as the primary focus.	There is evidence that educational programs can improve safety skills and knowledge of children about sexual abuse but no study has produced data that education actually reduces the occurrence of sexual abuse.
Berrick JD, Barth RP. Child sexual abuse prevention: Research review and recommendations. Social Work Research and Abstracts 1992; 28(4):6-15.	A reviews of 30 research studies on child sexual abuse prevention. Nine studies (published 1981-1990) deal with preschool-age children; 20 studies (published 1984-1991) deal with elementary school-age children; and 1 study (1990) deals with high school-age children.	A meta-analysis of 13 of the studies demonstrates that children at all ages can improve their scores on child abuse knowledge measures but does not inform whether type or amount of knowledge sufficiently protects them from abuse. Recommended directions for future research include school and community-based interventions, targeted services, teacher training, and integration of prevention efforts with the total community.
Casto G, Mastropieri M. The efficacy of early intervention programs: A meta-analysis. Exceptional Children 1984;52(5):417-24.	A meta-analysis of the effects of early intervention programs for environmentally at-risk infants	Results show that early intervention has an immediate positive effect of about one-half of a standard deviation. The analysis failed to find long-term benefits and failed to relate the degree of parental involvement to intervention effectiveness. Some support was found for the notion that the degree of structure and training of staff are positively related to effectiveness.

SOCIAL CARE AND SOCIAL WELFARE: Child abuse and neglect - interventions

CITATION	*REVIEW DETAILS*	*FINDINGS*
Macdonald G, Ramchandani P, Higgins J, Jones DPH. Cognitive-behavioural interventions for sexually abused children [Protocol for a Cochrane Review]. In: The Cochrane Library, Issue 2, 2000.Oxford: Update Software.	A systematic review of the effects of cognitive-behavioural interventions for children who have been sexually abused.	
White P, Bradley C, Ferriter M, Hatzipetrou L. Managements for people with disorders of sexual preference and for convicted sexual offenders [Cochrane Review]. In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.	A systematic review of the effects of treatments for sexual offenders. The review covered both antilibidinal drugs (a common form of treatment) and psychological interventions aimed at reducing the target sexual acts, urges or thoughts of offenders or patients (people presenting with problems they wish to change). Drug treatments included: testosterone lowering drugs: (i) stilboestrol (an oral synthetic non-steroidal aestrogen), (ii) oestrogen pellets (planted subcutaneously), (iii) medroxyprogesterone acetate (an oral or intramuscular injection synthetic progesterone that lowers testosterone levels) and (iv) cyproterone acetate (an oral antiandrogen that blocks the production of, and opposes the action of testerone); antipsychotics: any drug usually given for the purposes of management of pyschotic illnesses such as schizophrenia; bromides, and surgical castration. Psychological interventions included: behaviour therapy of any type; relapse prevention.	Available evidence does not support the use of anti-libidinal drugs in the diversion of sex offenders.[a]The value of group support/therapy, as widely used in the UK, as an intervention in the diversion of sex offenders is unclear.
Gallagher CA, Wilson DB, Hirschfield P, Coggeshall MB, MacKenzie DL. Quantitative review of the effects of sex offender treatment on sexual reoffending.	A meta-analysis of available data on the effectiveness of sex offender treatment programmes in reducing post-treatment sex offence rates. The study also examined the differential effectiveness of	Sex offender treatment resulted in lowered sexual offending. Cognitive-behavioural approaches appeared particularly promising whereas the data produced less support for behavioural, chemical and generalised psychosocial treatments.

SOCIAL CARE AND SOCIAL WELFARE: Child abuse and neglect - interventions

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Corrections Management Quarterly 3 1999;4:19-29.	behavioural, cognitive-behavioural, medical and other psychosocial approaches to sex offender treatment.	
Polizzi DM, MacKenzie DL, Hickman LJ. What works in adult sex offender treatment? A review of prison- and non-prison-based treatment programs. International Journal of Offender Therapy and Comparative Criminology 1999;43(3):357-74.	An evaluation of 21 studies of sex offender prison- and non-prison-based treatment programs was undertaken using the format of the University of Maryland's 1997 report to the US Congress (L. Sherman et al, 1997).	Eight of the studies were deemed too low in scientific merit to include in assessing the effectiveness of the treatment. Of the remaining studies, approximately 50% showed statistically significant findings in favour of sex offender treatment programs. Of 6 studies that showed a positive treatment effect, 4 incorporated a cognitive-behavioral approach. Non-prison-based sex offender treatment programs were deemed to be effective in curtailing future criminal activity. Prison-based treatment programs were judged to be promising, but the evidence is not strong enough to support a conclusion that such programs are effective. Too few studies focused on particular types of sex offenders to permit any type of conclusions about the effectiveness of programs for different sex offender typologies.
Alexander MA. Sexual offender treatment efficacy revisited. Sexual Abuse: Journal of Research and Treatment 1999;11(2):101-16	A meta-analysis of sex offender treatment efficacy which examined data from 79 sexual offender treatment outcome studies, encompassing 10,988 offenders.	A variety of treated sexual offenders re-offended at rates below 11%. This finding suggests that some effective components of the treatment process may have been identified. Juveniles responded well to treatment. Treatment effects only became apparent after subjects were subdivided by type (e.g. rapists, child molesters, exhibitionists, others).
Grossman LS, Martin B, Fichtner CG. Are sex offenders treatable? A research overview. Psychiatric Services 1999;50(3) 349-61.	Review of research on effectiveness of treatment for adult male sex offenders.	Outcome research suggests a reduction in sex offender recidivism of 30% over seven years. Hormonal and cognitive-behavioural treatment seem most effective. Treatment delivered in outpatient settings seems more effective than institutional settings.
Reeker J. Ensing D. Elliott R. A meta-analytic investigation of group treatment outcomes for sexually abused children. Child Abuse and Neglect 1997;21(7)669-80.	A meta-analysis of the effects of group treatment for sexually abused children and adolescents 15 studies were identified which used empirical measures and provided sufficient statistical information to calculate effect sizes.	The overall mean effect size across studies was .79. Effect size comparisons based on response perspective and outcome variable groupings yielded no significant differences. While statistically insignificant, a trend of larger effect sizes for groups comprised exclusively of females was found.
De-Jong TL, Gorey KM. Short-term versus long-term group work with female survivors of childhood sexual abuse: A brief meta-analytic review. Social Work with Groups. 1996;19(1):19-27.	This meta-analytic review synthesizes the findings of 7 published independent studies dealing with group work with female survivors of childhood sexual abuse and compares the effectiveness of short-term vs long-term methods. Six of the studies were 15 wks or less, and 1 was 50 wks long.	Results of the meta-analysis indicate that, generally, group work had large beneficial effects on female survivors' affect and self-esteem such that three-quarters of the group participants improved. No extant empirical evidence supports the differential effectiveness of either short-term or long-term groups, because only 1 study reported the size of long-term methods' clinical effect. Thus, the question of the differential effectiveness of short- vs long-term group work with female survivors is not yet answerable.
Bourke ML, Donohue B. Assessment and treatment of juvenile sex	A review evaluates support for the assessment and treatment methods used	The heterogeneous nature of juvenile sex offenders and the failure of most measures to assess reliability and validity with this population make it difficult to generalise findings.

CITATION	*REVIEW DETAILS*	*FINDINGS*
offenders: An empirical review. Journal of Child Sexual Abuse 1996; 5(1):47-70.	with juvenile sex offenders.	Standardised assessment and treatment methods for use with prepubescent children are conspicuously absent in the literature.
Hall GCN. Sexual offender recidivism revisited: A meta-analysis of recent treatment studies. Journal of Consulting and Clinical Psychology 1995;63(5)802-9.	Meta-analyses were performed on 12 studies of treatment with sexual offenders (N 1,313).	A small but robust, overall effect size was found for treatment versus comparison conditions (r = .12). The overall recidivism rate for treated sexual offenders was. .19 versus .27 for untreated sexual offenders. Treatment effect sizes across studies, however, were heterogeneous. Effect sizes were larger in studies that had higher base rates of recidivism, had follow-up periods longer than 5 years, included outpatients, and involved cognitive-behavioural or hormonal treatments. Cognitive-behavioral ($p < .0005$) and hormonal treatments ($p < .00005$) were significantly more effective than behavioural treatments but were not significantly different from each other.
Oates RK, Bross DC. What have we learned about treating child physical abuse? A literature review of the last decade. Child Abuse and Neglect 1995;19(4) 463-73.	A review of outcome studies of interventions targeting children and parents in physically abusive families. Inclusion criteria were: (i) studies had more than five subjects in the sample, (ii) at least 15% of the children in the sample having been physically abused and (iii) either protest, post-test; comparison group; or randomisation between different treatments used in the design were selected. Between 1983 and 1992 twelve papers meeting these criteria for abusive parents and 13 for treatment of abused children were found. None were concerned with routine service provision.	Although most programmes showed some improvement with treatment, many had no, or very short, follow-up periods so it was not possible to determine if improvements were maintained. The variety of therapeutic interventions considered precluded the possibility of comparing alternative methods of intervention.
Beaulieu KM. Meta-analysis of psychotherapeutic treatments with adult survivors of incest. Psy.D dissertation, University of Northern Colorado, Dissertation Abstracts International 1994;55/05-B: 2001	A meta-analysis of psychotherapeutic treatment for adult incest survivors. 400 papers were identified of which ten met inclusion criteria (listed quantified information of treatment outcome) of which only three contained statistical data which documented change in participants as a result of treatment, and only two of which contained sufficient data to compute an effect size.	Group psychotherapy appears to be an effective treatment for adult survivors of incest. However, data are slight. There is a dearth of data regarding the treatment of male incest survivors. Recommendations for future research include: (1) need for more outcome studies covering both individual and group psychotherapy, which differentiates between types of abuse and which includes work with male incest survivors, (2) examine whether individual psychotherapy provided simultaneously with group therapy enhances treatment outcome, (3) investigation of which psychotherapies are most effective for treating incest survivors, and (4) whether the inclusion of family members in treatment enhances effectiveness.
Wolfe DA, Wekerle C. Treatment strategies for child physical abuse and	Twenty one studies reporting treatment outcomes following interventions with	Findings support the significance of parent-focused interventions that include well-specified training components aimed at improving child rearing competence and stress

Cohn AH, Daro D. Is treatment too late: what ten years of evaluative research tell us. Child Abuse and Neglect 1987;11(3):433-42.	Evaluation of 89 federally funded demonstration programmes covering 4 multi-year evaluation studies. Interventions provided for 3,524 families.	Collectively, the studies document treatment approaches which improve clients' functioning (notably lay counseling and various group services including Parents Anonymous, group therapy, and parent evaluation) and suggest greater success with clients experiencing difficulty with sexual abuse than other forms of maltreatment. However, overall over one-third of the parents maltreated their children while in treatment, and over one-half of the families served continued to be judged likely to mistreat their children following termination.

SOCIAL CARE AND SOCIAL WELFARE: Substitute care

CITATION	*REVIEW DETAILS*	*FINDINGS*
Reddy LA, Pfeiffer SI. Effectiveness of treatment foster care with children and adolescents: a review of outcome studies. Journal of the American Academy of Child and Adolescent Psychiatry 1997;36(5):581-8.	A review of 40 published outcome studies were systematically reviewed to assess the impact of treatment foster care on five dependent variables: placement permanency, behavior problems, discharge status, social skills, and psychological adjustment.	Treatment foster care produced large positive effects on increasing placement permanency and children's social skills. Medium positive effects were found in reducing behaviour problems, improving psychological adjustment, and reducing restrictiveness of post-discharge placement. Few investigations collected data both at time of program completion and follow-up, precluding a test of the durability and generalisability of treatment foster care outcomes.

SOCIAL CARE AND SOCIAL WELFARE: Domestic violence

CITATION	*REVIEW DETAILS*	*FINDINGS*
Davis RC, Taylor BG. Does batterer treatment reduce violence? A synthesis of the literature. Women and Criminal Justice 1999;10(2)69-93.	A review of the effects of interventions designed to reduce violence in men who batter.	Among a handful of quasi- and true experiments there is fairly consistent evidence that treatment works and that the effect of treatment is substantial. There is little evidence to date that one form of treatment is superior to another or that longer programmes turn out less violent graduates than shorter ones. There area bases for hypothesising that some batterers may fare better in treatment (or fare better in certain types of treatment) than others, but empirical verification has been highly limited to date.
Chard KM. A meta-analysis of posttraumatic stress disorder treatment outcome studies of sexually victimized women. Indiana University. Dissertation Abstracts International 1995.	A meta-analysis of the effects of treatment on female rape, abuse and/or batter survivors diagnosed with PTSD. Only studies with group and individual treatment interventions with comparison/control groups or pre-post-test measures were included.	Meta-analysis of effects (N=467) from 14 studies showed an average effect size of just under one and a half standard deviations (Cohen d = 1.457) on multiple measures. Cognitive and psychodynamic interventions were found to have greater impact than supportive or cognitive-behavioural interventions. While all included treatments were effective, cognitive therapy offered in sequential individual sessions was the statistically superior intervention.
Weaver TL, Clum GA. Psychological distress associated with interpersonal violence: A meta-analysis. Clinical Psychology Review 1995;15(2):115-40.	The present meta-analytic review examined the relationship between interpersonal violence and psychological distress, utilizing 50 published or prepublication empirical studies. Studies were included in the review if they quantified psychological distress following childhood sexual or physical abuse, rape, criminal assault, or partner (domestic) physical abuse or rape.	The overall effect size, though heterogeneous, was clinically and practically significant, demonstrating empirically that interpersonal violence has deleterious effects on psychological functioning. Within victimized groups, specific objective and subjective stressor-related factors were examined for the magnitude of their effect on resulting psychological distress. Subjective factors, such as general appraisal, self-blame, and perceived life threat, contributed twice as much to the magnitude of psychological distress as did objective factors, such as physical injury, force, and use of a weapon. Generally, psychological distress in the domains of intra- and interpersonal functioning emerged as theoretically and clinically important avenues for further research.

SOCIAL CARE AND SOCIAL WELFARE: Anti-violence policies/interventions

CITATION	*REVIEW DETAILS*	*FINDINGS*
Wekerle C, Wolfe DA. Dating violence in mid-adolescence: theory, significance and emerging prevention initiatives. Clinical Psychology Review 1999;19(4):435-56.	A review of 6 relationships violence prevention programmes designed for and delivered to youth. Programs addressed specific skills and knowledge that oppose the use of violent and abusive behaviour toward intimate partners; one program addressed interpersonal violence more generally, and was also included in this review because of its implications for dating violence initiatives.	Positive changes were found across studies in violence-related attitudes and knowledge, also, positive gains were noted in self reported perpetration of dating violence, with less consistent evidence in self-reported victimisation. However, these findings should be considered preliminary due to limited follow-up and generalisability. This preliminary review of six programs aimed at addressing particular skills and knowledge that oppose the use of violent and abusive behaviour toward intimate partners identified positive changes in violence-related attitudes and knowledge, and positive gains in self-reported perpetration of dating violence. Less consistent evidence in self-reported victimisation.
Tolan P, Guerra N. Youth Violence: What Works. Boulder, CO: University of Colorado, Boulder Center for the Study and Prevention of Violence 1998.	Review of programmes aimed at reducing or preventing youth violence.	Authors point out that most approaches to youth violence have not been well evaluated, so conclusions of this review must be treated with caution. As in their earlier review (see Tolan and Guerra 1994) there is support for the effectiveness of programs at each of four levels. At the individual level there is support for the use of cognitive-behavioural multidimensional programmes, particularly those that combine generic problem-solving skills with other cognitive skills such as perspective taking. Programmes that provide for extensions into real-life skills and situations are more effective than others, and behaviour modification in real-life settings has shown some promise. Overall, the evidence relating to individual analytic therapy, supportive psychotherapy and intensive casework argues against their use. The last sometimes shows negative results. Biomedical interventions have produced equivocal results and are only indicated for extremely violent youths.
Wing JS, Marriott S, Palmer C, Thomas C. Management of imminent violence: clinical practice guidelines to support mental health services. Occasional Paper OP41: 1998:1-111.	A review of the evidence pertaining to the effectiveness of interventions aimed at preventing or dealing with imminent violence in adult users of the mental health services. Review excluded the elderly, people with learning disorders, people with problems due primarily to personality disorders or substance misuse, people receiving domicilliary visits and those attending general practices. Interventions included: environmental interventions, restraining and seclusion interventions, pharmacological interventions, and short-term prediction interventions. Review included descriptive studies as well as others of	There was weak quantitative evidence that training and experience reduces injuries to staff, although it is not clear whether overall incidents of violence (i.e. patient to patient) is reduced. Overcrowding may be a trigger for violence. Wards with cohesive teams with high morale appear to be less violent. It was not possible to draw strong evidence-based conclusions relating to the use of medication but there is some indication that if psychosocial methods have failed then benzodiazepines alone, or an antipsychotic alone can be used with a reasonable degree of safety for managing violent behaviour. Data did not permit conclusions to be drawn about items that would be clinically useful for the short-term prediction of violence across a range of clinical settings.The variety and methodological weaknesses of available dictated a narrative review. The authors develop 18 guidelines for practice under the general headings: *ward design and organisation, anticipating and preventing violence* and *medication in the context of violence*. The authors state that the guidelines 'should be seen as a companion to the Department of Health's guidance, the Health and Safety Executive's guidance on managing and assessing violence to staff and the Royal College of Psychiatrists' Council Report on the design of psychiatric facilities. Controlled studies on the use of atypical and short-acting

SOCIAL CARE AND SOCIAL WELFARE: Anti-violence policies/interventions

CITATION	*REVIEW DETAILS*	*FINDINGS*
	more appropriate design. The aim was to produce clinical guidelines.	depot neuroleptics in such contexts is identified as an area for further research.
Kellermann AL, Fuqua-Whitley DS, Rivara FP, Mercy J. Preventing youth violence: What works? .Annual Review of Public Health 1998;19:271-92.	A review of interventions designed to prevent youth violence.	Between 1985 and 1992, serious youth violence in the United States surged to unprecedented levels. The growing use of firearms to settle disputes has contributed to this phenomenon. Youth are most often victimised by one of their peers. In response to this problem, a wide variety of programmes have been implemented in an attempt to prevent youth violence or reduce its severity. Few have been adequately evaluated. In general, interventions applied between the prenatal period and age 6 appear to be more effective than interventions initiated in later childhood or adolescence. Community-based programs that target certain high-risk behaviours may be beneficial as well. A sustained commitment to evaluation research is needed to identify the most effective approaches to youth violence prevention.
Harris GR, Rice ME. Risk appraisal and management of violent behavior. Psychiatric Services 1997;48(9):1168-76.	A review analyses research published in the last decade on the prediction, management and treatment of violence persons.	Well-controlled studies have shown the effectiveness of behaviour therapy and of behavioral staff training programmes in reducing violence by patients in institutions, chronic psychiatric patients, and other populations. Little is known about which psychotherapeutic or pharmacological treatments reduce violent recidivism under what circumstances. Recent work on the neurophysiology of aggression holds exciting promise but does not yet provide a scientific basis for prescriptive treatment. The most exiting and promising avenues for research on the management of violence like in the joining of biology and psychology.
Tolan P, Guerra N. What works in reducing adolescent violence: an empirical review of the field. Boulder, CO: Center for the Study and Prevention of Violence. University of Colorado 1994.	Reviews programmes within each of 4 intervention categories that reflect risk factors for violence: individual factors, close interpersonal relationships, proximal social contexts and broader societal macrosystems within a biopsychosocial model.	Few evaluations exist. While effective programmes exist at each level examined those assessed typically target individual-level influences. There is some support for cognitive-behavioural multidimensional programmes, those that provide real life skills and behaviour modification. Proximal interpersonal systems programmes such as family-targeted interventions are effective. In this category peer-relation intervention was less effective. Interventions in proximal social settings, although not sufficiently evaluated, reported some success for increased parental involvement in schools, increasing youths' motivation to do well, and opportunities for prosocial roles. .Community organisation programmes have been minimally evaluated. Milieu or token programmes offered in residential setting appear effective while young people are incarcerated but are not promising in the long term. There were no tests of societal level influence.
Buchanan DR, Chasnoff P. Family crisis intervention programs: What works and what doesn't. Journal of Police Science and Administration 1986;14(2):161-8.	Reviews historical and anecdotal evidence that family crisis intervention (FCI) training	Historical and anecdotal evidence that family crisis intervention (FCI) training improves a police officer's performance in the resolution of family disturbance situations. Concludes that FCI training is a good investment for police departments; trained officers are more highly rated by the community, and their attitudes and skills increase. FCI training may also decrease assaults on police officers.

SOCIAL CARE AND SOCIAL WELFARE: Children in care

CITATION	*REVIEW DETAILS*	*FINDINGS*
Bates BC, English DJ, Kouidou-Giles S. Residential treatment and its alternatives: A review of the literature 1997;26(1):7-51.	This review summarises the literature for residential treatment, family preservation services, treatment foster care, and individualised services and evaluates characteristics of each model, methodological limitations of outcome studies, and treatment effectiveness with children.	Although residential care is often viewed negatively, empirical evidence does not suggest differential levels of effectiveness compared to non-residential alternatives. The results of some non-residential outcome studies are promising, but efficacy claims should be viewed critically due to the absence of methodologically rigorous evaluations for both residential and non-residential approaches. Treatment effectiveness for both residential and non-residential programs continues to be hampered by the use of small, non-random samples, failure to use comparison or control groups, poorly defined subjective outcome criteria, the use of non-standardised assessment tools, and the failure to explicate and link treatment components to outcomes. Future research should focus on establishing empirically grounded placement criteria, identifying what presenting problems are most amenable to each form of treatment, and maximising the maintenance of treatment gains in the post-discharge environment.

SOCIAL CARE AND SOCIAL WELFARE: Substance abuse

CITATION	*REVIEW DETAILS*	*FINDINGS*
Ley A, Jeffrey DP, McLaren S, Siegfried N. Treatment programmes for people with both severe mental illness and substance misuse [Cochrane Review] In: The Cochrane Library, Issue 1. Oxford: Update Software; 2000.	A review of the effectiveness of treatment programmes within psychiatric care for people with problems of both substance misuse and serious mental illness.	There is no evidence that any one programme is more effective than another in "dual diagnosis" – people with severe mental illness and substance abuse. Reviewers observe that the current momentum for integrated programmes is not based on good evidence. Implementation of new specialist substance misuse services for those with serious mental illnesses should be within the context of simple, well designed controlled clinical trials.
Kirchmayer U, Davoli M, Verster A. Naltrexone maintenance treatment for opioid dependence [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software.	A review of the eleven randomised controlled trials of the effects of naltrexone maintenance treatment in preventing relapse in opioid addicts after detoxification.	The available trials do not allow a final evaluation of naltrexone maintenance treatment. A trend in favour of traetment with naltrexone was observed for certain target groups. The place of naltrexone treatment remains uncertain, but may be useful as an adjunct in people for whom the consequences of relapse are severe (parolees, health care professionals). A well-conducted clinical trial is needed in order to obtain better evidence.
Irvin JE, Bowers CA, Dunn ME, Wang MC. Efficacy of relapse prevention: a meta-analytic review. Journal of Consulting and Clinical Psychology 1999;67(4):563-70.	A meta-analysis was performed to evaluate the overall effectiveness of RP and the extent to which certain variables may relate to treatment outcome. Twenty-six published and unpublished studies with 70 hypothesis tests representing a sample of 9,504 participants were included in the analysis.	Results indicated that RP was generally effective, particularly for alcohol problems. Additionally, outcome was moderated by several variables. Specifically, RP was most effective when applied to alcohol or polysubstance use disorders, combined with the adjunctive use of medication, and when evaluated immediately following treatment using uncontrolled pre-post tests.
Griffith JD, Rowan-Szal GA, Roark RR, Simpson DD. Contingency management in outpatient methadone treatment: a meta-analysis. Drug and Alcohol Dependence 1999.	A meta-analysis of contingency management interventions in outpatient methadone treatment settings. Outcome measures of interest was drug use during treatment, as detected through urinalysis.	Contingency management is effective in reducing supplemental drug use for these patients. The analysis of behavioural interventions yielded an overall effect size (r) of 0.25 based on 30 studies. Significant moderators of outcomes included type of reinforcement provided, time to reinforcement deliver, the drug targeted for behavioral change, number of urine specimens collected per week, and type of subject assignment. These factors represent considerations for reducing drug use during treatment.
Kownacki RJ, Shadish WR. Does alcoholics anonymous work? The results from a meta-analysis of controlled experiments. Substance Use and Misuse 1999;34(13)1897-1916	This article reviews the outcome (usually abstinence at 12 months) of 21 controlled studies of AA, with emphasis on methodological quality. Severe selection biases compromised all quasi-experiments.	Randomised studies yielded worse results for AA than non-randomised studies, but were biased by selection of coerced subjects. Attending conventional AA meetings was worse than no treatment or alternative treatment; residential AA-modelled treatments performed no better or worse than alternatives; and several components of AA seemed supported (recovering alcoholics as therapists, peer-led self-help therapy groups, teaching the Twelve-Step process, and doing an honest inventory).
White D, Pitts M. Educating young people about drugs: A systematic review. Addiction 1998;10:1475-87.	A systematic review of interventions targeting illicit drug use which provided sufficient detail of the intervention and design of the evaluation to allow judgements to be made of their	Identified evaluations were delivered in a range of settings including: schools and colleges; community settings; the family; medical/therapeutic settings; mass media. Findings: The majority of studies identified were evaluations of interventions introduced in schools and targeting alcohol, tobacco and marijuana simultaneously. These studies were methodologically stronger than interventions targeting other drugs and implemented

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	methodological soundness. A meta-analyses were conducted combining the data of the methodologically sound studies.	outside schools. Meta-analyses showed that the impact of evaluated interventions was small with dissipation of programme gains over time. Interventions targeting hard to reach groups have not been evaluated adequately. Conclusions: Effort needs to be directed towards the development of improved evaluative solutions to the problems posed by these groups. There is still insufficient evidence to assess the education; more methodologically sound evaluations are required. There is also a need to target interventions to reflect the specific needs and experiences of recipients. [References: 52]
Cross JE, Saunders CM, Bartelli D. The effectiveness of educational and needle exchange programs: a meta-analysis of HIV prevention strategies for injecting drug users. Quality and Quantity 32, 1998;2:165-80.	A meta-analysis examining the effects of educational interventions and needle exchange programmes published in papers between 1984 and 1995.	The weighted mean effect size for 6,251 study participants of 16 educational interventions included in the review was 0.749 (95% CI, 0.708 to 0.790), and the weighted mean effect size for the 1,675 study participants of the 10 needle exchange programmes was 0.279 (95% CI, 0.207 to 0.352). suggesting that both interventions had a positive effect on reducing HIV risk behaviours associated with injecting drug use. However results were dependent on research design, outcome type, and follow-up time.
Minozzi S, Grilli R. The systematic review of studies on the efficacy of interventions for the primary prevention of alcohol abuse among adolescents. [Italian] Epidemiologia e Prevenzione 1997;21(3)180-8.	A systematic review of 21 randomised controlled trials indexed on Medline between 1983 and July 1995.	21 studies covering 27 preventive programmes were included using 5 different interventions. Only 3 were effective on all the outcomes measures utilised and 6 were partially effective. Low methodological quality of studies and range of outcome measures made it difficult to compare the results of different studies and impossible to reach definitive conclusions.
Tobler NS, Stratton HH. Effectiveness of school-based drug prevention programs: A meta-analysis of the research. Journal of Primary Prevention 1997;18(1):71-128.	A meta-analysis of 120 school-based programs (5th-12th) that evaluated success on self-reported drug use measures.	Two major types of programs were identified: Interactive and Non- Interactive. Six factors related to program effectiveness (sample size, targeted drug type of control group, special populations, type of leader, and attrition) were included as covariates. The superiority of the Interactive programs was both clinically and statistically significant to the Non-Interactive programs for tobacco, alcohol, marijuana and illicit drugs and for all adolescents including minority populations. The larger Interactive programs were less effective, although still significantly superior to the Non-Interactive programs, which suggests implementation failures.
Wilk AI, Jenson NM. Meta-analysis of randomised control trials addressing brief interventions in heavy alcohol drinkers. Journal of General Internal Medicine 1997;12(5):274-83.	To assess the effectiveness of brief interventions in heavy drinkers.	Heavy drinkers who received a brief intervention were twice as likely to moderate their drinking 6 to 12 months after an intervention when compared with heavy drinkers who received o intervention. Brief intervention is a low-cost effective preventive measures for heavy drinkers in outpatient settings.
Hoag MJ, Burlingame GM. Evaluating the effectiveness of child and adolescent group treatment: a meta-analytic review. Journal of Clinical Child Psychology	Utilizing 56 outcome studies published between 1974 and 1997, this meta-analysis specifically examines the effect of group treatment with children and adolescents (ages 4-18). Various types of	Results indicate that group treatment was significantly more effective for children than wait-list and placebo control groups (effect size = .61). That is, the average child or adolescent treated by group treatment is better off than 73% of those in control groups. This meta-analysis strengthens and supports conclusions in the current literature and challenges others regarding the treatment of children and adolescents by group treatment.

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1997;26(3):234-46.	group treatment were assessed, including preventative programs, psychotherapy, counseling, guidance, and training groups.	For instance, allegiance of the experimenter, setting of the therapy, socioeconomic status of the patient, and publication year of the study were variables that were significantly related to improvement, whereas diagnosis, content and source of the outcome measure were unrelated to improvement.
Stanton MD, Shadish WR. Outcome, attrition and family couples treatment for drug abuse: a meta-analysis and review of the controlled, comparative studies. Psychological Bulletin 1997;122(2)170-91.	This review synthesizes drug abuse outcome studies that included a family-couples therapy treatment condition.	The meta-analytic evidence, across 1,571 cases involving an estimated 3,500 patients and family members, favours family therapy over (a) individual counselling or therapy, (b) peer group therapy, and (c) family psycho-education. Family therapy is as effective for adults as for adolescents and appears to be a cost-effective adjunct to methadone maintenance. Because family therapy frequently had higher treatment retention rates than did non-family therapy modalities, it was modestly penalised in studies that excluded treatment dropouts from their analyses, as family therapy apparently had retained a higher proportion of poorer prognosis cases. Re-analysis, with dropouts regarded as failures, generally offset this artefact. Two statistical effect size measures to contend with attrition (dropout d and total attrition d) are offered for future researchers and policy makers.
Heneghan AM, Horwitz SM, Leventhal JM. Evaluating intensive family preservation programs: a methodological review. Pediatrics 1996;97(4):535-42.	A review of the adequacy of evaluations of family preservation services (FPS), which are designed to support families and prevent out of home placements of children at risk of abuse or neglect, and to assess the effectiveness of FPS at reducing out of home placements of children. References published from 1977 to 1993 were identified from a computerized search of databases for English-language publications using the key phrases "family preservation," "child abuse," and "family-based services." Unpublished references were identified by mail or phone from a listing of more than 200 programs in a national directory. Of 802 references initially identified, 46 program evaluations were reviewed. Ten studies met the following inclusion criteria: (1) evaluated an intensive family preservation program, (2) included outcome data in the report, and (3) used a comparison group. Five were randomized	Only two studies were rated acceptable, four were adequate, and four were unacceptable. Methodological shortcomings included poorly defined assessment of risk, inadequate descriptions of the interventions provided, and nonblinded determination of the outcomes. Rates of out of home placements were 21% to 59% among families who received FPS and 20% to 50% among comparison families. The relative risk of placement was significantly reduced by FPS in only two studies (one randomized trial and one quasi-experimental study). Despite current widespread use of FPS to prevent out of home placements of children, evaluations of FPS are methodologically difficult and show no benefit in reducing rates of out of home placements of children at risk of abuse or neglect in 8 of 10 studies. Consistent, methodologically rigorous evaluations are needed to determine the effectiveness of FPS and to guide social policy for high-risk children and their families.

CITATION	*REVIEW DETAILS*	*FINDINGS*
	trials, and 5 were quasi-experimental studies (nonrandomized).	
Allen M, Burrell N. Comparing the impact of homosexual and heterosexual parents on children: meta-analysis of existing research. Journal of Homosexuality 1996;32 (2):19-35.	A meta-analysis of the available quantitative literature comparing the impact of heterosexual and homosexual parents, using a variety of measures, on the child(ren). The analyses examine parenting practices, the emotional well-being of the child, and the sexual orientation of the child.	The results demonstrate no differences on any measures between the heterosexual and homosexual parents regarding parenting styles, emotional adjustment, and sexual orientation of the child(ren). In other words, the data fail to support the continuation of a bias against homosexual parents by any court.
Edwards ME, Steinglass P. Family therapy treatment outcomes for alcoholism. Journal of Marital and Family Therapy 1995;21(4):475-509.	A meta-analysis of 21 studies from 1972-1993 of family-involved therapy for alcoholism, evaluating them for design adequacy, clinical significance, and effect size. The review is divided into studies of family involvement in 3 phases of treatment: initiation, primary treatment, rehabilitation, and aftercare.	It is concluded that family therapy is effective in motivating alcoholics to enter treatment. Once the drinker enters treatment, family-involved treatment is marginally more effective than individual alcoholism treatment. The data suggest that 3 factors may mediate the effect of treatment: gender, investment in the relationship, and perceived support from the spouse for abstinence. Modest benefits have been obtained in family-involved relapse prevention programs.
Shadish WR, Ragsdale K, Glaser RR, Montgomery LM. The efficacy and effectiveness of marital and family therapy: A perspective from meta-analysis. Journal of Marital and Family Therapy 1995;21(4):345-60.	A meta-analysis of 163 randomised trials of the effects of marital and family therapy (MFT).	Across 163 randomised trials, MFT demonstrated moderate, statistically significant, and often clinically significant effects. No orientation was yet demonstrably superior to any other, nor was MFT superior to individual therapy. Cost-effectiveness information was scant but supportive. Randomised experiments yielded very different answers from nonrandomized experimental studies of the effects of MFT, calling into question whether the 2 types should be mixed in reviews. New differences were found in the ways that marital therapy (MT) and family therapy (FT) studies are conducted, making them harder to compare. Questions still exist about whether any psychotherapy, including MFT, yet has sufficient information about how well research generalises to everyday clinical practice.
Suss HM. The effectiveness of the treatment of alcoholics: results of a meta-analysis Psychologishe Rundschau 1995;46(4):245-66.	A meta-analysis of 23 experimental and 21 non-experimental prospective studies.	Different general success rates for total abstinence and improvement of drinking behaviour are found depending on the method of calculation (handling of treatment dropouts and follow-up dropouts).
Elmquist DL. A systematic review of parent-oriented programs to prevent children's use of alcohol and other drugs. Journal of Drug Education 1995;25(3):251-79.	A systematic review of the characteristics of twenty-two instructor-led parent-oriented programs designed to prepare parents to prevent their children's alcohol and other drug use. To conduct this program review, the author developed	The results of the reviews are summarized according to program characteristics. Recommendations are based upon the review results. These results and recommendations can help prospective users make an informed decision before they adopt or invest in a program

SOCIAL CARE AND SOCIAL WELFARE: Substance abuse

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	120 criteria for analysing and reviewing the characteristics of the programs. The criteria were grouped under five main topics or components: 1) general characteristics, 2) instructional characteristics, 3) skills addressed, 4) generalisation methods, and 5) evaluation. The author then trained two uninformed reviewers to review with reliability each program	
Ennett ST, Tobler NS, Ringwalt CL, Flewelling RL. How effective is drug abuse resistance education? A meta-analysis of Project DARE outcome evaluations 1994.	A meta-analysis of eight studies of the effectiveness of Project DARE (Drug Abuse Resistance Education) the most widely used school-based drug use prevention program in the United States.	Weighted effect size means for several short-term outcomes also were compared with means reported for other drug use prevention programs. The DARE effect size for drug use behaviour ranged from .00 to .11 across the eight studies; the weighted mean for drug use across studies was .06. For all outcomes considered, the DARE effect size means were substantially smaller than those of programs emphasising social and general competencies and using interactive teaching strategies. CONCLUSIONS. DARE's short-term effectiveness for reducing or preventing drug use behaviour is small and is less than for interactive prevention programs.
Hansen WB. School-based substance abuse prevention: A review of the state of the art in curriculum, 1980-1990. Health Education Research 1992;7(3):403-30.	A review of substance use prevention studies published between 1980 and 1990	Six groups of programs (Information/Values Clarification, Affective Education, Social Influence, Comprehensive, Alternatives and Incomplete programs) were identified. Reports were analyzed for two major threats to validity, selection bias and statistical power. Program groups generally have similar selection biases but have important differences in statistical power. Comprehensive and Social Influence programs were found to be most successful in preventing the onset of substance use.
Bruvold WH. Meta-analysis of the California School-Based Risk Reduction Program. Journal of Drug Education 1990;20(2):139-52.	A review of 8 projects meeting certain inclusion criteria, viz. comparison groups, pre-testing, participant tracking, control of attrition, dependent variable validity, and effect size computation. 6 of the 8 studies were based upon a rational model and 2 on a developmental model of intervention.	The rational model programs impact more on knowledge and less on attitudes and behaviour. Developmental programmes impact more on attitudes and behaviour and less on knowledge At present the results indicate that the developmental approach, because of its effects on behaviour, has more potential for deterring drug use.

SOCIAL CARE AND SOCIAL WELFARE: People with learning disabilities

CITATION	*REVIEW DETAILS*	*FINDINGS*
Felce D. Quality of Life for People with Learning Disabilities in Supported Housing in the Community: A Review of Research. The Centre for Evidence-Based Social Services, University of Exeter, Exeter. 2000.	Narrative review of 148 research articles comparing quality of life for people with learning disabilities in different residential service models. Also sets out a framework for quality of life assessment covering physical, material, social, productive, emotional and civic well-being, and user satisfaction.	Standard approaches to care in this field still fall well short of the outcomes exhibited in the best of international research. In other words, routine services in Britain are not necessarily in line with the best of international experience revealed by research. Outcome research reveals that ordinary housing within the community appears to be the most advantageous model for the provision of services for people with learning disabilities. Thus "normalised", homely environments with ordinary housing architecture and domestic furnishings should be adopted as the norm. Housing should be near to community amenities and to family and established friends. Small size, community location and ordinary housing, however, do not guarantee quality- a complex array of environmental factors interact to determine outcome quality. There is little evidence that staff qualifications or characteristics effect the quality of outcomes.
Simons K, Watson D. New Directions? Day Services for People with Learning Disabilities in the 1990s. A Review of the Research. Exeter: The Centre for Evidence-Based Social Services, University of Exeter 1999.	A narrative review of 130 published research sources on the effects of day services for people with learning disabilities.	There is a lack of evaluative research on many aspects of day services. There is still considerable confusion about the function of day services Day services are in the early stages of fundamental reform The performance of day services is very variable. There is an important, potential role for employment-related support services Wider policy changes would appear to provide a favourable context for the modernisation of day services.
Swanson HL. Reading research for students with LD: A meta-analysis in intervention outcomes. Journal of Learning Disabilities 1999;32(6):504-32.	Provides a meta-analysis of instructional research with children and adolescents with learning disabilities in the domains of word recognition and reading comprehension. Provides a meta-analysis of instructional research with children and adolescents with learning disabilities in the domains of word recognition and reading comprehension. The results of the synthesis showed that a prototypical intervention study has an effect size (ES) of .59 for word recognition and .72 for reading comprehension.	The results of the synthesis showed that a prototypical intervention study has an effect size (ES) of .59 for word recognition and .72 for reading comprehension. Four important findings emerged from the synthesis: (1) ESs for measures of comprehension were higher when studies included derivatives of both cognitive and direct instruction, whereas ESs were higher for word recognition when studies included direct instruction; (2) ESs related to reading comprehension were more susceptible to methodological variation than studies of word recognition; (3) the magnitude of ES for word recognition studies was significantly related to samples defined by cutoff scores, whereas the magnitude of ES for reading comprehension studies was sensitive to discrepancies between IQ and reading when compared to competing definitional criteria; and (4) instructional components related to word segmentation did not enter significantly into a weighted least square hierarchical regression analysis for predicting ES estimates of word recognition beyond an instructional core model, whereas small-group interactive instruction and strategy cuing contributed significant variance beyond a core model to ES estimates of reading comprehension.
Swanson HL, Hoskyn M. Experimental intervention research on students with learning disabilities: A meta-analysis of treatment outcomes. Review of Educational	Summarizes a comprehensive synthesis of experimental intervention studies that have included students with learning disabilities. Effect sizes for 180 intervention studies were analyzed across	The overall mean effect size of instructional intervention was positive and of high magnitude (M = 0.79). Effect sizes were more positive for a combined model that included components of direct and strategy instruction than for competing models. Interventions that included instructional components related to controlling task difficulty, small interactive groups, and directed responses and questioning of students were

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Research 1999.	instructional domains, sample characteristics, intervention parameters, methodological procedures, and article characteristics.	significant predictors of effect size; and interventions that varied from control conditions in terms of setting, teacher, and number of instructional steps yielded larger effect sizes than studies that failed to control for such variations. Results are supportive of the pervasive influence of cognitive strategy and direct instruction models for remediating the academic difficulties for children with learning disabilities.
Swanson HL, Hoskyn M. Definition treatment interactions for students with learning disabilities. School Psychology Review 1999;28(4):644-58.	Investigated whether intervention outcomes for students with learning disabilities (LD) vary as a function of IQ and/or reading level. Effect sizes for 180 intervention studies were analyzed across instructional domains (e.g., reading, mathematics), and sample characteristics (e.g., intelligence, reading).	The findings were (1) a significant intelligence * reading level interaction emerges related to the magnitude of treatment outcomes indicating that studies which produced the highest effect sizes reported the smallest discrepancy between intelligence and reading when compared to other studies; (2) effect sizes were higher for strategy instruction and direct instruction-only models when studies met cut-off score criteria (study samples report standardized IQ scores at or above 85 and reading scores at or below the 25th percentile) when compared to other studies; and (3) effect sizes were more positive for a Combined Strategy and Direct Instruction model when compared to competing instructional models, but the difference in magnitude was weakened when compared to competing models when samples were defined as meeting cut-off score criteria. Overall, the results support the notion that variations in how LD samples are defined are related to the magnitude of treatment outcomes.
Lumley VA, Miltenberger RG. Sexual abuse prevention for persons with mental retardation. American Journal of Mental Retardation. 1997;101(5):459-72	A narrative review of issues relating to ways of reducing the apparently increased risk of sexual abuse among people with "mental retardation" (learning disability). The problem of sexual abuse among persons with learning disability, skills for preventing sexual abuse, and methods for assessing prevention skills are discussed. No search methods described and the authors do not state that the paper constitutes a comprehensive review. Because very little research on teaching sexual abuse prevention skills exists, research on abduction prevention programs for persons with learning disability as well as on sexual abuse prevention programs for children, was reviewed. Suggestions for future research in the area of sexual abuse prevention for persons with learning disability are	The authors postulate that as behavioural skills training (BST) has been successful in people with learning disabilities for abduction training and that BST has been successful in sexual abuse prevention for children, then BST techniques should be explored in sexual abuse prevention for people with learning disabilities.The other main conclusion is that existing research has typically measured improvements in knowledge but that these do not necessarily translate into action. Therefore, skills need to be assessed as outcomes. This can be done using role play and/*or in situ* assessment (i.e., under controlled conditions, using confederates to approach people to test their reactions).

SOCIAL CARE AND SOCIAL WELFARE: People with learning disabilities

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	discussed.	
Didden R, Duker PC, Korzilius H. Meta-analytic study on treatment effectiveness for problem behaviors with individuals who have mental retardation. American Journal of Mental Retardation 1997;101(4): 387-99.	A meta-analysis of 482 empirical studies on treatment of problem behaviors of individuals with mental retardation was conducted. A metric of treatment effectiveness was computed for 1,451 comparisons between baselines and treatments, 34 topographies of problem behaviour, and 64 treatment procedures.	Analysis of variance with percentage of nonoverlapping data as the dependent variable and comparison as the basic unit of analysis revealed that treatment of externally destructive behaviors had significantly lower mean percentage of nonoverlapping data scores than did treatment of socially disruptive and internally maladaptive behaviors. Response contingent procedures were significantly more effective than were other procedures. No significant interactions were found. Results of a stepwise regression showed that only performing a functional analysis made a significant contribution. These results may lead to more objective assignment of treatment procedures to problem behaviors.
Forness ST, Kavale KA. Treating social skill deficits in children with learning disabilities: A meta-analysis of the research. Journal of Learning Disabilities 1996;29:226-37.	A meta-analysis of 53 studies from the past 15 yrs on social skills training or intervention for children with learning disabilities (LDs).	Learning Disability Quarterly. 19, (1): 2-13 Although social skills deficits seem to be characteristic of children with LDs, such deficits appear highly resistant to treatment. Across the 53 studies analyzed, the training mean effect size obtained was only .211, with very few differences among teachers, peers, or children who judged effectiveness of training. Children with LDs seemed the most impressed with their social skills after training. However, peers without LDs tended to view the same results as significantly less positive. Teacher impressions were modest regarding the impact of training on overall social adjustment and almost negligible regarding intervention for such problems as conduct disorders or hyperactivity. Among all 3 groups, actual social interaction was rated among the least improved skills.
Feldman MA. Parenting education for parents with intellectual disabilities: a review of outcome studies. Research in Developmental Disabilities 1994;15(4):299-332.	Parents with intellectual disabilities (i.e., IQ < 80; mental retardation) are overrepresented in child maltreatment cases and have a variety of parenting skill deficits. Their children are at risk for neglect, developmental delay, and behavioral disorders. This review of parenting education interventions for such parents identified 20 published studies with adequate outcome data. A total of 190 such parents (188 mothers, 2 fathers), with IQs ranging from 50 to 79 were involved. Parenting skills trained included basic child-care, safety, nutrition, problem solving, positive parent-child interactions, and child behaviour management.	The most common instructional approach was behavioral (e.g., task analysis, modeling, feedback, reinforcement). Overall, initial training, follow-up, and social validity results are encouraging. Generalization and child outcome data are weak. Further research is needed to (a) identify variables associated with responsiveness to intervention, and (b) develop and compare innovative programs that teach parents with cognitive disabilities the necessary generalized skills to demonstrate long-term beneficial effects on their children.
Corrigan PW. Social skills training	A meta-analysis of 73 studies of social	Patients participating in social skills training programs broadened their repertoire of

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adult psychiatric populations: a meta-analysis. Journal of Behavior Therapy and Experimental Psychiatry 1991;22(3):203-10.	skills training in four adult psychiatric populations: developmentally disabled, psychotic, nonpsychotic and legal offenders	skills. Changes were maintained at several months follow-up. Patients showed reductions in psychiatric symptoms relating to social dysfunctions. Although results from ANOCVA comparing effect sizes across the four populations (with design quality as a covariate) were non-significant, consistent trends suggested that social skills training had the greatest effect on developmentally disabled groups and the least effect on offender groups. Social skills training was relatively more effective in outpatient than inpatient settings.

SOCIAL CARE AND SOCIAL WELFARE: Older people

CITATION	*REVIEW DETAILS*	*FINDINGS*
Cuijpers P. Psychological outreach programmes for the depressed elderly: A meta-analysis of effects and dropout. International Journal of Geriatric Psychiatry 1998;13(1):41-8.	A meta-analysis of the effectiveness of these 14 outreach programmes in which psychological treatment was offered to depressed elderly in the community.	The effect size is large (0.77), comparable to the effect sizes found in younger adults. In a regression analysis it was found that the effect sizes of cognitive behavioural therapies are larger than those of other therapies. The mean dropout rate is 23%. It was also found that dropout was larger in group interventions, in cognitive-behavioural therapies, in interventions with more female participants, and in interventions offering more sessions. It is noted that analyses of the dropout rate should be part of every meta-analysis of intervention studies.
Engels GI, Vermey M. Efficacy of nonmedical treatments of depression in elders: A quantitative analysis. Journal of Clinical Geropsychology 1997;l3(1):17-35.	Meta-analysis of 17 studies on the efficacy of nonmedical (psychological) treatments for depression in the elderly showed that treatment was more effective than placebo or no treatment. Effects were equal for mild and severe depression and proved to be maintained over time.	The mean effect size indicated that the mean treated client was better off than 74% of the clients in control conditions. Behavior therapy and cognitive-behavior therapy separately produced larger effect sizes than a combination (cognitive-behavior therapy), reminiscing therapy, and anger expression. The attention-placebo factor proved to be important. Individual therapy produced better results than group therapy. A number of client characteristics, treatment characteristics, and research characteristics had an impact on the magnitude of the effect sizes. Because of the small number of studies, the interdependence of these variables could not be studied. It is concluded that psychological therapies are effective for treating depression in the elderly. However, given the small sample size of this meta-analysis, the results have to be interpreted with caution.
Carlson M, Fanchiang SP, Zemke R, Clark F. A meta-analysis of the effectiveness of occupational therapy for older persons. American Journal of Occupational Therapy 1996;50(2): 89-98.	Conducted a meta-analysis to determine the degree of effectiveness of occupational therapy (OT) in enhancing the psychosocial well being, daily functioning, and physical health of older persons (mean age 60+ yrs). 15 relevant studies were included from various journals on OT and gerontology. The design variables included year of publication, type of research design, treatment setting, type of OT, duration of treatment, and type of outcome variable.	Results show that OT services for older people produced positive results across a wide range of treatment contexts. Beneficial effects of treatment extended to functional activities of daily living and psychosocial outcomes. Physical outcomes were also found to be beneficial, although not every meta-analytic test yielded such results. It is concluded that OT can contribute to the quality of life of elderly persons when incorporated in health care programs.
Evans RL, Connis RT, Hendricks RD, Haselkorn JK. Multidisciplinary rehabilitation versus medical care: A meta-analysis. Social Science and Medicine 1995;40(12).	A meta-analysis of 68 studies, published 1974-1994, to compare the effect of specialised rehabilitative care and conventional medical care on improvement of health outcomes on the basis of survival, functional ability, and discharge location.	Results indicated that rehabilitation services were significantly associated with better rates of survival and improved function during hospital stay, but significance was not observed at follow-up. Rehabilitation participants return to their homes and remain there more frequently than controls, function better at hospital discharge, and have a better chance of short term survival. However, long term survival and function were the same for experimental and controls. The sustaining benefit of returning home may justify inpatient rehabilitation, although services may need to be continued at home or in sub-

SOCIAL CARE AND SOCIAL WELFARE: Older people

CITATION	*REVIEW DETAILS*	*FINDINGS*
		acute care settings to optimise their effectiveness.
Scogin F, McElreath L. Efficacy of psychosocial treatments for geriatric depression: A quantitative review. Journal of Consulting and Clinical Psychology. 1994;62(1):69-73.	A meta-analysis of 17 studies examined the efficacy of psychosocial treatments for depression among older adults. Studies were included only if a comparison was made to a control condition (no treatment, delayed treatment, or placebo treatment) or another psychosocial intervention.	Results indicated that treatments were reliably more effective than no treatment on self-rated and clinician-rated measures of depression. Effect sizes for studies involving participants with major depression disorder were also reliably different from zero, as were effect sizes from studies involving participants with less severe levels of depression. These findings compare favorably with several other quantitative reviews of treatments for depression. Results suggest more balanced presentations of the potential benefits of psychosocial interventions are warranted.
Klawansky S. Meta-analysis on the treatment of depression in late life. In: L.S. Schneider, and C.F. Reynolds (Eds) Diagnosis and treatment of depression in late life: Results of the NIH Consensus Development Conference. Washington, DC 1994.	A meta-analysis of the diagnosis and treatment of geriatric depression. Based on randomised controlled trials published between 1960 and 1991 that compared [drug] treatments for depression in elderly patients.	Highlights the fact that the small number of RCTs makes it premature to expect to obtain summary results from formal meta-analyses of antidepressants.
Gorey KM, Cryans AG. Group work as interventive modality with the older depressed client: A meta-analytic review. Journal of Gerontological Social Work 1991; 16(1-2):137-57.	This review analyses 19 empirical studies dealing with the effectiveness of group work intervention with depressed older clients (aged 65+ years).	Overall, group work was found to account for 32% positive change in client affective states; however, most of this improvement (87%) appears to be attributable to non-specific interventive variables (i.e., factors outside the control and intent of the group worker). Group work is optimally effective for clients who live alone and are moderately to severely depressed. Client age is no factor in group work effectiveness, and the most effective format is constituted by small client groups and interventions of short duration.

SOCIAL CARE AND SOCIAL WELFARE: People with physical disabilities

CITATION	*REVIEW DETAILS*	*FINDINGS*
Mountain G. Occupational Therapy in Social Services Departments. A Review of the Literature. Exeter: Centre for Evidence-Based Social Services, University of Exeter/College of Occupational Therapists. 2000.	A narrative review of 150 published research sources on the effects of occupational therapy services in social services departments.	Outcomes of provision of equipment and housing adaptations are positive in the main from the service users' perspective, once the service has been received. However, the purported problem of non-utilisation and dissatisfaction with disability equipment is poorly researched. Work is needed to review whether users' experiences have improved in recent times. It is often difficult to isolate the specific outcomes of social services occupational therapy from the conclusions drawn from wider studies, which have looked at global outcomes of services to older people with disabilities. Studies which, have examined different factors which impact upon levels of independence (particularly for older people) suggest that the contribution of occupational therapists can be significant. Local authority occupational therapy is a specialist role which can be highly effective. However, outcomes are often compromised by requirements set by existing legislation and the need for better collaborative working between the different organizations who are required to be involved. There are benefits to be gained by specialist health services directly providing small items of equipment. Outcomes of equipment provision are demonstrably improved if time is spent educating people about correct usage. For those people who are hospitalised, there are strong arguments for commencing this education during admission, with follow up after discharge. Research also supports the value of follow up home visits to evaluate the effectiveness and safety of prescribed equipment, to determine the impact of education upon the confidence of the user, and to explore the contribution of the device towards the quality of their overall lifestyle. Studies demonstrates the adverse effects of disjointed, service led occupational therapy, particularly for people being discharged from hospital care. Research suggests that services can either be duplicated by hospital and social services employed occupational therapists, or conversely that services which are needed are not provided. Cessation of occupational therapy upon discharge from hospital can be highly detrimental for people with complex needs for rehabilitation. Evidence also demonstrates that assessments conducted in hospital prior to discharge do not accurately predict ability to cope once home. Outcomes for users and for services can be improved through close working relationships between occupational therapy and home care. Benefits can be derived from promoting independence and thus reducing demand for care services, and by training home care staff to prescribe simple pieces of equipment. Evidence demonstrates that access to community rehabilitation provided by occupational therapists can significantly improve outcomes for people who have had a CVA, and those who care for them. However, there are unanswered questions about whether this benefit is primarily a consequence of the provision of a dedicated service staffed by specialists;

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		or derived from rehabilitation provided in a community setting. There is little evidence of occupational therapy input or outcomes with respect to visual impairment or visual problems created by the environment, even though these are commonly encountered in the community, particularly among older people.
Godfrey M, Randall T, Long A, Grant M. Home Care: A Review of Effectiveness and Outcomes. Nuffield Institute of Health, University of Leeds; Health Care Practice Research and Development Unit, University of Salford. 2000.	A systematic review of published research articles on outcomes, and service-user/carer satisfaction with different models of home care provision. (Research addresses the methodological quality of 101 international studies)	Service users in all schemes have multiple health and social care needs. The most widely addressed services – outcome measures were community tenure and cost difference vis a vis hospital or other residential care and home care. No impact on acute hospital admissions was found. However, lower mortality rates were associated with the use of these services. Service users report good levels of satisfaction with service, improvements with health and social wellbeing. There was no favourable impact on carers however.
Bauman LJ, Drotar D, Leventhal JM, Perrin EC, Pless IB. A review of psychosocial interventions for children with chronic health conditions. Pediatrics 1997;100(2): 244-51.	A review of randomised controlled trials of the effectiveness of psychosocial interventions for children with chronic health conditions.	Some psychosocial interventions can help children and families cope with the psychological and social consequences of chronic health conditions. However there is a need for more methodologically rigorous evaluations.
Test DW, Wood WM. Natural supports in the workplace: The jury is still out. Journal of the Association for Persons with Severe Handicaps 1996;21(4):155-73.	The potential impact of natural supports on both supported employment policy and practice is considered, and a review of the research literature to document the contributions of strategies based on the concept of natural supports to supported employment is presented.	Results are discussed in terms of separating the concept of natural supports from strategies based on the concept of natural supports. Future research areas are examined, and the potential problems of having natural supports as policy without empirical support for practice.

SOCIAL CARE AND SOCIAL WELFARE: People with mental illness

CITATION	*REVIEW DETAILS*	*FINDINGS*
Pharoah FM, Mari JJ, Streiner D. Family intervention for schizophrenia [Cochrane Review] In: The Cochrane Library, Issue 2, 2000. Oxford: Update Software.	A systematic review of randomised and quasi-randomised controlled trials of the the effects of family psychosocial interventions in community settings for the care of those with schizophrenia or schizophrenia-like conditions compared to standard care.	Main results: Family intervention may decrease the frequency of relapse (one year OR 0.57 CI 0.4-0.8, NNT 6.5 CI 4-14). The trend over time of this main finding is towards the null and some small but negative studies may not have been identified by the search. Family intervention may decrease hospitalisation and encourage compliance with medication but data are few and equivocal. Family intervention does not obviously effect the tendency of individuals/families to drop out of care. It may improve general social impairment and the levels of expressed emotion within the family. This review provides no data to suggest that family intervention either prevents or promotes suicide. Reviewers' conclusions: Clinicians, researchers, policy makers and recipients of care cannot be confident of the effects of family intervention from the findings of this review. Further data from already completed trials could greatly inform practice and more trials are justified as long as their participants, interventions and outcomes are generalisable to routine care.
Lart R, Payne S, Beaumont B, Macdonald G, Mistry T. Women and secure psychiatric services: a literature review. CRD Report 1999;14:1-102.	A scoping review of services for mentally disordered women offenders which incorporates a review of the effectiveness of different service delivery models.	Women make up less than one-fifth of the population in secure settings in the UK, but are a heterogeneous group in terms of age, personal, psychiatric and forensic histories. As a group they differ from men in that they are less likely to have committed serious criminal offences but are more likely to have experienced previous psychiatric admissions. They had different patterns of diagnoses than men, being more likely to be diagnosed as having a personality disorder, or as having a borderline personality disorder. This is particularly true of women in medium secure services. Services in secure psychiatric settings either provide gender blind services (in which the particular needs of women are not considered) or include women as an 'afterthought'. Services do not address the needs of women, who often have histories of physical and sexual abuse. Research has not addressed the impact of available services on women and no studies exist on the effectiveness of psychiatric care for women in secure accommodation
Cuijpers, P. The effects of family interventions on relatives' burden: A meta-analysis 1999.	A meta-analysis is conducted to test the hypothesis that family interventions have a positive effect on the burden and distress of relatives of psychiatric patients	An analysis of the 16 studies that were found, indicate that family interventions can have considerable effects on relatives' burden, psychological distress, the relationship between patient and relative and family functioning. Interventions with more than 12 sessions have larger effects than shorter interventions. Several other success predictors can be hypothesised to be related to outcome.
McRoberts C, Burlingame GM, Hoag M, Cuijpers J. Comparative efficacy of individual and group psychotherapy: A meta-analytic perspective. Group Dynamics 1998;2(2):101-17.	Recent reviews of the group psychotherapy literature indicate that group is a beneficial and cost-effective treatment format. However, collective findings on the differential efficacy of group when compared with individual therapy remain problematic, incomplete,	Results were consistent with previous reports that indicated no difference in outcome between the group and individual formats. This finding generally held true when client, therapist, methodology, treatment, and group variables were examined for possible relationship with effect sizes comparing group and individual therapy. Results bolster past findings that group therapy can be used as an efficacious cost-effective alternative to individual therapy under many different conditions.

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	or controversial. To remedy this problem, the authors conducted a meta-analysis of 23 outcome studies that directly compared the effectiveness of the individual and group therapy formats when they were used within the same study.	
Baucom DH, Mueser KT, Daiuto AD, Stickle TR. Empirically supported couple and family interventions for marital distress and adult mental health problems. Journal of Consulting and Clinical Psychology 1998;66(1):53-88.	This article evaluates the efficacy, effectiveness, and clinical significance of empirically supported couple and family interventions for treating marital distress and individual adult disorders, including anxiety disorders, depression, sexual dysfunctions, alcoholism and problem drinking, and schizophrenia. In addition to consideration of different theoretical approaches to treating these disorders, different ways of including a partner or family in treatment are highlighted: (a) partner-family-assisted interventions, (b) disorder-specific partner-family interventions, and (c) more general couple-family therapy. Findings across diagnostic groups and issues involved in applying efficacy criteria to these populations are discussed	
Diamond GS, Serrano AC, Dickey M, Sonnis WA. Current status of family-based outcome and process research. Journal of the American Academy of Child and Adolescent Psychiatry 1996;35(1):6-16.	Reviewed advances in family-based therapy (FBT) research and their implications for future research. Selected studies on the treatment of schizophrenia, depression, anxiety, eating disorders, attention deficit, conduct disorder, and substance abuse are presented, as well as several process research and meta-analytic studies.	Results indicate that FBT has been shown to be effective for treating schizophrenia, conduct disorder, and substance abuse, and some data support their effectiveness in the treatment of eating disorders. Few studies have targeted internalising disorders. A process research tradition is emerging, but it is in need of methodological advances. Meta-analytic studies suggest that FBT is as effective as other models. The authors conclude that more well-designed studies with diverse populations are needed to assess accurately the effectiveness of this increasingly popular treatment approach.

SOCIAL CARE AND SOCIAL WELFARE: People with mental illness

CITATION	*REVIEW DETAILS*	*FINDINGS*
Taylor S. Meta-analysis of cognitive-behavioral treatments for social phobia. Journal of Behavior Therapy and Experimental Psychiatry 1996;27(1):1-9.	A meta-analysis was conducted using 42 treatment-outcome trials for social phobia. Six conditions were compared: Waiting-list control, placebo, EXP (within-session exposure and homework exposure), CT (cognitive restructuring without exposure exercises), CT + EXP, and SST (social skills training). All interventions, including placebo, had larger effect sizes than that of the waiting-list control, and the interventions did not differ in drop-out proportions. Only CT + EXP yielded a significantly larger effect size than placebo. Effects of treatments tended to increase during the follow-up period. These results support the use of cognitive-behavioral treatments for social phobia, especially the use of CT + EXP.	
Cook JA, Razzano LA, Straiton D, Madison RY. Psychosocial Rehabilitation Journal. 1994;17(3):103-16.	Explores the challenges faced when attempting to secure employment and ways in which rehabilitation staff can best market the value of working with persons with mental illness.	Research on employer attitudes, financial incentives, employment policies, job task analysis, job development efforts, and support is outlined. Results of a study of 62 employers and matched nonemployers of persons with psychiatric disabilities revealed that traditional concerns about workers with mental illness (poor social skills, behavior control problems, mental confusion) are not problematic issues for employers in long-term employment relationships.
Cook JA, Razzano LA, Straiton DM Ross Y. Cultivation and maintenance of relationships with employers of people with psychiatric disabilities. Psychosocial Rehabilitation Journal 1994;17(3):103-16.	Explores the challenges faced when attempting to secure employment and ways in which rehabilitation staff can best market the value of working with persons with mental illness. Research on employer attitudes, financial incentives, employment policies, job task analysis, job development efforts, and support is outlined.	Results of a study of 62 employers and matched non-employers of persons with psychiatric disabilities revealed that traditional concerns about workers with mental illness (poor social skills, behaviour control problems, mental confusion) are not problematic issues for employers in long-term employment relationships

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CITATION	*REVIEW DETAILS*	*FINDINGS*
Videka-Sherman L. 'Metaanalysis of Research on Social Work Practice in Mental Health' Social Work 1988;33:325-38.	A meta-analysis of 38 research studies on the effectiveness of social work practice in mental health, focusing on (1) relationships between intervention techniques and treatment efficacy and (2) services delivered by social workers to the chronically mentally ill.	Findings of Part 1, practice in outpatient settings, show that methodological and theoretical differences in effectiveness were small; however, certain practice techniques were associated with effectiveness. Findings of Part 2 indicate that successful practice involves considerable practitioner activity to engage and maintain clients in treatment, interventions to improve clients' living environments, and creation and support of clients' social networks.

Crime, Drugs and Alcohol

This section of the report summarises the findings of systematic reviews of the effects of interventions relevant to the prevention, treatment and control of crime, drug or alcohol abuse. It also includes summaries of systematic reviews of programmes relevant to improving the operations and management of the criminal justice system including services for victims of crime.

CRIME: Services for crime victims

CITATION	*REVIEW DETAILS*	*FINDINGS*
Holmes WC, Slap GB. Sexual abuse of boys: definition, prevalence, correlates, sequelae, and management. JAMA 1998;280(21):1855-62.	Publications were included in the review if they appeared in peer-reviewed journals 1985-1997; had clear research designs; reported results for at least 20 male subjects; and were not reviews, perspectives, theoretical treatises, editorials, or letters.	Evaluation of management strategies was limited. Sexual abuse of boys appears to be undertreated.
Comer EW, Fraser MW. Evaluation of six family-support programs: are they effective? Families in Society 1998;79(2):134-48.	Rigorous program evaluations for six family support programs	Program families demonstrated enhanced child, parent, and family functioning, as well as gains in both immediate and long-term effects on housing and income
Sherman JJ. Effects of psychotherapeutic treatments for PTSD: a meta-analysis of controlled clinical trials. Journal of Traumatic Stress 1998;11(3):413-35.	Sample included controlled, clinical trials of psychotherapeutic treatments for posttraumatic stress disorder (PTSD).	The impact of psychotherapy on PTSD and psychiatric symptomatology was significant when measured immediately after treatments were administered. Similarly, there was no delay in the effect of treatment at follow-up. Moreover, for target symptoms of PTSD and general psychological symptoms (intrusion, avoidance, hyperarousal, anxiety, and depression), effect sizes were non-trivial and statistically significant.
Reeker J, Ensing D, Elliott R. A meta-analytic investigation of group treatment outcomes for sexually abused children. Child Abuse and Neglect 1997;21(7):669-80.	Data were gathered from 15 studies that: investigated the effectiveness of group treatment for sexually abused youths, based results on empirical measures, and provided sufficient statistical information to calculate effect sizes.	The mean effect size across studies was 0.79. Effect-size comparisons based on response perspective and outcome variable groupings yielded no significant differences. Results support the conclusion that effective group treatments for sexually abused children and adolescents do exist.
Reddy LA, Pfeiffer SI. Effectiveness of treatment foster care with children and adolescents: a review of outcome studies. Journal of the American Academy of Child and Adolescent Psychiatry.	40 outcome studies published between 1974 and 1996	The analysis indicated that treatment foster care produced large positive effects on increasing placement permanency and children's social skills. Medium positive effects were found in reducing behaviour problems, improving psychological adjustment, and reducing the “restrictiveness” of post-discharge placement.

CRIME: Services for crime victims

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1997;36(5):581-8.		
Finkelhor D, Berliner L. Research on the treatment of sexually abused children: a review and recommendations. Child and Adolescent Psychiatry 1995;34(11): 1408-23.	29 studies that used quantitative outcome measures to evaluate the effectiveness of various therapeutic alternatives for sexually abused children.	The studies document improvements in sexually abused children consistent with the belief that therapy facilitates recovery; however, only five of the studies provide evidence that the recovery is not simply due to the passage of time or some factor outside therapy. The studies suggest that certain problems, such as aggressiveness and sexualized behavior, are particularly resistant to change and that some children do not improve.
Weaver TL, Clum GA. Psychological distress associated with interpersonal violence: a meta-analysis. Clinical Psychology Review 1995;15(2):115-40.	The present meta-analytic review examined the relationship between interpersonal violence and psychological distress, utilizing 50 published or prepublication empirical studies. Studies were included in the review if they quantified psychological distress following childhood sexual or physical abuse, rape, criminal assault, or partner (domestic) physical abuse or rape.	The overall effect size, though heterogeneous, was clinically and practically significant, demonstrating empirically that interpersonal violence has deleterious effects on psychological functioning. Within victimized groups, specific objective and subjective stressor-related factors were examined for the magnitude of their effect on resulting psychological distress. Subjective factors, such as general appraisal, self-blame, and perceived life threat, contributed twice as much to the magnitude of psychological distress as did objective factors, such as physical injury, force, and use of a weapon. Generally, psychological distress in the domains of intra- and interpersonal functioning emerged as theoretically and clinically important avenues for further research.
Chard KM. A meta-analysis of posttraumatic stress disorder treatment outcome studies of sexually victimized women [dissertation]. Indiana University . Dissertation Abstracts International 1995;55/10-B:4589.	The purpose of this study was to examine the available treatment outcome studies on female rape, abuse, and/or battery survivors diagnosed with PTSD using systematic review procedures outlined by Rosenthal. Only studies on group and individual treatment interventions with comparison/control groups or pre-posttest measures were selected for the analysis.	The systematic review of effects (N = 467) from 14 studies showed an average effect size of just under one and a half standard deviations (Cohen d = 1.457) on multiple measures. Cognitive and psychodynamic interventions were found to have greater impact than supportive or cognitive-behavioral interventions. While all included treatments were effective, cognitive therapy offered in sequential individual sessions was the statistically superior intervention model. These objective and replicable conclusions should provide direction to psychological practitioners as to the most empirically effective intervention for the treatment of PTSD in sexually victimized women.
Oates RK, Bross DC. What we have learned about treating child physical abuse? A literature review of the last decade. Child Abuse and Neglect 1995;19(4):463-73.	Articles were included in the review if they had more than five subjects in the sample; had at least 15 percent of the children in the sample having been physically abused; and used a pretest and posttest measure, a comparison group, or randomization between different treatment in the design. Results show that 12 papers meeting these criteria for abusive parents and 13 for treatment of abused children were found, 1983-1992.	Although most programs showed some improvement with treatment, many had no, or very short, follow-up to determine if improvement was sustained.
Beaulieu KM. Meta-analysis of	The purpose of this study was to conduct a	Results of the study show that group psychotherapy is an effective treatment

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psychotherapeutic treatments with adult survivors of incest [dissertation]. University of Northern Colorado, Psy.D. dissertation; Dissertation Abstracts International 1994;55/05-B: 2001.	systematic review of articles pertaining to the psychotherapeutic treatment results of working with adult incest survivors. Over 400 articles pertaining to incest were initially identified through extensive electronic literature searches. Of those articles, only ten met the criteria of listing quantified information pertaining to the results of psychotherapeutic treatment of adult incest survivors. Of those ten, only three contained statistical data that specifically pertained to documented changes in incest survivors as a result of psychotherapeutic treatment, and only two contained sufficient data to compute effect size.	condition for adult survivors of incest. Also, based upon the data in the selected studies, the women who sought treatment after being incested as children: were in their early thirties; had sought some type of previous psychotherapeutic treatment; had been incested by their biological fathers to a greater percent and had been incested at a younger age and for a longer period of time than previous indicated. Recommendations for future research are: (1) More data needs to be collected pertaining to the results of working with incest survivors. This data needs to be collected for both individual and group psychotherapy. Data needs to be collected regarding working with male incest survivors. The data needs to differentiate between types of abuse, i.e., incest and rape. For groups, it needs to be determined what are the optimum number of sessions. (2) It should be examined whether or not it is beneficial to the incest survivors to attend individual psychotherapy simultaneously with group psychotherapy. (3) It needs to be determined which psychotherapies are most effective for treating incest survivors. (4) The diagnosis of Post Traumatic Stress Disorder may be inappropriate for some incest survivors. Because of the importance of a diagnosis in treatment planning, this area also needs investigation. (5) An investigation needs to be conducted concerning the effectiveness of including family members in the treatment procedure.
Wolfe DA, Wekerle C. Treatment strategies for child physical abuse and neglect: a critical progress report. Clinical Psychology Review 1993;13:473-500.	Twenty-one studies reporting on treatment outcomes with abusive and-or neglectful parents and their children.	Findings support the significance of parent-focused interventions that include well-specified training components aimed at improving child-rearing competence and stress management. In addition, therapeutic programs for child victims show value in regaining some of the developmental milestones and peer competencies often lagging in maltreated children.
O'Donohue WT, Elliott AN. Treatment of the sexually abused child: a review. Journal of Clinical Child Psychology 1992;21(3):218-28.	Eleven treatment outcome studies of sexually abused children were located through various methods.	No study has demonstrated definitively the efficacy of any treatment method.
Coln, Harris A, Daro D. Is treatment too late: what ten years of evaluative research tell us. Child Abuse and Neglect: The International Journal 1987;11(3):433-42.	Evaluations of 89 federally funded demonstration programs for child abuse and neglect treatment (involving 3,253 families) in the United States were studied.	Treatment programs for abusers and their victims do not seem to be effective.

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Dinh-Zarr T, DiGuiseppi C, Heitman E, Roberts I. Interventions for preventing injuries in problem drinkers [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000.Oxford: Update Software.	Twelve computerized databases: MEDLINE (1966-8/96), EMBASE (1982-1/97), Cochrane Controlled Trials Register (1997, issue #1), PSYCHINFO (1967-1/97), CINAHL (1982-10/96), ERIC (1966-12/96), Dissertation Abstracts International (1861-11/96), IBSS (1961-1/97), ISTP (1982-1/97) and three specialized transportation databases, using terms for problem drinking combined with terms for controlled trials; bibliographies of relevant trials; and contact with authors and government agencies. Selection criteria: Data Selection.- Randomized controlled trials of interventions among participants with problem drinking, which are intended to reduce alcohol consumption or to prevent injuries or their antecedents, and which measured injury-related outcomes. Of 7014 studies identified, 19 (0.3%) met the inclusion criteria. Data collection and analysis: Data Extraction.- Two authors extracted data on participants, interventions, follow-up, allocation concealment, and outcomes, and independently rated allocation concealment quality.	In completed trials, interventions for problem drinking were associated with reduced suicide attempts, domestic violence, falls, drinking-related injuries, and injury hospitalizations and deaths, with reductions ranging from 27-65%. Several interventions among convicted drunk drivers reduced motor vehicle crashes and injuries. Because few trials were sufficiently large to assess effects on injuries, individual effect estimates were imprecise. We did not combine the results quantitatively because the interventions, patient populations, and outcomes were so diverse. Reviewers' conclusions: Conclusion.- Interventions for problem drinking may reduce injuries and their antecedents. Because injuries account for much of the morbidity and mortality from problem drinking, further studies are warranted to evaluate the effect of treating problem drinking on injuries.
Mentore JL. The Effectiveness of Early Intervention with Young Children 'At Risk': A Decade in Review. Ph.D. Dissertation, Fordham University, DAI-B 60/07, p. 3573, Jan 2000.	The goal of this systematic review was to synthesize research on the effectiveness of early intervention programs with children at-risk and to examine the contributions of specific mediating variables to these programs. Overall, 86 studies from 1986 through 1998 were examined. A total of 319 effect sizes were yielded from the total sample, and 185 effect sizes were yielded from the sample of high quality studies.	The primary analysis assessed the overall efficacy of early intervention for at-risk children. This analysis indicated that early intervention programs are efficacious for at-risk children and did not reveal any significant differences between specific types of early intervention programs (i.e., educational, psychological, medical, and mixed). The secondary analysis explored specific program variables that have contributed to efficacy. This analysis indicated that efficacious programs were those that were structured and utilized trained intervenors. This analysis also showed that early intervention programs were more effective for low birthweight/premature children than economically/socially disadvantaged children. There were several variables that did not contribute to early intervention efficacy. Less intense programs were found to be as effective as more intense programs. Similarly, there was no evidence to suggest that early intervention programs with a longer duration were more effective. The location of the early intervention

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		program, degree of parental involvement, and time period of study also did not impact efficacy. There was inconclusive evidence regarding whether there was a specific age when early intervention programs were most effective. The third level of analysis was conducted separately from the systematic review. This analysis assessed whether early intervention studies utilized non-traditional (e.g., adaptive behavior, attachment) outcome measures over time. This analysis revealed that within the past decade, non-traditional measures have been used as frequently as traditional measures. In sum, these findings provide more definitive conclusions on the positive impact of early intervention programs for this newer at-risk population, and there are several mediating variables impacting efficacy. This study also revealed that early intervention studies have kept abreast of the research demands of this field by the utilization of non-traditional outcome measures.
Lart R, Payne S, Beaumont B, MacDonald G, Mistry T. Women and secure psychiatric services: a literature review. CRD Report 1999;14:1-102	To examine the evidence for effectiveness and efficiency of different service delivery models. Type of intervention. Management. Specific interventions included in the review interventions/regimes in services for women assessed as needing psychiatric care in conditions of security. Participants included in the review. Women admitted for secure psychiatric care. Outcomes assessed in the review. A "subjective rating" (as defined by the authors of the study concerned) of progress, based on subsequent psychiatric condition, behaviour in and out of hospital or prison, work record, further court appearances and hospital re-admissions. Study designs of evaluations included in the review. Initially, all studies which provided information on short, medium or long-term outcomes of interventions regimes in services for women assessed as needing psychiatric care in conditions of security were included. The authors then intended to apply stricter criteria, but no papers met this second set of criteria. Length of follow up was not reported, even though data extraction forms suggest this information was collected. What sources were searched to identify primary	Results of the review. Of the 33 women included, 32 women were followed up (one escaped). Of these, 18 were given a rating of "poor" outcome, and 14 one of "good" outcome. The group of woman admitted from other psychiatric hospitals, particularly those admitted following violence in hospital, tended to have poorer outcomes than those admitted from the courts. Outcome was not related to length of stay. Was any cost information reported? No. Author's conclusions. Only one study was identified examining the effectiveness of psychiatric care. This study found a poorer outcome amongst women admitted from psychiatric hospital compared with women admitted from courts. CRD commentary. This abstract focuses only on the "effectiveness of psychiatric care" section of a larger review entitled "Women and secure psychiatric services: a literature review". This section addresses a well defined research question. The literature search was very thorough, but only one study was found. Appropriate inclusion and exclusion criteria are reported. The study was summarised appropriately. Some details of the individual study were included, although it would have been useful to include information about the age of participants and the length of follow up. The validity of the included study was not assessed. The authors present a thorough review, but the conclusions that can be drawn from it are limited, due to the fact that only one relevant study was found. The design of the included study was not clearly described. The characteristics of women admitted from psychiatric hospitals were likely to be different from those from courts. Thus the study result should not be used to evaluate the relative effect of different service delivery models. What are the implications of the review? The authors stress that there is a key gap in the knowledge about the effects of different service models. They suggest

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	studies? The following databases were searched: MEDLINE (1972 to June 1997), EMBASE (1980 to 1997), PsycLIT (1972 to June 1997), Sociofile (1974 to June 1997), Cochrane Library(1997 issue 3), SIGLE (Blaiseline On-line), Mental Health Abstracts (DIALOG On-line). The search terms were provided. Calls for information were sent to government departments, professional organisations, relevant agencies and key researchers and authors. Criteria on which the validity (or quality) of studies was assessed. Not stated. How were decisions on the relevance of primary studies made? Judgements about inclusion were made by two independent reviewers. Disagreements were to be resolved by discussion between assessors, and reference where necessary to a third member of the team -however, this did not prove necessary. How were judgements of validity (or quality) made? Not stated. How was the data extracted from primary studies? The number of authors who extracted data from the primary studies was not stated. Data were retrieved from case records of hospitals and prisons and then extracted onto previously designed data extraction forms. Number of studies included in the review One cohort study, comprising 33 participants. How were the studies combined? Not applicable, as only one relevant study was found. How were differences between studies investigated? Not applicable, as only one relevant study was found.	the opportunity for developing and monitoring different service models should be taken and comparative evaluation studies carried out. The authors note that Dolan and Coid (1993; see Other Publications of Related Interest) found no outcome studies of treatment regimes provided in secure conditions which provided separate data on woman. Dolan and Coid (1993) suggest "there is a need for new research strategies which take a naturalistic approach by following large cohorts of patients through a number of statutory and voluntary treatment, with differing levels of security, within health, social and penal services". The authors state that although they are referring to specific diagnostic groups, this suggestion is a reasonable one to apply more generally to women who experience the secure psychiatric services.
Elvik R. The effects on accidents of studded tires and laws banning their use: a meta-analysis of evaluation studies. Accident Analysis and Prevention 1999;31(1-2):125-134.	Two types of studies are reviewed: (1) studies of the effect on accidents of studded tires; (2) studies of the effect on accidents of laws banning the use of studded tires.	Varies considerably, but recent studies employing multivariate statistical techniques have found 2-5% reductions in accidents.

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Von Hirsch A, Bottoms AE, Burney E et al. Criminal deterrence and sentence severity: an analysis of recent research Oxford, UK: Hart. 1999.	A review examines recent research addressing the potential impact on general deterrence of increasing sentence severity, particularly the use and length of custodial sentences. The review also considers the marginal deterrent impact of altering the certainty of punishment (apprehension and/or conviction) for a particular crime.	The research clearly suggests that punishment has deterrent effects: when potential offenders recognize the substantial risks of punishment, many desist from offending. Research on marginal deterrence - how much extra deterrence is achieved by get-tough policies of increased severity or certainty – is less clear, with a notable distinction between certainty and severity impacts. While increasing punishment certainty influences deterrence, evidence on enhancing sentence severity is not as convincing, and fails to distinguish how much additional punishment would be necessary. Deterrence policy should be gauged in relation to: its costs; the likelihood of substantial deterrence effects and counterproductive impacts; tensions with concerns for proportionality; and possible alternative crime prevention strategies.
Grossman DC, Garcia CC. Effectiveness of health promotion programs to increase motor vehicle occupant restraint use among young children. American Journal of Preventive Medicine 1999;16(1): 12-22.	To review the effectiveness of nonlegislative community and clinical programs to increase the rate of child motor vehicle occupant restraint use among children under the age of 5 years. METHOD: This was a systematic review of the world's published literature. The Cochrane Collaboration protocol was used to conduct the literature search. The following databases were searched for literature on this topic: MEDLINE, EMBASE, NTIS, PsychINFO, ERIC, Nursing and Allied Health, Transportation Research and Information Service, and EI Compendex. The bibliographies of relevant publications were used to search for additional references. SELECTION CRITERIA: Studies were included if they evaluated a clinical or community-based intervention designed to increase the use child restraint devices among motor vehicle passengers under the age of 5 years. Studies of the effects of legislation or law enforcement programs were excluded. All study design types, including randomized controlled trials, controlled trials, and controlled or uncontrolled pre/post evaluations were included. Studies were excluded if there was either no control group or no baseline data	A total of 18 studies met inclusion criteria for in-depth review. Pooling of results was not possible because of the large differences between studies with regard to study design, settings, target groups, intervention methods, and units of analysis. There were a total of three randomized controlled trials, four controlled trials without random individual or group assignment, three controlled pre-post evaluations, and eight uncontrolled pre/post studies. Among preschool programs, short-term absolute percentage point gains in seat belt use rates ranged from 12% to 52% but only from 8% to 14% one month or more after the intervention. Among community-based media campaigns, long-term child restraint use increased by an absolute margin of 5% to 14%. Of the eleven peripartum counseling programs, long-term follow-up revealed gains of 6% to 27% with most between 10% to 15%. Many studies had serious design flaws that could overestimate the magnitude of the effect. CONCLUSIONS: Programs to increase the rate of child restraint use among child occupants of motor vehicles appear to have overall moderate short-term effectiveness. The magnitude of the positive program effects one or more months after the intervention appear to diminish substantially. There is a strong need for high quality randomized controlled trials to determine the long-term effectiveness of child restraint promotion programs.

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	with which to compare outcome data. Studies were also excluded if they did not use observed restraint use as at least one of the outcome measures. DATA COLLECTION: Each study was reviewed in depth with special attention to the strength of study design. Outcomes were assessed in terms of the absolute difference in observed restraint use within and/or between groups across study intervals.	
Phillips C. A review of CCTV evaluations: crime reduction effects and attitudes towards its use. In Kate Painter and Nick Tilley (eds.) Surveillance of Public Space: CCTV, Street Lighting and Crime Prevention. Monsey, NY: Criminal Justice Press 1999:123-56.	A review analyzes studies that have evaluated the effectiveness of closed-circuit television (CCTV) in reducing crime, disorder and fear of crime in a variety of sites	CCTV can be effective in deterring property crime, but the findings are more mixed in relation to personal crime, public order offenses, and fear of crime.
Segui-Gomez M. Evaluating interventions that promote the use of rear seats for children. American Journal of Preventive Medicine 1999;16(1):23-9.	Cochrane review, examined 4 studies that tested effects of law banning front seat use for children (along with two studies that looked at mass media campaign).	Laws prohibiting children to sit in front seats produces a non-significant increase in children riding in back seats.
Murphy-Brennan MG, Oei TP. Is there evidence to show that fetal alcohol syndrome can be prevented? Journal of Drug Education 1999;29(1):5-24.	Review effectiveness of prevention programs in lowering incidence of FAS.	Programs are successful in raising awareness, but no in behavioral change in "high risk" groups.
Wekerle C, Wolfe DA. Dating violence in mid-adolescence: Theory, significance, and emerging prevention initiatives. Clinical Psychology Review 1999;19:435-56.	Review of 6 relationship violence prevention programs designed for and delivered to youth.	Programs addressed specific skills and knowledge that oppose the use of violent and abusive behavior toward intimate partners; 1 program addressed interpersonal violence more generally, and was also included in this review because of its implications for dating violence initiatives. Positive changes were found across studies in violence-related attitudes and knowledge; also, positive gains were noted in self-reported perpetration of dating violence, with less consistent evidence in self-reported victimization. However, these findings should be considered preliminary due to limited follow-up and generalizability.

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Pease K. A review of street lighting evaluations: crime reduction effects. In Kate Painter and Nick Tilley (eds.) Surveillance of Public Space: CCTV, Street Lighting and Crime Prevention. Crime Prevention Studies, Monsey, NY: Criminal Justice Press. 1999;10:47-76.	A review analyzes the literature on the effectiveness of street lighting improvements in preventing crime.	The following conclusions are supported: (1) Precisely targeted increases in street lighting generally have crime reduction effects. (2) More general increases in street lighting seem to have crime prevention effects, but this outcome is not universal. Older and U.S. research yield fewer positive results than more recent U.K. research. (3) Even untargeted increases in crime prevention generally make residents less fearful of crime or more confident of their own safety at night. (4) In the most recent and sophisticated studies, street lighting improvements have been associated with crime reductions in the daytime as well as during the hours of darkness. (5)The debate about lighting effects has served to preclude a more refined analysis of the means by and circumstances in which lighting might reduce crime.
Poikolainen K. Effectiveness of brief interventions to reduce alcohol intake in primary health care populations: a meta-analysis. Preventive Medicine 1999;28(5):503-9.	Earlier meta-analyses have not made a distinction between very brief (5- to 20-min) interventions and extended (several visits) brief interventions. METHODS: Literature searches identified seven publications, comprising 14 data sets, meeting the inclusion criteria: sampling from primary care populations, random allocation to intervention and to control groups, and follow-up time 6-12 months.	For very brief interventions, the change in alcohol consumption was not significant among men nor among women. For extended brief interventions, the pooled effect estimate of change in alcohol intake was -51 g of alcohol per week (95% confidence interval -74, -29) among women. Among men the estimate was of similar magnitude, but significant lack of statistical homogeneity implied that the summary estimate was not meaningful. Significant statistical heterogeneity was observed when data on very brief interventions among men and women were pooled. That was the case also for gamma-glutamyltransferase activity. CONCLUSIONS: Extended brief interventions were effective among women. Other brief interventions seem to be effective sometimes, but not always, and the average effect cannot be reliably estimated. The reasons for the lack of uniform effectiveness should be explored.
Tobler NS, Lessard T, Marshall D, Ochshorn P, Roona M. Effectiveness of school-based drug prevention programs for marijuana use. School Psychology International 1999;20:105-137.	37 evaluations of universal drug use prevention programs (e.g., D. Ary et al, 1989) implemented in American schools between grades 6-12 were quantitatively synthesized by coding program characteristics and calculating weighted effect sizes (WES) for marijuana use. Programs, a subset of those reported in the systematic review by N. Tobler and H. Stratton (1997), were divided into 2 types, Interactive and Non-Interactive, based on a combination of content and delivery method. To determine the characteristics of programs that most effectively reduce, delay or prevent marijuana use, a weighted least squares multiple	Program type and sample size were found to be significant predictors of program effectiveness. Non-Interactive lecture-oriented prevention programs that stressed knowledge about drugs or affective development of students showed minimal reductions in marijuana use. Interactive programs that fostered the development of social competencies showed greater reductions in marijuana use. The primary finding for prevention program planners is that interactive cultivation of social skills reduces marijuana use.

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	regression analysis was performed using the WES of marijuana use as the dependent variable, type of program as the predictor and sample size as an additional covariate.	
Posavac EJ, Kattapong KR, Dew DE. Peer-based interventions to influence health-related behaviors and attitudes: a meta-analysis. Psychological Reports 1999;85: 1179-94.	The effects of 47 peer-based health education programs described in 36 published studies were examined.	The overall effect size was small: the mean d was .190 when controls received no program and .020 when controls received an alternative program. Programs were divided into those focusing on preventing or reducing smoking and programs on other health issues; the latter were further divided into primary prevention and secondary prevention programs. Differences among studies suggested several biases likely to have influenced the effect sizes. Preventive interventions that produce only small effects can be valuable because many participants would not have developed the problem even without the program. This review suggested that, when health education programs are studied, (a) detailed statistical information should be provided to facilitate using the research findings in meta-analyses and (b) the costs of innovative programs should be presented to judge whether the results are worth the cost.
Cohen JH, Larkin GL. Effectiveness of ignition interlock devices in reducing drunk driving recidivism. American Journal of Preventive Medicine 1999;16:81-7.	Cochrane review was conducted. Ten studies met selection criteria; six studies left in final analysis.	Five of the six studies found that ignition interlock devices were effective in reducing drunk driving – while the interlock was installed in the car. Reductions on the order of 15-69%.
Cross JE, Saunders CM, Bartelli D. The effectiveness of educational and needle exchange programs: a meta-analysis of HIV prevention strategies for injecting drug users. Quality and Quantity 1998;32:165-180.	A systematic review of educational interventions and needle exchange programs (total N = 26 studies, published 1984-1995) was performed to estimate the effectiveness of reducing human immunodeficiency virus (HIV) risk behaviors in the injecting drug user population. Information on intervention, outcome, design and demographics was coded and analyzed.	The weighted mean effect size for the 6,251 study subjects of the 16 educational interventions was 0.749 (95% CI, 0.708 to 0.790), and the weighted mean effect size for the 1,675 study subjects of the 10 needle exchange programs was 0.279 (95% CI, 0.207 to 0.352), suggesting that both interventions had a positive impact on reducing HIV risk behaviors associated with injecting drug use. However, results were dependent on research design, outcome type, and follow-up time.
Durlak JA, Wells AM. Evaluation of indicated preventive intervention (secondary prevention) mental health programs for children and adolescents. American Journal of Community Psychology 1998;26 (5):775-802.	Evaluated the outcomes of 130 indicated preventive interventions (secondary prevention) mental health programs for children and adolescents that seek to identify early signs of maladjustment and to intervene before full-blown disorders develop.	Results indicate such programs significantly reduce problems and significantly increase competencies. In particular behavioral and cognitive-behavior programs for children with subclinical disorders (mean ESs in the 0.50s) appear as effective as psychotherapy for children with established problems and more effective than attempts to prevent adolescent smoking, alcohol use, and delinquency. In practical terms the average participant receiving behavioral or cognitive-behavior intervention surpasses the

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		performance of approximately 70% of those in a control group. Of particular interest was the high mean effect (0.72) achieved by programs targeting incipient externalizing problems which are customarily the least amenable to change via traditional psychotherapeutic efforts when they reach clinical levels. priorities for future research include greater specification of intervention procedures, assessment of treatment implementation, more follow-up studies, and identifying how different participants respond to early intervention.
Zoritch B, Roberts I, Oakley A. The health and welfare effects of day-care: a systematic review of randomised controlled trials. Social Science and Medicine 1998;47(3): 317-27.	Randomized controlled trials of day care for preschool children were identified using electronic databases, hand searches of relevant literature, and contacts with authors, yielding eight usable trials, all from the US.	Results generally showed that day care promotes children's intelligence, development, and school achievement. Long-term follow-up demonstrates increased employment, lower teenage pregnancy rates, higher socioeconomic status, and decreased criminal behavior. There are positive effects on mothers' education, employment, and interaction with children; effects on fathers have not been examined. However, the trials had significant methodological weaknesses, pointing to the importance of improving on study design in this field. There is a need for well-designed research on day care to provide an evidence base for social policy in GB and elsewhere.
Coben JH, Larkin GL. Effectiveness of ignition interlock devices in reducing drunk driving recidivism. American Journal of Preventive Medicine 1998;16(1S):81-7.	A review analyzes 6 methodologically-screened studies of the impact of ignition interlock devices on driving while intoxicated (DWI) recidivism.	Five of the 6 studies found interlocks to be effective in reducing DWI recidivism while the interlock was installed in the car. In these 5 studies, participants in the interlock programs were 15%-69% less likely than controls to be re-arrested for DWI. The only randomized, controlled trial demonstrated a 65% reduction in rearrests for DWI in the interlock group. Future studies should attempt to control for exposure (i.e., number of miles driven) and determine if certain subgroups are most benefited by interlock programs.
Roth J, Brooks-Gunn J, Murray L, Foster W. Promoting healthy adolescents: Synthesis of youth development program evaluations. Journal of Research on Adolescence 1998;8:423-59.	Evaluates the usefulness of the youth development framework based on 15 program evaluations.	First, programs incorporating more elements of the youth development framework seem to show more positive outcomes. Second, the evaluations support the importance of a caring adult-adolescent relationship, although these relationships need not be limited to 1-on-1 mentoring. Third, longer term programs that engage youth throughout adolescence appear to be the most effective.
White D, Pitts M. Educating young people about drugs: a systematic review. Addiction 1998;(10):1475-87.	To assess the effectiveness of interventions directed at the prevention or reduction of use of illicit substances by young people, ages 8-25, a systematic review was conducted of methodologically well-designed studies that reported evaluations of such interventions.	Findings indicate that effort needs to be directed toward development of improved evaluative solutions to the problems posed by these target groups. There is still insufficient evidence to assess the effectiveness of the range of approaches to drug education; more methodologically sound evaluations are required. There is also a need to target interventions to reflect the specific needs and experiences of recipients.

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Kellermann A, Fuqua-Whitley DS, Rivara FP, Mercy J. Preventing youth violence: what works. Annual Review of Public Health 1998;19:271-92.	A wide variety of programs have been implemented in an attempt to prevent youth violence or reduce its severity. Few have been adequately evaluated.	In general, interventions applied between the prenatal period and age 6 appear to be more effective than interventions initiated in later childhood or adolescence. Community-based programs that target certain high-risk behaviors may be beneficial as well.
Farrell G. A global empirical review of drug crop eradication and United Nations' crop substitution and alternative development strategies. Journal of Drug Issues 1998;28(2):395-436.	A review evaluates 2 decades of United Nations programs in 11 countries to reduce illicit cultivation of coca bush, opium poppy and cannabis.	Programs encouraging farmers to cultivate alternative crops have had little if any significant impact on illicit cultivation at the national and regional levels, and less at the global level. There is some evidence that, within targeted areas, alternative development work can facilitate a transition from illicit to licit cultivation if: (1) There is effective control of an area by a central government, and an absence or weakening of insurgent groups; (2) Market forces make illicit cultivation less attractive, primarily because of increased competition from expanding illicit cultivation elsewhere; and (3) Disincentives are consistently applied through law enforcement and eradication. When these 3 prerequisites converge, incentives in the form of reasonable alternative sources of income may make a negotiated reduction in illicit cultivation attractive within a specific area.
Cornah DK, Stein K, Stevens A. The therapeutic community method of treatment for borderline personality disorder. Southampton: Wessex Institute for Health Research and Development. 1997.	The electronic databases Medline, Embase, HealthPlan, GEARS, BIDS, PsycLit, NRR, DARE and the Cochrane Database were searched.	Results of the review. Treatment effects are difficult to summarise given the heterogeneity of the client group and methodological problems. Clinically significant improvements have been reported in up to 40% of clients, including changes in psychometric test performance, reduction in deliberate self-harm, fewer hospital admissions (but increased outpatient service use) and reduced criminal behaviour. Was any cost information reported? To put a patient in a therapeutic community costs 1115 GBP per week. In a survey of 29 patients, the mean cost of their use of the mental health and prison services in the year before their admission to a therapeutic community was 14,590 GBP per patient. A 7-month stay in a therapeutic community costs 23,310 GBP per patient. Another study found that the average annual cost of psychiatric and prison services was 13,966 GBP pre-treatment compared with1,308 GBP post-treatment representing a saving of 12,658 GBP per patient. The average cost of the specialist admission was 25,641 GBP. The costs concerned could therefore be re-couped within two years and represent a saving thereafter if treatment effects are sustained. However, costs pre- and post-treatment were not discounted to allow valid comparison, and other important costs (eg. primary care, probation service, social services) were not considered. Author's conclusions There have been no randomised controlled trials of the approach. Observational studies show potentially important clinical effects which may be associated with some savings to secondary care and prison services, although the validity of these findings

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		remains open to some doubt. Importantly, it remains impossible to conclude which people would be expected to benefit. The authors conclude that the treatment's validity is not proven
Mullen PD, Simons-Morton D, Ramirez G, Frankowski RF, Green LW, Mains DA. A meta-analysis of trials evaluating patient education and counseling for three groups of preventive health behaviors. Patient Education and Counseling 1997;32 (3):157-73.	Conducted a meta analysis to examine the overall effectiveness of patient education and counseling on preventive health behaviors and to examine the effects of various approaches for modifying specific types of behaviors. Computerized databases and bibliographies from 1971 to 1994 served as data sources. Randomized and non-randomized controlled trials measuring behavior in clinical settings with patients without diagnosed disease were included in the analysis. Behaviors were grouped based on whether the behavior is addictive and whether the desired change required subtraction of existing behaviors or adding new behaviors.	The weighted average effect size from a random effects model for smoking/alcohol studies was 0.61, for nutrition/weight, 0.51, and for other behaviors, 0.56, indicating that the behavioral outcomes for these subgroups were significantly different from zero. Multiple regression models for the 3 groups indicated that using behavioral techniques, particularly self-monitoring, and using several communication channels (e.g., media plus personal communication), produces larger effects for the smoking/alcohol and nutrition/weight groups.
Minozzi S, Grilli R. [The systematic review of studies on the efficacy of interventions for the primary prevention of alcohol abuse among adolescents]. [Review] [Italian]. Revisione sistematica degli studi sulla efficacia degli interventi di prevenzione primaria dell'abuso di alcool fra gli adolescenti. Epidemiologia e Prevenzione 1997;21(3):180-8.	PURPOSE OF THE STUDY: To evaluate the effect of educational preventive interventions addressed to youths from 10 to 18 years old on alcohol use. MATERIALS AND METHODS: We have done a systematic review of articles indexed on Medline between 1983 and July 1995. We also consulted the bibliography of the articles retrieved for further references. Randomized controlled trials using alcohol consumption as outcome measure have been included.	Of the 100 articles found only 21 were included, in which 27 preventive programs, using 5 different types of intervention, were evaluated. Only 3 resulted effective on all the outcome measures utilized and 6 were partially effective. Overall the methodological quality was low. CONCLUSIONS: The low methodological quality and the great variability of outcome measures utilized made it difficult to compare the results of different studies and impossible to reach definitive conclusions. All the studies were done in the United States and therefore their results cannot be presently generalized to Italy. Consequently, prior to implementing expensive prevention programs in the Italian schools, it would be opportune to perform further well-designed effectiveness trials.
Tobler NS, Stratton HH. Effectiveness of school-based drug prevention programs: a meta-analysis of the research. Journal of Primary Prevention 1997;18(1):71-128	Examines the effectiveness of different types of drug prevention programs through systematic review of 120 school-based programs (grades 5-12) that evaluated success on self-reported drug use measures.	Findings indicated that interactive programs were statistically and clinically superior to the noninteractive programs for self-reported reduction of use of tobacco, alcohol, marijuana, and illicit drugs, and for all adolescents including minority populations. The larger interactive programs were less effective, although still significantly superior to the noninteractive programs, suggesting implementation failures.

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Foxcroft DR, Lister-Sharp D, Lowe G. Alcohol misuse prevention for young people: a systematic review reveals methodological concerns and lack of reliable evidence of effectiveness. Addiction 1997;92(5):531-537.	Author's objective. To assess the effectiveness of alcohol misuse prevention programmes with young people and the methodological quality of the evaluations. Type of intervention. Prevention. Specific interventions included in the review. Prevention programmes for alcohol misuse, whether primary prevention measures to arrest onset of alcohol use or secondary prevention measures to minimise alcohol misuse. Participants included in the review. Young people aged 8 to 25 years. No other subject characteristics are provided. Outcomes assessed in the review. Outcomes reported included changes in actual or self-reported drinking behaviour and changes in alcohol related incidents such as accidents or crime. Study designs of evaluations included in the review. Experimental or quasi-experimental designs were included, where pre- and post-intervention measures and a control group were incorporated. What sources were searched to identify primary studies? Online search using electronic databases, including Project CORK, BIDS ISI, Psyclit, Eric, Assia, MEDLINE, Family Resources Database, Health Periodicals Database, Drug Info, Somed, Social Work Abstracts, National Clearing House on Alcohol and Drug Information, Mental Health Abstracts, and ETOH. Obtained papers and selected journals (specifically Preventive Medicine, Journal of alcohol and Drug Education Research and Health Education Quarterly) were hand searched. Key individuals and organisations were contacted for information. There were no language restrictions. Search strategy available from the authors. Criteria on which the validity (or quality) of studies was assessed. Validity criteria included adequacy of control, method	Results of the review. Assessment of the quality of the studies showed that only 10 of the 33 studies included met four core methodological criteria, indicating the poor quality of the studies. Overall, no prevention programme was convincingly effective. Of the 29 studies of prevention programmes with short-term follow-up, 16 were partially effective (ie. some self-reported measures were positively influenced), 11 were ineffective (ie. having no influence on self-reported drinking behaviour) and five had negative effects (increased alcohol consumption). The prevention programmes with negative effects did not appear to differ in content from the effective and partially effective programmes. There were 12 prevention programmes with medium-term follow-up. Of these five were partially effective, five ineffective and two had negative effects on self-reported drinking behaviour. Quality assessment of the five partially effective programmes revealed poor quality. Only two prevention programmes had long-term follow-up, one was effective and one ineffective. Was any cost information reported? None stated. Author's conclusions. The prevention programmes reviewed provided limited evidence to recommend any of the programmes. There were limited differences between the programmes that claimed partial success, no effect or negative effects. In fact, some programmes varied in effectiveness depending on length of follow-up. Good quality research, in terms of methodology, was rare. Studies considered for review lacked suitable control groups (non-random allocation or non-equivalent design), lack of pre-test information, high levels of attrition and poor quality presentation of results. CRD commentary. The review adheres to most of the criteria of a good quality systematic review. The objective, outcomes assessed, inclusion and quality criteria, sources searched, synthesis of data and assessment of heterogeneity, as well as methods of applying inclusion criteria, judging validity and extracting data are discussed. Results are clearly presented. The review lacks detailed information about the programmes, setting and subjects within the included studies. Unfortunately, discrepancies exist between the text and tables in the results section.

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	of randomisation or allocation, comparability of group's baseline characteristics, validity of self-reported behaviour, adjustments for confounding, attrition rate and how dealt with, and whether unit of analysis corresponded to unit of randomisation. In addition, effects of chance, confounding and bias were considered. How were decisions on the relevance of primary studies made? Obtained papers were pre-screened by two reviewers, and studies not meeting the inclusion criteria were rejected. How were judgements of validity (or quality) made? Independently by at least two reviewers, with discussion on disagreement and recourse to other reviewers. How was the data extracted from primary studies? By at least two independent reviewers using standard data extraction forms. Number of studies included in the review. 33 studies, of which 24 were randomised controlled trials (RCTs) or had well matched controls. How were the studies combined? Studies were combined through narrative synthesis by effectiveness (behavioural outcomes) and by follow-up period. Follow-up periods were classified as short term (up to 1 year), medium term (1 to 3 years) and long term (over 3 years). How were differences between studies investigated? Although no statistical test for heterogeneity was presented, the studies included in the review are assessed using several quality criteria, including: clearly stated aims; RCT or baseline equivalence; replicable intervention; numbers recruited provided; pre-intervention data provided; attrition discussed; all outcomes discussed; and, post-intervention data provided.	

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Rispens J, Aleman A, Goudena PP. Prevention of child sexual abuse victimization: a meta-analysis of school programs. Child Abuse and Neglect 1997;21(10):975-87.	The evaluation studies were identified through searches of the PsycLit, ERIC, and Medline databases from January 1993 to March 1993, using the key words child sexual abuse prevention.	Results revealed that these programs succeed in teaching children sexual abuse concepts and skills in self-protection. Intervention characteristics such as the duration and content of the program, as well as child characteristics such as age and socioeconomic status were important moderators of the size of the effect. Findings corroborate and refine the positive conclusions of traditional narrative reviews. Findings indicated that the most beneficial programs focus on skill training and allow sufficient time for children to integrate self-protection skills into their cognitive repertoires.
Durlak JA, Wells AM. Primary prevention mental health programs for children and adolescents: a meta-analytic review. American Journal of Community Psychology 1997;25(2):115-152.	Systematic review was used to review literature on 177 primary prevention mental health programs designed to prevent behavioral and social problems in children and adolescents.	Most programs produced outcomes similar to or better than those obtained by many other established preventive and treatment interventions in the social sciences and medicine. Programs modifying the school environment, individually focused mental health promotion efforts, and attempts to help children negotiate stressful transitions yield significant mean effects. In practical terms, the average participant in a primary prevention program surpasses the performance of 59%-82% of those in a control group, and outcomes reflect an 8%-46% difference in success rates favoring prevention groups. Most programs had the dual benefit of significantly reducing problems and increasing competencies.
Hagenzieker MP, Bijleveld FD, Davidse RJ. Effects of incentive programs to stimulate safety belt use: a meta-analysis. Accident Analysis and Prevention 1997;29(6):759-77.	The effects of campaigns using tangible incentives (rewards) to promote safety belt usage have been evaluated by means of a meta-analytic approach. Two coders extracted a total number of 136 short-term and 114 long-term effect sizes and coded many other variables from 34 journal articles and research reports	The results show a mean short-term increase in use rates of 20.6 percentage points; the mean long-term effect was 13.7 percentage points. Large scale studies report smaller effect sizes than small scale studies; when studies were weighted by the (estimated) number of observations, the weighted mean effect sizes were 12.0 and 9.6 percentage points for the short and long term, respectively. The main factors that influence the magnitude of the reported short-term effect of the programs were the initial baseline rate (which was highly correlated with the presence or absence of a safety belt usage law), the type of population involved, whether incentives were delivered immediately or delayed, and whether incentives were based on group or individual behaviour. Together these four variables accounted for 64% of the variance. Other variables, such as the duration of the intervention, the probability of receiving a reward, and the value of the reward were not related to the short-term effect sizes. The relationship between moderating variables and long-term effects was less clear.
Dusenbury L, Matthea F, Lake A. A review of the evaluation of 47 drug abuse prevention curricula available nationally. Journal of School Health 1997;67(4):127-32.	Review determined how many of the available drug prevention curricula for schools had been tested in rigorous evaluation. 47 curricula were included.	Only 10 had been subjected to rigorous evaluation. Eight of the ten had shown some positive effect at least some of the time.

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Tucker S, Gross D. Behavioral parent training: an intervention strategy for guiding parents of young children. Journal of Perinatal Education 1997;6(2):35-44.	Review effectiveness of Behavioral Parent Training (BPT) as an early intervention strategy for parents of young children.	Findings indicate BPT to be effective strategy.
Kellermann AL, Fuqua-Whitley D, Rivara FP. Preventing Youth Violence. A Summary of Program Evaluations. Urban Health Initiative Monograph Series, Monograph 1. Washington, DC: Publisher unknown. 1997.	This summary explaining the results of evaluations of programs to prevent youth violence is an attempt to fill the gap in information about what works and what does not.	In the first category are programs for the prevention of unintended pregnancy and infancy and early childhood interventions that include a variety of approaches, such as home visits, various types of family therapy, programs for children, and innovative policing. The category for less effective programs includes a number of individual-level interventions, including some mentoring programs, peer counseling, drug education, and vocational and employment programs. Also grouped with the less effective programs are some community-level interventions, including neighborhood cleanups and gun buybacks. Strategies that appear promising, but have not been tested include: (1) family literacy programs; (2) firearm safety training; (3) disrupting gun trafficking to youth; and (4) support groups for victims. This review is extensive, but not exhaustive. New programs are being developed every day, and these new approaches deserve careful evaluation.
Garrido V, Esteban C, Molero C. The effectiveness in the treatment of psychopathy:a meta-analysis. Issues in Criminological and Legal Psychology 1996;24:57-9.	Reviews the effectiveness of the treatments applied to psychopaths in a systematic review of research published during 1983-1993. The selection criteria includes: program focus on adult males and females; a diagnosis of psychopathy/sociopathy or antisocial personality disorder; a connection of intervention and treatment method with the data; and a quantitative transformation of program results (effects).	It is concluded that psychopaths improve when: (1) treatment does not apply to drug abuse; (2) treatment is applied to inpatients; (3) Ss are less than 30-yrs old; (4) there is an intervention increase; (5) psychopaths are the offenders; (6) there is a low level of psychopathy; and (7) treatment is applied in prison
Serketich WJ, Dumas JE. The effectiveness of behavioral parent training to modify antisocial behavior in children: A meta-analysis. Behavior Therapy 1996;27(2):171-86.	Conducted a systematic review of 26 controlled studies on the outcome of behavioral parent training (BPT) for the modification of antisocial behavior in preschool and/or elementary school age children.	Results support the short-term effectiveness of BPT to modify child antisocial behavior at home and school, and to improve parental personal adjustment. However, research still needs to examine if positive changes as a function of BPT are maintained over time, are comparable to changes resulting from other interventions for child antisocial behavior, and are related to important methodological and contextual variables.
Elvik R. A meta-analysis of studies concerning the safety effects of daytime running lights on cars. Accident Analysis and Prevention 1996;28(6):685-94.	A systematic review of 17 studies. Distinguishes between studies examining relationship between DRL and traffic safety, and studies examining effect of mandatory DRL on safety.	Use of DRL reduces accidents by 3-12% and multi-party accidents 10-15%.

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Edwards ME, Steinglass P. Family therapy treatment outcomes for alcoholism. Journal of Marital and Family Therapy 1995;21(4):475-509.	A systematic review of 21 studies of family-involved therapy for alcoholism, evaluating them for design adequacy, clinical significance, and effect size.	It is concluded that family therapy is effective in motivating alcoholics to enter treatment. Once the drinker enters treatment, family-involved treatment is marginally more effective than individual alcoholism treatment. The data suggest that 3 factors may mediate the effect of treatment: gender, investment in the relationship, and perceived support from the spouse for abstinence. Modest benefits have been obtained in family-involved relapse prevention programs.
Wagenaar AC, Zobeck TS, Williams DG, Hingson R. Methods used in studies of drink-drive control efforts: a meta-analysis of the literature from 1960 to 1991. Accident Analysis and Prevention. 1995;27(3):307-16.	We searched the drink-drive control literature over the past three decades, finding over six thousand documents. After detailed review of the abstracts and papers, 125 studies contained separate empirical evaluations of the effects of 12 DWI control policies and enforcement efforts (administrative license suspension, illegal per se, implied consent, preliminary breath test, mandatory jail sentence, mandatory community service, mandatory license suspension, limits on plea bargaining, mandatory fines, selective enforcement patrols, regular police patrols, and sobriety checkpoints). The 125 studies contained 664 distinct analyses that formed the basis for systematic review.	All of the DWI control efforts were associated with reductions in drink-driving and traffic crashes. The DWI control literature is limited by the preponderance of weak study designs and reports that often fail to include basic data required for systematic review.
Cox SM, Davidson WS, Bynum TS. A meta-analytic assessment of delinquency-related outcomes of alternative education programs. Crime and Delinquency 1995;41 (2):219-34.	A systematic review quantitatively summarizes empirical research on delinquency-related outcomes for alternative school programs. Data are based on 57 evaluations obtained from computerized database searches.	Alternative education programs had a small overall effect on school performance, attitudes toward school and self-esteem, but no effect on delinquency. Programs that targeted a specific population of at-risk delinquents or low school achievers produced larger effects than programs with open admissions.
Kraus JF, Blander B, McArthur DL. Incidence, risk factors and prevention strategies for work-related assault injuries: a review of what is known, what needs to be known, and countermeasures for intervention. Annual Review of Public Health 1995;16:355-79.	An assessment of available information on risk factors and countermeasures considered important in reducing injury occurrence.	Unfortunately, the potency of specific countermeasures for prevention of violence-related injury in work settings continues to be largely unknown. Numerous fundamental questions remain to be answered: Critical is a full assessment of risk, identification of situations and circumstances amenable to intervention, and evaluations to demonstrate effectiveness.

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Elmquist DL. A systematic review of parent-oriented programs to prevent children's use of alcohol and other drugs. Journal of Drug Education 1995;25(3):251-79.	The purpose of this review was to analyze systematically the characteristics of twenty-two instructor-led parent-oriented programs. An objective of each of these programs was to prepare parents to prevent their children's alcohol and other drug use. To conduct this program review, the author developed 120 criteria for analyzing and reviewing the characteristics of the programs. The criteria were grouped under five main topics or components: 1) general characteristics, 2) instructional characteristics, 3) skills addressed, 4) generalization methods, and 5) evaluation. The author then trained two uninformed reviewers to review with reliability each program.	The results of the reviews are summarized according to program characteristics. Recommendations are based upon the review results. These results and recommendations can help prospective users make an informed decision before they adopt or invest in a program.
Roy R. Frankel H. How Good Is Family Therapy? A Reassessment. Toronto (Canada): University of Toronto Press. 1995.	Summarizes and assesses outcome studies based on life stages and on specific problems.	Overall, the research studies indicated that family therapy was an effective method of treatment. However, the field of family therapy research is relatively new and methodology is still in development. Many of the studies are limited by methodological flaws such as lack of control groups, small samples, unclear outcome measures, lack of attention to certain variables, and inappropriate data analysis. For example, evaluations of placement prevention programs in child welfare practice have yielded disappointing results because they are conducted too early in the development of the program or overemphasized placement rates as an outcome measure. Other problems with family preservation research are attributed to demands on staff and lack of standards for selection criteria and case documentation.
Zobeck TS, Williams GD. Evaluation synthesis of the impacts of DWI laws and enforcement methods. Final report. Washington, DC: U.S. National Institute on Alcohol Abuse and Alcoholism. 1994	A study evaluates the effectiveness of driving-while-intoxicated (DWI) laws and enforcement methods in reducing deaths, injuries, and the prevalence of drinking and driving. This is accomplished through a quantitative synthesis of 125 empirical research studies,78 from the U.S. and 47 from other countries. Each of the DWI laws and enforcement methods evaluated was supported by at least some evidence of effectiveness in reducing DWI-related outcomes, though in most cases this evidence was mixed.	Administrative license suspension, illegal "per se" laws and sobriety checkpoints exhibited the strongest evidence of effectiveness in reducing adverse outcomes in U.S. studies. Illegal per se laws, mandatory jail sentences and sobriety checkpoints showed the strongest evidence of effectiveness in studies conducted in other countries.

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MacMillan HL, MacMillan JH, Offord DR, Griffith L, MacMillan A. Primary prevention of child physical abuse and neglect a critical review. Part I. Journal of Child Psychology and Psychiatry 1994;35(5):835-56.	Prospective controlled trials published between January 1979 and May 1993 were systematically identified. The quality of each study was determined using criteria which assessed methodological rigor. Interventions aimed at the prevention of physical abuse and neglect were classified into six main categories within the broad group of perinatal and early childhood programs.	While many of these programs did not show a reduction in physical abuse or neglect, there is evidence that extended home visitation can prevent physical abuse and neglect among disadvantaged families.
MacMillan HL, MacMillan JH, Offord DR, Griffith L, MacMillan A. Primary prevention of child sexual abuse: a critical review. Part II. Journal of Child Psychology and Psychiatry 1994;35(5):857-76.	The results of 19 prospective controlled trials assessing eight interventions are included. The studies used a wide range of assessment devices and outcomes, so conclusions reached were based on the quality of each study as assessed by validity criteria. Outcomes were divided into four principal categories: 1) basic knowledge of prevention concepts, 2) assessment of prevention skills of children, 3) behavioral responses of children under simulated conditions, and 4) child disclosure of abuse.	There is evidence that educational programs can improve safety skills and knowledge of children about sexual abuse, but these specific studies do not address whether or not those educational programs actually reduce the number of occurrences of sexual abuse.
Ennett ST, Tobler NS, Ringwalt CL et al. How effective is drug abuse resistance education? A meta-analysis of Project DARE outcome evaluations. American Journal of Public Health 1994;84(9):1394-1401.	A study reviews 8 methodologically rigorous Project DARE (Drug Abuse Resistance Education) program evaluations.	Weighted effect-size means for several short-term outcomes were compared with means reported for other drug use prevention programs. The DARE effect size for drug use behavior ranged from .00 to .11 across the 8 studies; the weighted mean for drug use across studies was .06. For all outcomes considered, the DARE effect-size means were substantially smaller than those of programs emphasizing social and general competencies and using interactive teaching strategies. Thus, DARE's short-term effectiveness for reducing or preventing drug use behavior is small, and is less than for interactive prevention programs.
Barker M, Bridgeman C. Preventing vandalism: what works? Crime Detection and Prevention Series Paper 56 London, UK: Home Office Police Research Group. 1994.	A review examines what works in vandalism prevention in the U.K.	Subtle approaches aimed at building up social responsibility by showing children the consequences of their vandalism may be helpful in reducing damage caused inadvertently. Much damage goes unreported, and it is often difficult to identify the offenders in those incidents that are reported. Making targets less vulnerable, particularly through increased surveillance, appears to have measurable effects. However, this approach may displace vandalism to softer targets elsewhere. Other successful efforts include: deploying uniformed staff on public transport; instituting packages of measures rather than individual attempts; and creating single- rather than

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		multi-agency initiatives.
Erwin PG. Effectiveness of social skills training with children: a meta-analytic study. Counseling Psychology Quarterly 1994;7(3): 305-10.	An exhaustive search of the published literature yielded 43 studies that met stringent criteria for inclusion in a meta-analytic study designed to evaluate the relative effectiveness of three methods of social skills training with socially isolated children: coaching, interpersonal cognitive problem solving, and modeling.	Social skills training produced significant improvements in children's levels of social interaction, sociometric status, and cognitive problem-solving abilities. No one training technique produced a significantly greater improvement than the others. Isolated children showed larger increases in their levels of social interaction and sociometric status than nonisolated children. Multimodal training programs are recommended to capitalize on the independent therapeutic effects that derive from different social skills training techniques.
Lester D. Controlling crime facilitators: evidence from research on homocide and suicide. Ronald V. Clarke (ed). Crime Prevention Studies. Monsey, NY: Criminal Justice Press 1993;1:35-54.	A review analyzes a body of research conducted by D Lester and his colleagues in the last 10 years on the effects of limiting access to lethal methods for suicide and for homocide.	Results provide evidence that limiting access to a preferred method of committing suicide and homocide has a preventive effect, more clearly so for suicide than for homocide. However, there was also evidence that some switching of method may take place after limiting access to one method, again more clearly for suicide than for homocide. However, the body of research as a whole indicates that this line of investigation may prove fruitful in the future for documenting the impact of restricting access to lethal implements in the prevention of crime, and of other social and public health problems.
Poyner B. What works in crime prevention: an overview of evaluation. Ronald V Clarke (ed) Crime Prevention Studies. Monsey, NY: Criminal Justice Press 1993;1:7-34	A review of 122 evaluations of crime prevention projects groups prevention measures into six general categories: campaigns and publicity; policing and other surveillance; environmental design or improvements; social and community services; security devices; and target removal or modification.	Using objective indices of crime, about half of the measures evaluated were found to be effective. Successes were documented in all six categories of measures, but target removal or modification enjoyed the largest number of successes, and social and community services the least.
Weiss H.B. Home visits: necessary but not sufficient. Future of Children 1993;3(3):113-128.	Several experimental and quasi-experimental studies are reviewed that have examined the critical role of home visiting in successful programs for children and young families.	The review suggests that the most effective programs will be comprehensive, continuous, and family focused. Program effectiveness rests, in part, on the availability and quality within the community of other services for families as well as on the capacity of the families to connect with such services. The article concludes with a call for national commitment to a universal home visiting program, to be phased in through a series of demonstration projects.

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Hansen WD. School-based substance abuse prevention: a review of the state of the art in curriculum, 1980-1990. Health Education Research 1992;7:403-30.	Reviews substance use prevention studies (published 1980-1990) for content, methodology, and behavioral outcomes. Studies were classified based on the inclusion of 12 content areas: information, decision making, pledges, values clarification, goal setting, stress managements, self-esteem, resistance skills training, life skills training, norm setting, assistance and alternatives.	Six groups of programs (information/values clarification, affective education, social influence, comprehensive, alternatives and incomplete programs) are identified. Reports are analyzed for 2 major threats to validity, selection bias and statistical power. Program groups generally have similar selection biases but have important differences in statistical power. Comprehensive and social influence programs were found to be most successful in preventing the onset of substance use.
Berrick JD, Barth RP. Child sexual abuse prevention: research review and recommendations. Social Work Research and Abstracts 1992;28(4): 6-15.	This article reviews the methodology and results of more than 30 studies that evaluated child sexual abuse prevention programs. Outcomes for programs designed for preschool children, elementary school-age children, and high school students are presented. A systematic review offers an overall assessment of the study results.	The systematic review demonstrates that children at all ages can improve their scores on child abuse knowledge measures but does not indicate whether the type or amount of knowledge they can learn sufficiently protects them from abuse. The systematic review also confirms that most evaluations have demonstrated both immediate and long-term gains after exposure to a prevention presentation.
Corrigan PW. Social skills training in adult psychiatric populations: a meta-analysis. Journal of Behavior Therapy and Experimental Psychiatry 1991;22(3):203-10.	A systematic review was conducted on 73 studies of social skills training in four adult psychiatric populations: developmentally disabled, psychotic, nonpsychotic, and legal offenders.	Findings from this analysis showed that patients participating in social skills training programs broadened their repertoire of skills, continued to demonstrate these skills several months after treatment, and showed diminished psychiatric symptoms related to social dysfunctions. Although results from an ANCOVA comparing effect sizes across the four populations (with design quality as a covariate) were nonsignificant, consistent trends suggested that social skills training had the greatest effect on developmentally disabled groups and the least effect on offender groups. In addition, social skills training was found to be relatively more effective in outpatient than inpatient settings.
Evans WN, Neville D, Graham JD. General deterrence of drunk driving: evaluation of recent American policies. Risk Analysis 1991;11(2): 279-89.	A review of research and of national and state-level data, 1975:1986.	No evidence that any specific form of punitive legislation is having a measurable effect on motor vehicle fatalities. However, there is suggestive evidence that multiple laws designed to increase the certainty of punishment (e.g., sobriety checkpoints, and breath test) has a synergistic deterrent effect. A striking finding is that mandatory seat belt laws and alcohol taxes are reducing drunk driving fatalities.
Bruvold WH. Meta-Analysis of the California School-Based Risk Reduction Program Journal. Journal of Drug Education 1990;20:139-52	Eight project evaluations comprising of the California school-based risk-reduction programs met the following methodological requirements for evaluation research: comparison groups; pretesting; participant tracking; control of attrition; dependent	The rational model programs impact more on knowledge and less on attitudes and behavior, whereas developmental programs impact more on attitudes and behavior and less on knowledge. At present, the results indicate that the developmental approach, because of its effects on behavior, has more potential for deterring drug use.

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	variable validity; and effect size computation. Of these eight studies, six were based upon a rational model and two upon a developmental model of intervention.	
Linden R. Crime prevention and urban safety in residential environments. Winnipeg, CAN: Prairie Research Associates. 1990.	A review assesses the results of crime prevention activities directed at housing and residential environments in Canada and Western nations.	Analysis of programs that have experienced some success indicates that crime prevention efforts must be comprehensive and situation-specific, using some or all of 7 responses: improving management of public safety through the public housing authority; making changes in environmental design; using tenant organizations; creating social development programs; designing services to deal with crime and to assist tenants; enhancing police services; and building stronger links with other agencies that can assist programs.
Cedar B, Levant RF. A meta-analysis of the effects of parent effectiveness training. American Journal of Family Therapy 1990;18 (4):375-84.	20 studies from the outcome research literature on PET (Parent Effectiveness Training).	Results indicate that the overall effect of PET is significantly greater than that of alternative treatments. PET has effects on parents' knowledge, attitudes, and behavior, and on children's self-esteem, and these effects endured (up to 26 weeks) after the programs were completed. There was also a trend suggesting that the effect on child behavior may have a latency period. Better designed studies were found to have significantly greater effect sizes than those less well-designed.
Sherman LW. Police crackdowns: initial and residual deterrence. Michael Tonry and Norval Morris (eds.) Crime and Justice: A Review of Research. Chicago and London: University of Chicago Press. 1988;12:1-48.	A review examines the effectiveness of police crackdowns: i.e., sudden increases in officer presence, sanctions, and threats of apprehension for specific offenses or all offenses in specific places. The analysis covers 18 case studies of various target problems that illustrate the extent and limits of knowledge about crackdowns.	Fifteen of the case studies appeared to demonstrate initial deterrent effects, including 2 examples of long-term effects. In most long-term crackdowns with apparent initial deterrence, however, the effects began to decay after a short period, sometimes despite continued dosage of both police presence and sanctions. Post-crackdown data in 5 studies indicated a "free bonus" of continued deterrence well after the crackdown ended. Crackdowns might be more effective if limited in duration and rotated across targets.
Rundall TG, Bruvold WH. A meta-analysis of school-based smoking and alcohol use prevention programs. Health Education Quarterly 1988;15(3):317-34.	Systematic review of 29 school based alcohol prevention programs.	Evidence of moderate effect on immediate behavioral outcomes. Smoking interventions more successful in altering long-term outcomes.
Fryer GE. Efficacy of hospitalization of nonorganic failure to thrive children: a meta-analysis. Child Abuse and Neglect 1988;12 (3):375-81		It was found that hospitalization enhanced the probability that nonorganic failure to thrive children would experience compensatory physical growth, yet hospitalization was not found to be effective in stimulating their psychological development.

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Rosenbaum DP. Community crime prevention: a review and synthesis of the literature. Justice Quarterly 1988;5(3):323-95.	Primary attention is given to the results of evaluation research.	There is a paucity of strong demonstrations and evaluations showing that such interventions can alter the behavior and local environments of individuals who are not already predisposed to crime prevention.
Breunlin DC. A review of the literature on family therapy with adolescents 1979-1987. Journal of Adolescence 1988;11(4):309-34.	A review updates a 1979 analysis of the literature on the use of family therapy with adolescents. The models described in the 1979 review including psychoanalytic, behavioral and systems-oriented (the latter incorporating structural and strategic family therapy) have continued to receive attention.	Results of outcome studies clearly suggest that family therapy with adolescents is a viable treatment approach that is often superior to more traditional treatments.
US General Accounting Office. Drinking-Age Laws: An Evaluation Synthesis of Their Impact on Highway Safety Washington, DC: US GAO 1987.	Analysis of 49 evaluations of laws raising the legal drinking age	Raising the drinking age has a direct effect on reducing alcohol-related traffic accidents among youths affected by the laws. A higher legal drinking age also reduces the number of traffic accidents in a State. Raising the legal drinking age also results in less alcohol consumption and less driving after drinking by the age group affected by the law. There is only limited evidence for assessing if a higher drinking age protects youth younger than the minimum age from traffic accidents. Insufficient evidence exists to assess the extent to which under-aged youths cross State lines to obtain alcoholic beverages. Long-term effects of the new law cannot yet be measured.
Buchanan DR, Chasnoff P. Family crisis intervention programs: what works and what doesn't. Journal of Police Science and Administration 1986;14(2):161-8.	A review of evaluations of family crisis intervention (FCI) programs.	Washington, DC is the only major police department to record a decrease in assaults on police officers (APOs) as a result of FCI training. There is anecdotal evidence elsewhere of increased officer skills, and some marginal empirical evidence of lower APO rates, but most studies show no effect.
Tobler NS. Meta-Analysis of 143 adolescent drug prevention programes: quantitative outcome results of program participants compared to a control or comparison group. Journal of Drug Issues 1986;16(4):537-67.	A systematic review of the reported outcomes of 143 adolescent drug prevention program in the US from 1972-1984 identifies the most effective program modalities.	Peer programs, combining positive peer influence with specific skill training, produced the only reduction in drug abusing behaviors. Alternative programs emphasize remedial tutoring, one-on-one counseling, job skills and physical adventure to compensate for deficits. They were successful for special population groups (drug abusers, juvenile delinquents and problem students), showing superior results in increasing skills and changing behavior in both direct drug use and indirect correlates of drug use. However, alternative programs were very intensive and costly.

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Kaufman P. Meta-Analysis of Juvenile Delinquency Prevention Programs. Unpublished paper, Claremont Graduate School, Claremont, California. 1985.	Supplementing computerized searches of the Educational Resources Information Center (ERIC) and Juvenile Justice Clearinghouse data bases with manual searches of relevant psychological, sociological and education indexes, Kaufman located 20 studies which tested some program with preadjudicated youths available through 1983.	He found that experimental treatment subjects performed .20 SDs better than controls on subsequent measures of delinquency.[1] Kaufman found, like some of the other meta-analyses, that increased treatment exposure and intensity was related to effect size; when treatment was increased to 2.1 contacts or more per week, the average effect size increased from d=.15 to d=.63.
Ottenbacher, Kenneth and Paul Petersen. The efficacy of early intervention programs for children with organic impairment: a quantitative review. Evaluation and Program Planning 1985;8(2):135-46.	The results of studies examining the effectiveness of early intervention for infants and children with organic impairment and developmental delay were reviewed using recently developed quantitative methods that treat the literature review process as a unique scientific inquiry. Thirty-eight studies meeting certain predetermined criteria were included in the review.	An analysis of these tests based on the calculation of effect sizes reveals that receiving early intervention performed better on a wide range of dependent measures than controls. The outcomes were related to several design and study characteristics. Larger effect sizes were associated with pre-experimental designs, and also with studies in which the internal validity was rated as poor. Several other design variables are related to study outcome. It is concluded that an accurate interpretation of the early intervention research literature cannot be made without consideration of specific design variables and study characteristics.
Larson RC, Cahn MF. Synthesizing and extending the results of police patrol studies. Washington, DC: U.S. Government Printing Office. 1985.	A meta-evaluation of research.	Studies of preventive patrol have not confirmed the presence or absence of any relationship between patrol and crime deterrence, but foot patrol (as opposed to motor patrol) is directly related to increased citizen satisfaction. Response time studies demonstrate that the difference between anticipated and actual response time is a major determinant of citizen satisfaction; the response time/apprehension rate relationship is ambiguous. Evaluations of team policing are hampered by methodological problems. Theoretical and empirical results favor 1-officer cars over 2-officer cars, but analyses of differences in officer safety are inconclusive.
Casto G, White K. The efficacy of early intervention programs with environmentally at-risk infants. Journal of Children in Contemporary Society 1984;17(1): 37-50.	A systematic review of early intervention research literature.	Early intervention has an immediate positive effect of about ½ standard deviation. No evidence of long-term benefits.

[1] Since studies often report more than one outcome, Kaufman also averaged outcomes within each study, producing a higher effect size (d=.25).

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DiChiara A, Galligher JF. Thirty years of deterrence research: characteristics, causes, and consequences. Contemporary Crises 1984;8:243-63.	DiChiara and Galliher (1984) conducted a possibly systematic review of 30 years of deterrence research (1950-1979). Their work has more a feel of a content analysis but they do include 'evidence of effectiveness' as one the issues they address. They included only empirical studies on deterrence reported in the leading journals in criminology, sociology, economics, politicalscience, two interdisciplinary journals (Law and Society Review, Social Science Quarterly), as well as those found in searches of Sociological Abstracts, Social Science Citation Index, Psychological Abstracts, Psychology and Law Review, and Law and Human Behavior. They provide detail on coding and reliability checks.	They note large increase in publication after 1968 in deterrence research. Evidence for deterrence effects is categorized by using the following responses: yes, no, mixed results, and neutral or no position. They find that a lower percentage of studies report efficacy of deterrence in the 1970s than the 1960s.
Susskind EC, Bond RN. The potency of primary prevention: a meta-analysis of effect size. 1981.	A systematic review of 47 primary prevention studies; only 13 provided enough data to calculate effect size.	Wide variability in prevention program effects; average effect was improvement of 8% in outcomes.
Rubenstein H, American Institutes for Research, et al. The link between crime and the built environment: the current state of knowledge. Washington, DC: U.S. National Institute of Justice 1980;1.	A study was undertaken to assess the state of knowledge, at the end of the 1970s, about the link between crime and the built environment (C/BE). The focus of the study is on two topics: what has been established about the C/BE link, and what the key outstanding issues are. The answers are based on an exhaustive review of all empirical studies on the topic conducted during the 1970s. This volume synthesizes the results. Every study included in the review met three criteria: The study had an empirical base, the study used the build environment as the independent variable, and the dependent variable included occurrence of stranger-to-stranger crimes or the fear of crime. Preliminary assessments were made of 52 studies, of which 15 were identified as sufficiently promising to warrant a more thorough assessment. The studies are organized on the basis of how they fit into theory (i.e.,	The available evidence suggests that changes in the physical environment (and especially combinations of changes) can reduce crime and the fear of crime. This does not happen consistently. The evidence does not illuminate the dynamics. Because of the lack of cause-effect information, the present knowledge base cannot be used to prescribe strategies likely to be effective in given situations. Changes in the physical environment are probably the fastest way of reducing fear of crime. There is probably only one type of situation in which interventions expressly designed to reduce the level of fear are useful. This is in the context of anticrime initiatives that depend on an active resident role. There are two primary ways in which changing the physical environment is expected to counter crime. One is by increasing the difficulty of access or evasion. The other is by creating a social ambience that is mutually protective.

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	how they fit into "rationales" or "logic models" that connect the build environment and crime).	
Berleman WC. Juvenile delinquency prevention experiments: a review and analysis Washington DC: U.S. Government Printing Office. 1980.	A review was conducted of ten delinquency prevention studies using a classical experimental design. The delinquency prevention programs included in the review served children who had been found to have propensities to commit serious antisocial behavior but who partook of the service without official coercion, and adhered to a research protocol for evaluating service effectiveness. The ten projects evaluated and their years of operation are as follows: (1) Cambridge-Somerville Youth Study in Cambridge and Somerville, Massachusetts, 1937 45; (2) New York City Youth Board Validation of Prediction Scale, 1952-57; (3) Maximum Benefits Project in Washington, D.C., 1954 57; (4) Mid-City Project in Boston, 1954-57; (5) Youth Consultation Service in New York City, 1955-60; (6) Chicago Youth Development Project, 1961-66; (7) Seattle Atlantic Street Center Experiment in Seattle, Washington, 1962-68; (8) Youth Development Program in Columbus, Ohio, 1963-66; (9) opportunities for Youth Project in Seattle, Washington, 1964-65 (estimated); and (10) Wincroft Youth Project in Manchester, England, 1966-68.	Except for the Wincroft Youth Study, the delinquency prevention experiments were deemed ineffective. Treatment produced no better results than no treatment. Cultural and societal differences complicate any assessment of the applicability of the Wincroft study to the United States. The experiments reviewed in this project probably represent the best efforts to date to prevent delinquency. The dedication of the project personnel in each of the experiments was evident; the nature of the experimental design would have prompted the best efforts of those providing treatment. The rigor and honesty with which each experiment was evaluated and the convergence of the evidence in a negative direction leave little doubt that we do not yet know how to prevent delinquency.
Lundman RJ, Scarpitti F. Delinquency prevention: recommendations for future projects. Crime and Delinquency 1978;24:207-20.	They conducted a possibly systematic review of 40 delinquency prevention projects. They limited their documents to reports published in journals and preliminary reports for projects in progress. They searched the following indexes: Monthly Catalog of United States Government Publications (1958-73); Crime and	They find little evidence for effectiveness, also citing the poor quality of the evidence.

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	Delinquency Abstracts (1968-71); The Challenge of Crime in a Free Society (1967); Social Science and Humanities Index (1952-1974); and NationalCriminal Justice Reference Service/Juvenile Delinquency Prevention (an LEAA computerized bibliographic service). They also provide data on pipeline of reports: over 1,000 citations were screened down to 127potential studies. These led to 25 prior and 15 continuing prevention projects.	
Nagin D. General deterrence: a review of the empirical evidence. In Deterrence and incapacitation: estimating the effects of criminal sanctions on crime rates. U.S. National Academy of Sciences. Panel on Research on Deterrent and Incapacitative Effects. Washington, D.C. National Academy Press 1978.	In this critique over 20 published analyses are cited, and even this list is less than exhaustive.	The empirical evidence is still not sufficient for providing a rigorous confirmation of the existence of a deterrent effect. Perhaps more important, the evidence is woefully inadequate for providing a good estimate of the magnitude of whatever effect may exist.
Smart RG, Goodstadt MS. Effects of reducing the legal alcohol-purchasing age on drinking and drinking problems: a review of empirical studies. Journal of Studies on Alcohol 1977;38(7):1313-23.	A review of studies on the effects of reducing the legal age for drinking and purchasing alcoholic beverages.	Suggests that there are public health reasons for not introducing such changes in jurisdictions which have not already done so. Both self-report and sales studies indicate that substantial increases in youthful drinking occurred in Canada after the legal age for purchasing alcoholic beverages was reduced probably, but not certainly, because of the change. Relevant data for the United States do not seem to be available. The largest changes in drinking involved on premise consumption rather than sales in liquor stores or drinking with families. There are usually greater increases in alcohol-related automobile accidents in areas where the purchasing age has been reduced than in comparison areas. These increases do not occur in all states. Changes in the alcohol-purchasing age probably affect the automobile crash experience of those fifteen to seventeen as well as those eighteen to twenty. No information is available which shows conclusively that reducing the purchasing age has caused increases in educational, family, or public-order problems.
Chaiken JM. What's known about deterrent effects of police activities. Santa Monica, CA: Rand Corporation. 1977.	Several techniques have been used to estimate the effect of police activities on the incidence of crime. These include (1) cross-sectional analysis of reported crime rates in various jurisdictions as compared to resources devoted	This review indicates that most studies are consistent with the view that a substantial increase in police activity will reduce crime for a time, but, in the real world, increases in police manpower tend to follow increases in crime. The magnitude and duration of deterrence effects are essentially unknown

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	to all police functions or certain police functions, (2) longitudinal analysis of the incidence of crime in several jurisdictions or in a single jurisdiction where police deployment or operations changed over time, and (3) experimental manipulation of the nature or amount of police activities.	
Smart RG. Effects of legal restraint on the use of drugs: a review of empirical Studies. Bulletin on Narcotics 1976;28(1):55-65.	A review of the empirical studies.	Little can be concluded with any certainty from available. However it appears that successful attempts to reduce the supply of heroin by means of seizures and crop reductions have produced reductions, sometimes small, in illicit heroin availability, heroin addiction, and deaths from heroin. Large reductions in cannabis availability can probably reduce cannabis consumption, at least temporarily, but probably with the substitution of other drugs. In general, it appears that legal restraints work best where legal drug distribution is being controlled by bringing pressure to bear on ethically motivated and well-regulated agencies, e.g., the pharmaceutical industry and physicians.
Walker JP, Cardarelli AP, Billingsley D. The theory and practice of delinquency prevention in the United States: review, synthesis and assessment. Columbus, Ohio: Ohio State University. Center for Vocational Education. 1976.	The purpose of the Juvenile Delinquency Prevention/National Evaluation program was to provide an information base for policy-makers by assembling what is currently known of the state of the art of delinquency prevention nationally.	Few programs that focused on the individual, the community, or the school has been successful in preventing delinquency. Some efforts, such as detached worker programs, may even have increased it. The enthusiasm which greeted the introduction of opportunity-type programs in the 1960's was unwarranted; these programs also failed. This failure cannot be explained by poor planning or management and should not be attributed to the political climate. Just as psychology has been unable to account for the selective criminality of individuals with similar personality traits, so sociology has been unable to account for the selective criminality of individuals exposed to similar social conditions. This raises serious questions about the ability of policy-makers to create those conditions that will prevent delinquency from occurring.
Emrich RL et al. Evaluating the prevention or preventing the evaluation. Davis, CA: National Council on Crime and Delinquency. Research Center. 1975.	A review was made of the state of the art of evaluations of primary drug abuse prevention projects to help improve the use of such evaluations. The findings are based on an analysis of a selection of twenty-nine of the most promising evaluations of primary drug abuse prevention programs in the United States.	Special techniques are required to organize the delivery of primary drug abuse prevention services. Most programs are concerned with stimulating growth in the individual as the principal means of helping him to deal with pressures to abuse drugs. There is growing consensus that, although difficult to evaluate, this must be the heart of any primary prevention program. The survey findings continued to support the generally accepted belief that old-fashioned approaches to education about drugs probably do more harm than good, although some projects are now putting such education in richer, more balanced educational settings where the dispensing of information about drugs may prove to be an asset. One of the saddest types of programs is the

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		"quick and dirty" program which gives the participant a few hours of exposure to the message and then assumes that his lifestyle is changed. The problems of drug abuse are too pervasive to respond to such superficial interventions. Programs are moving toward more student initiative and participation in program planning. The findings strongly suggest that the more responsibility that can be reasonably given to young people the more effective a primary prevention effort will be.
Dixon MC, Wright WE. Juvenile delinquency prevention programs: an evaluation of policy related research on the effectiveness of prevention programs. Nashville, TN: Peabody College for Teachers. 1975.	A survey was made of approximately 6,600 abstracts of studies published in the last ten years that describe delinquency prevention services that do not remove youth from their home community. 350 articles, pamphlets and reports were collected.	The overview revealed that certain types of prevention and treatment projects recreational programs, guided group interaction, social casework, and detached worker/gang worker projects have failed to show evidence of effectiveness and should be discarded. Evidence which suggests that community treatment, the use of volunteers, diversion programs, youth service bureaus, and special school projects hold some promise of success has begun to accumulate. These efforts deserve further exploration and should be thoroughly evaluated to test their promise.
Berleman WC, Steinburn TW. The value and validity of delinquency prevention experiments. Crime and Delinquency 1969;15:471-8.	They reviewed five experiments that tested the provision of service to juveniles not formally adjudicated by the justice system to prevent future delinquency.	Authors conclude that the experiments show that the provision of services to prevent delinquency is ineffective. But they caution that most of the studies provide no evidence that services were delivered as intended or that contact levels were sufficient.
Gray E. Early Parenting Intervention to Prevent Child Abuse: A Meta-Analysis. Final Report. Final Report. National Council of Jewish Women, New York, NY. Center for the Child. no date	Research findings from a broad variety of parenting interventions were synthesized to improve current knowledge about these programs as preventive interventions. Some insights were afforded by the attempt to use meta-analytic techniques on this data, but, in general, it appeared that the use of systematic review on these studies is premature, largely because of the great variance in theoretical base and methods of intervention. However, this review of 48 documents did result in some conclusions about intervention programs.	The greatest and most consistent mean effects were produced by programs referred to as home-visiting programs. Such programs also served more people at risk for poor parenting than other types of programs in the sample. Effects in the observed behavior domain tended to be larger than effects in other outcome domains. Lack of external evaluation in the assessment of program effects is an additional problem in the application of meta-analytic methods. If program planners spell out their models and present their research designs more clearly, additional efforts to integrate the literature on early parenting intervention should meet with more success.

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White P, Bradley C, Ferriter M, Hatzipetrou L. Managements for people with disorders of sexual preference and for convicted sexual offenders. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000.Oxford: Update Software.	A substantive amendment to this systematic review was last made on 24 August 1998. Cochrane reviews are regularly checked and updated if necessary. Background: The reviewers recognise that it may be thought that convicted sex offenders and those with disorders of sexual preference are quite different groups. In combining them within this review we have taken the view that legal process alone should not define the population. Illegal behaviours in one jurisdiction may not be considered so in others. Studies of those who are convicted of sexual offending describe reconviction rates for sexual offences of up to 40-60%. It would seem important to know if there are interventions that might reduce this high rate of re-offending. This review examines antilibidinal management of those who have been convicted of sexual offences or who have disorders of sexual preference. Objectives: To determine the effectiveness of a range of management techniques to assist people who have disorders of sexual preference and those who have been convicted of sexual offences. Search strategy: Biological Abstracts, the Cochrane Schizophrenia Group Register of Trials, The Cochrane Library, EMBASE, MEDLINE, and PsychLIT were searched. Further references were sought from published trials and their authors. Relevant pharmaceutical manufacturers were contacted. Selection criteria: All relevant randomised controlled trials. Data collection and analysis: Reviewers evaluated data independently and analysed on an intention-to-treat basis. Data were extracted for short and medium term outcomes.	Main results: A single trial (McConaghy 1988) found the effect of antilibidinal medication (medroxyprogesterone acetate) plus imaginal desensitisation was no better than imaginal desensitisation for problematic/anomalous sexual behaviour and desire. A relapse prevention programme was trialed by Marques (Marques 1994) and participants were followed up for an average of 3 years. What data there are suggest that although there is no discernible effect on the outcome of sex offending (OR 0.76 CI 0.26-2.28), those treated with response prevention do have less non-sexual violent offences (OR 0.3, CI 0.1-0.89, NNT 10 CI 5-85). In addition those committing both sexual and violent offences also declined in the response prevention group (OR 0.14 CI 0.02-0.98, NNT 20 CI 10-437). A large pragmatic trial investigated the value of group therapy for sex offenders (Romero 1983). This study finds no effect on recidivism at ten years. Reviewers' conclusions: It is disappointing to find that this area lacks a strong evidence base, particularly in light of the controversial nature of the treatment and the high levels of interest in the area. The relapse prevention programme did seem to have some effect on violent reoffending but large, well-conducted randomised trials of long duration are essential if the effectiveness or otherwise of these treatments are to be established.
Ley A, Jeffery DP, McLaren S, Siegfried N. Treatment	A substantive amendment to this systematic review was last made on 22 February 1999.	Main results: Six relevant studies, four of which were small, were identified. In general, the quality of design and reporting was not high. Clinically

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programmes for people with both severe mental illness and substance misuse. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000.Oxford: Update Software.	Cochrane reviews are regularly checked and updated if necessary. Background: Effective treatment of people with both severe mental illness and substance misuse is frequently affected by systems, programmes or philosophies which have developed to treat only one of these conditions. Objectives: To evaluate the effectiveness of treatment programmes within psychiatric care for people with problems of both substance misuse and serious mental illness. Search strategy: Biological Abstracts (1985-1998), CINAHL (1982-1998), The Cochrane Library (Issue 3, 1998), The Cochrane Schizophrenia Group's Register of trials (August 1998), EMBASE (1980-1998), MEDLINE (1966-1998), PsycLIT (1974-1998) and Sociofile (1974-1998) were comprehensively searched. Citations of all trials were searched and further studies sought from published trials and their authors. Selection criteria: All randomised trials of any programme of substance misuse treatment for people with serious mental illness and current problems of substance misuse. Data collection and analysis: Citations and, where possible, abstracts were independently inspected by reviewers, papers ordered, re-inspected and quality assessed. Data were also independently extracted. For homogeneous dichotomous data the Peto odds ratio (OR), and 95% confidence intervals (CI) were calculated on an intention-to-treat basis.	important outcomes such as relapse of severe mental illness, violence to others, patient or career satisfaction, social functioning and employment were not reported. There is no clear evidence supporting an advantage of any type of substance misuse programme for those with serious mental illness over the value of standard care. No one programme is clearly superior to another. Reviewers' conclusions: The problems posed by substance misuse in the context of severe mental illness will not go away. The current momentum for integrated programmes is not based on good evidence. Implementation of new specialist substance misuse services for those with serious mental illnesses should be within the context of simple, well designed controlled clinical trials.

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Kirchmayer U, Davoli M, Verster A. Naltrexone maintenance treatment for opioid dependence. [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000.Oxford: Update Software.	Background: Despite widespread use of naltrexone maintenance in many countries for more than ten years now (e.g., USA since 1984, UK since 1988) a sound documentation of the research on this drug is still missing. Objectives: To evaluate the effects of naltrexone maintenance treatment in preventing relapse in opioid addicts after detoxification. Search strategy: We searched MEDLINE, EMBASE, CCTR and handsearched the "Bolletino per le pharmacodipendenze el Alcolismo"; contact was sought with pharmaceutical producers of naltrexone, with authors and other CRGs; references of obtained studies. Trials were reliably identified and data extracted. Date of most recent searches: June 1998. Selection criteria: All studies controlled for naltrexone; treatment of heroin addicts after detoxification with naltrexone. Studies were classified into three categories (high, moderate or low risk of bias) according to their methodological quality. Data collection and analysis: Reviewers evaluated data independently and analysed outcome measures taking into consideration adherence to and success of the study intervention. Data was extracted and analysed stratifying for the three categories of study quality. Where possible, systematic review was performed.	Main results: Eleven studies were included in this review, and not all of them were randomised. Systematic review could be done to a low degree only, because the studies and their outcomes were very heterogeneous. The result of this quantitative analysis was statistically poor, and so was the methodological quality of the included studies. Reviewers' conclusions: The available trials do not allow a final evaluation of naltrexone maintenance treatment yet. A trend in favour of treatment with naltrexone was observed for certain target groups, as described in the literature before. A well-done clinical trial is needed in order to get better evidence as soon as possible.
Wilson SJ, Lipsey MW. Wilderness challenge programs for delinquency youth: a meta-analysis of outcome evaluations. Evaluation and Program Planning 2000;(23):1-12.	Systematic review techniques, exhaustive search methods, 1950+.	The overall effect size was .18, equivalent to a recidivism rate of 29% for program participants and 37% for controls. Programs with the most intensive activities or included a therapeutic component showed the greatest reductions in delinquency.

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Petrosino A, Petrosino C, Finckenauer JO. In press. Our well-meaning programs can have harmful effects! Lessons from the Scared Straight experiments. Crime and Delinquency. 2000.	Systematic review of nine randomized experiments testing the effects of Scared Straight programs.	Scared Straight-like programs, including confrontational and interactive sessions with inmates, tours and orientations in prisons, and educational sessions in prisons, not only are ineffective but likely increase crime and delinquency.
White JB. An efficacy study of the laws of living cognitive restructuring program for the rehabilitation of criminals, using an historical-descriptive meta-analysis method. Dissertation Abstracts International: Section B: the Sciences and Engineering. 1999;59(7-B):3729.	Thirteen studies yielded 17 sets of data to be included in the systematic review.	It was hypothesized that LOL would not produce larger effect sizes in experimental groups than in control groups, as measured by MMPI-I scores, recidivism rates, and discrete historical-descriptive variables. Each of the five null hypotheses were rejected. Offenders who participated in the LOL cognitive restructuring program showed positive movement on MMPI-I scores and reduced recidivism.
Rawlings B. Therapeutic communities in prisons: A research review. Therapeutic Communities: the International Journal for Therapeutic and Supportive Organizations 1999;20(3):177-93.	**T**his review covers the democratic therapeutic communities for personality-disordered offenders, found mainly in British and European prisons and hierarchical therapeutic communities for drug users, found mainly in the US. Evaluative research has looked either at changes in behavior and reported feelings during treatment, or at changes in behavior after treatment has finished. Post-treatment follow-up research largely takes the form of reconviction studies.	The main body of research finds that therapeutic communities have a positive effect on reconviction and reoffending, and a positive effect on behavior whilst in prison.
Holbrook AM, Crowther R, Lotter A, Cheng C, King D. Meta-analysis of benzodiazepine use in the treatment of acute alcohol withdrawal. CMAJ 1999;160(5): 649-55.	To analyse the evidence for the efficacy and potential harmful effects of benzodiazepines compared with other therapies in the treatment of acute alcohol withdrawal. DATA SOURCES: MEDLINE and the Cochrane Controlled Trials Registry were searched for English-language articles published from 1966 to December 1997 that described randomized controlled trials (RCTs) of benzodiazepines in the treatment of acute alcohol withdrawal. Key words included "benzodiazepines" (exploded) and "randomized controlled trial." Bibliographies of relevant	DATA SYNTHESIS: The systematic review of benefit (therapeutic success within 2 days) showed that benzodiazepines were superior to placebo (common odds ratio [OR] 3.28, 95% confidence interval [CI] 1.30-8.28). Data on comparisons between benzodiazepines and other drugs, including beta-blockers, carbamazepine and clonidine, could not be pooled, but none of the alternative drugs was found to be clearly more beneficial than the benzodiazepines. The systematic review of harm revealed no significant difference between benzodiazepines and alternative drugs in terms of adverse events (common OR 0.67, 95% CI 0.34-1.32) or dropout rates (common OR 0.68, 95% CI 0.47-0.97). INTERPRETATION: Benzodiazepines should remain the drugs of choice for the treatment of acute alcohol withdrawal.

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	articles were reviewed for additional RCTs, and manufacturers of benzodiazepines were asked to submit additional RCT reports not in the literature. STUDY SELECTION: Articles were considered for the systematic review if they were RCTs involving patients experiencing acute alcohol withdrawal and comparing a benzodiazepine available in Canada with placebo or an active control drug. Of the original 23 trials identified, 11 met these criteria, representing a total of 1286 patients. DATA EXTRACTION: Data were extracted regarding the participants, the setting, details of the intervention, the outcomes (including adverse effects) and the methodological quality of the studies.	
Davis RC, Taylor BG. Does batterer treatment reduce violence? A synthesis of the literature. Women and Criminal Justice 1999;10(2): 69-93.	A review	Among the handful of quasi- and true experiments there is fairly consistent evidence that treatment works and that the effect of treatment is substantial. There is little evidence to date that 1 form of treatment is superior to another or that longer programs turn out less violent graduates than shorter ones. There are bases for hypothesizing that some batterers may fare better in treatment (or fare better in certain types of treatment) than others, but empirical verification has been highly limited to date.
Santiago R, Sanchez-Meca J, Garrido V. The influence of treatment programmes on the recidivism of juvenile and adult offenders: a European meta-analytic review. Psychology, Crime and Law 1999;5(3):251-78.	A systematic review of the European literature sought to identify the most effective treatments in reducing recidivism. Thirty-two studies met the inclusion criteria, for a total sample of 5,715 participants. The papers, which were both published and unpublished, covered the period 1980 to 1991.	The studies, which evaluated recidivism during an average follow-up period of 2 years, obtained a global effect size equivalent to a 12% reduction in recidivism. Behavioral and cognitive-behavioral techniques were most beneficial in reducing recidivism.
Dowden C, Andrews DA. What works for female offenders: a meta-analytic review. Crime and Delinquency 1999;45(4):438-52.	A systematic review addresses the principles of effective correctional treatment for female offenders.	The clinically relevant and psychologically informed principles of human service, risk, need and responsivity identified in past meta-analytic reviews were associated with enhanced reductions in reoffending. The strongest predictors of treatment success were interpersonal criminogenic need targets and, in particular, family process variables.
Polizzi DM, MacKenzie DL, Hickman LJ. What works in adult sex offender treatment? A review of prison- and non-prison-based	An evaluation of 21 sex offender prison- and non-prison-based treatment programs was undertaken using the format of the University of Maryland's 1997 report to the U.S.	Of the remaining research projects, approximately 50% showed statistically significant findings in favor of sex offender treatment programs. Of 6 studies that showed a positive treatment effect, 4 incorporated a cognitive-behavioral approach. Non-prison-based programs were considered to be

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treatment programs. International Journal of Offender Therapy and Comparative Criminology 1999;43(3):357-74.	Congress. Eight of the studies were deemed too weak in scientific merit to be included in the assessment of treatment effectiveness.	effective in curtailing future criminal activity. Prison-based programs were judged to be promising, but the evidence was not strong enough to support a conclusion that such programs are effective.
Alexander MA. Sexual offender treatment efficacy revisited. Sexual Abuse: A Journal of Research and Treatment 1999;11(2):101-16.	A systematic review of sex offender treatment efficacy reviewed 79 outcome studies conducted from 1943 through 1996, encompassing 10,988 subjects. Recidivism rates for treated versus untreated offenders were investigated according to age of offender and victim, offender type, treatment type, location of treatment, decade of treatment and length of follow-up. Each study is used as the unit of analysis, and studies are combined according to the number of treated versus untreated subjects who reoffended in each category.	A variety of treated sexual offenders reoffended at rates below 11%. This finding suggests that some effective components of the treatment process may have been identified. Juveniles responded well to treatment. Treatment effects only became apparent after subjects were subdivided by type (e.g., rapists, child molesters, exhibitionists, other).
Wilson DB, Gallagher CA, Coggeshall MB, MacKenzie DL. Quantitative review and description of corrections-based education, vocation, and work programs. Corrections Management Quarterly 1999;3(4):8-18.	The studies were all published or written after 1975 in the English language.	Results revealed that participants in these programs recidivated at a lower rate than did nonparticipants and that the overall effects were roughly comparable across the different types of programs. However, the data did not permit the conclusion that this reduction was due to the effects of the programs. The typical study was quasi-experimental and compared naturally occurring groups of program participants with nonparticipants. Few studies made serious attempts to control for biases produced by this self-selection into programs. The higher-quality studies revealed promising findings but did not provide a sufficient foundation to support a general statement about the effectiveness of these programs. This review did not examine other potential benefits of education, vocation, and work programs, including increased employability of the offenders. However, high-quality evaluation studies are needed to resolve the issue of the effectiveness of typical corrections-based education, vocation, and work programs.
Grossman LS, Martin B, Fichtner CG. Are sex offenders treatable? A research overview. Psychiatric Services 1999;50(3):349-61.	Review of research on effectiveness of treatment for adult male sex offenders, 1970-1998.	Outcome research suggests a reduction in sex offender recidivism of 30% percent over seven years. Hormonal and cognitive-behavioral treatment seem most effective. Treatment delivered in outpatient settings seems more effective than institutional settings.
Gallagher CA, Wilson DB, Hirschfield P, Coggeshall MB, MacKenzie DL. Quantitative review of the effects of sex offender	This study used the latest meta-analytic techniques to synthesize all available data on the effectiveness of sex offender treatment programs in reducing post treatment sex	Sex offender treatment resulted in lowered sexual offending. Cognitive-behavioral approaches appeared particularly promising, whereas the data produced less support for behavioral, chemical, and generalized psychosocial treatment.

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treatment on sexual reoffending. Corrections Management Quarterly 1999;3(4):19-29.	offense rates. The study also examined the differential effectiveness of behavioral, cognitive behavioral, medical, and other psychosocial approaches to sex offender treatment	
McArthur DL, Kraus JF. The specific deterrence of administrative per se laws in reducing drunk driving recidivism. American Journal of Preventive Medicine 1999;(16/1S):68-75.	Research was analyzed on the specific effects of these laws in reducing drunk-driving recidivism, traffic crashes and other alcohol-related driving offenses by drivers with suspended licenses. Types of studies, conducted since 1966, included randomized and non-randomized controlled trials, cohort studies and case-control research.	Administrative per se laws governing license restrictions for drivers were effective in some states but not in others, decreasing the rates at which these same drivers were subsequently involved in a motor vehicle crash or another alcohol-related offense compared with drivers sanctioned through other conventional judicial processes.
Irvin JE, Bowers CA, Dunn ME, Wang MC. Efficacy of relapse prevention: a meta-analytic review. Journal of Consulting and Clinical Psychology 1999;67(4):563-70.	A systematic review was performed to evaluate the overall effectiveness of RP and the extent to which certain variables may relate to treatment outcome. Twenty-six published and unpublished studies with 70 hypothesis tests representing a sample of 9,504 participants were included in the analysis.	Results indicated that RP was generally effective, particularly for alcohol problems. Additionally, outcome was moderated by several variables. Specifically, RP was most effective when applied to alcohol or polysubstance use disorders, combined with the adjunctive use of medication, and when evaluated immediately following treatment using uncontrolled pre-post tests.
Griffith J.D, Rowan-Szal GA, Roark RR, Simpson DD. Contingency management in outpatient methadone treatment: a meta-analysis. Drug and Alcohol Dependence. 1999.	A systematic review was conducted on contingency management interventions in outpatient methadone treatment settings. The outcome measure of interest was drug use during treatment, as detected through urinalysis.	The results confirm that contingency management is effective in reducing supplemental drug use for these patients. The analysis of behavioral interventions yielded an overall effect size (r) of 0.25 based on 30 studies. Significant moderators of outcomes included type of reinforcement provided, time to reinforcement delivery, the drug targeted for behavioral change, number of urine specimens collected per week, and type of subject assignment. These factors represent considerations for reducing drug use during treatment.
Ruether W. International experiences with the treatment of sex offenders [original title Internationale erfahrungen bei der behandlung von sexualstraftaetern]. Monatsschrift fuer Kriminologie und Strafrechtsreform 1998;81(4): 246-61.	A review analyzes research findings on the effectiveness of sex offender treatment, with particular reference to Dutch, Scandinavian and North American studies.	International research tends to support the notion that intensified treatment is worthwhile. Cognitive behavioral therapy as reported from the United States and Canada deserves particular attention. Further evaluation studies on an international level are needed.

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Lipsey MW, Wilson DB. Effective intervention for serious juvenile offenders: a synthesis of research. In Rolf Loeber and David P. Farrington (eds.) Serious and Violent Juvenile Offenders: Risk Factors and Successful Interventions. 1998:313-45	The chapter attempts to determine whether intervention programs generally are capable of reducing reoffending rates for serious delinquents and, if so, what types of programs are most effective. The review reported in this chapter used techniques of systematic review to synthesize experimental and quasi-experimental research on the effectiveness of intervention for serious juvenile offenders. The review examined programs for offenders in the community, though possibly on probation or parole, and programs for institutionalized juvenile offenders.	The average intervention effect for these studies was positive, statistically significant, and equivalent to a recidivism reduction of about 6 percentage points, for example, from 50 percent to 44 percent (mean effect size =.12). The variation around this overall mean, however, was considerable. With regard to the effectiveness of interventions, the chapter notes that it depends on a good match between program concept, host organization, and the clientele targeted.
Belenko S. Research on drug courts: a critical review. National Drug Court Institute Review 1998;1(1):1-42.	A review of 30 evaluations pertaining to 24 drug courts in the U.S. explores the effectiveness of the drug court model in overseeing offenders participating in the program.	Drug courts provided closer, more comprehensive supervision, and more frequent drug testing and monitoring during the program, than other forms of community supervision. Offender drug use and criminal behavior were substantially reduced while offenders participated in drug courts.
Febbraro G, Clum GA. Meta-analytic investigation of the effectiveness of self-regulatory components in the treatment of adult problem behaviors. Clinical Psychology Review 1998;18(2):143-61.	Author's objective. To examine the effectiveness of self-regulatory components in the treatment of adult behaviour problems. Type of intervention. Treatment. Specific interventions included in the review. Self-regulatory treatment that involves self-monitoring (SM), self-reflection or self-evaluation (SE; including goal setting and feedback) and self-reaction or self-reinforcement (SR). Control groups consisted of no treatment, minimal contact or wait-list control. Participants included in the review. Adults with habit disturbances, affective and anxiety problems, and health related problems. Eighty five percent of the studies used non-clinical populations. Outcomes assessed in the review. Changes in adults exhibiting behaviour problems. It was not clear what measurement tools were used to measure the outcomes, but all quantifiable outcomes were transformed to a common metric. Study designs of evaluations	Results of the review. Effectiveness of interventions based on self-regulation theory: There was significant heterogeneity in the magnitude of the self-regulatory intervention effect sizes (chi-squared = 23.56, df = 12, $p<0.02$). Thirteen studies yielded an average effect size (ES) of 0.25 ($z = 2.59$, $p<0.005$). The ES comparing interventions using self-monitoring plus any other self-regulatory component (SM plus) was 0.42 ($z = 3.78$, $p<0.001$) at post-treatment. Significant heterogeneity was found in the magnitude of SM plus effect sizes for these 10 studies (chi-squared = 17.8, df = 9, $p<0.03$). The possible factors accounting for significant variability within self-regulatory interventions compared to controls and within SM plus compared to SM alone were explored. Examination of variability within self-regulatory interventions compared to controls: Post-treatment effectiveness of SM alone compared to controls yielded an average ES of 0.29 ($N = 10$, $z = 1.71$, $p<0.05$) at post-treatment. No heterogeneity was found across these effect sizes. Post-treatment effectiveness of SM plus compared to controls yielded an average ES of 0.37 ($N = 7$, $z = 2.70$, $p<0.05$). Significant heterogeneity of variance was found across these ES estimates (chi-squared = 19.81, df = 6, $p<0.002$). Post-treatment effectiveness of studies combining SM plus interventions and SM alone yielded an average ES of 0.45 ($N = 4$, $z = 3.22$, $p<0.0001$). Significant heterogeneity was found across these ES estimates (chi-squared = 8.85, df = 3, $p<0.03$. Between-group tests comparing the

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	included in the review. Only between-subjects designs were included in the review. Controlled studies were included which compared interventions based on a self-regulatory model to no-treatment, wait-list, and minimal contact attention controls to other self-regulatory components. What sources were searched to identify primary studies? PsycLIT and Psychological Abstracts were searched and a review of references from relevant articles/books was performed. Search terms and dates were not stated. Only published studies were included in the review. Only studies which presented quantifiable data that could be transformed to a common metric were included. Criteria on which the validity (or quality) of studies was assessed. The authors perform an assessment of internal validity, including type of control group, level of psychopathology and length of treatment and external validity, including type of behavioural disturbance and treatment modality. How were decisions on the relevance of primary studies made? Not stated. How were judgements of validity (or quality) made? Not stated. How was the data extracted from primary studies? A 50 variable coding system was developed that provided information on study, subject, methodological, and intervention characteristics. Ten studies were randomly chosen for coding by an independent rater in order to establish reliability. Percent agreement and kappa estimates of agreement were computed for each of the categorical variables utilised. Sixteen of the 21 variables presented had kappa values of 1.0 and the remaining 5 variables had kappa values ranging from 0.32 to 0.87. Effect sizes were calculated for each study from the r, t and F statistics, or from the	above three sub-datasets (SM alone vs controls, SM plus vs controls, SM plus and SM alone versus controls) were nonsignificant. Examination of variability within SM plus compared to SM alone: post-treatment effectiveness of SM plus goalsetting (GS) yielded an average ES of 0.60 (N = 3, z = 3.61, p<0.0002). There was significant heterogeneity across these ES estimates (chi-squared = 7.87, df = 2, p = 0.01). Post-treatment effectiveness of SM plus feedback (FB) yielded an average ES of 0.80 (N = 2, z = 2.29, p<0.01). No heterogeneity was present. Post-treatment effectiveness of SM plus self reinforcement (SR) yielded a non-significant average ES of 0.15 (N = 5, z = 0.83, p = 0.20) with no heterogeneity present. Between-group tests comparing the above three sub-datasets revealed that interventions combining SM and GS are significantly more effective than interventions combining SM and SR (z = 1.68, p<0.05). Treatment of drop-out: Drop-out rates for treatment groups and controls were 16.6% and 9.5% respectively (not significant). Follow-up: No significant decrease in ES emerged between end-of-treatment and follow-up (1-8 weeks) for self-regulatory interventions and SM plus interventions. An examination of the discrepancy in overall ES estimates between self-regulatory interventions compared to controls and SM plus compared to SM alone was also performed. Factors affecting SM, effects of motivational variables, goals and feedback were also explored. Internal validity analysis: No differences emerged among studies due to control groups, instillation of hope to control groups, and treatment length. In terms of level of pathology, between-group tests revealed that studies utilising outpatient samples had a significantly larger ES than studies utilising college samples (z=1.64, p<0.05). For assessment method, studies utilising behavioural measures had a larger ES than studies utilising self-report measures (z=1.66, p<0.05). External validity analyses: No differences emerged for target behaviour. For treatment format, studies utilising individual treatment formats had a significantly larger ES than studies utilising group treatment formats (z=2.12, p<0.02). Was any cost information reported? No. Author's conclusions. Compared to no intervention at all, the effect size for self-regulatory interventions was significant but small (ES = 0.25). However, significant variability existed for self-regulatory interventions relative to controls, complicating the interpretation of this finding. The findings suggest that the more self-regulatory components are present in an intervention, the more effective the self-regulatory intervention is compared to no intervention at all. The authors noted several limitations to the present review. First, most of the studies (12 of 20) targeted habit disturbances, making it difficult to compare

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	raw means, standard deviations and Ns using a computer programme by Mullen (see Other Publications of Related Interest). Drop-out rates were examined for each group using a relatively conservative non-parametric procedure that compares proportional differences. Number of studies included in the review. There were 20 studies included in the review. The total sample size was not given. Thirteen studies, comprising 385 participants were used to examine differences due to control groups. How were the studies combined? Individual effect sizes were combined to form the overall effect size. The procedure used to perform this calculation was not stated. How were differences between studies investigated? Heterogeneity was tested using chi-squared tests. The sources of heterogeneity were investigated. To examine the variability within self-regulatory interventions compared to controls, the dataset was divided into several sub-datasets: SM alone compared to controls; b. Interventions using self monitoring plus any other self-regulatory components (SM plus) compared to controls; c. SM plus and SM alone compared to controls. To examine the effects of adding specific self-regulatory components to SM alone, the following analyses were conducted: a. SM plus goal-setting (GS) compared to SM alone. b. SM plus feedback (FB) compared to SM alone. c. SM plus self-reinforcement (SR) compared to SM alone. Sub-group (internal validity) analyses were performed for type of control group (no treatment, wait list and minimum contact/attention controls), promise of treatment (control groups in which treatment was promised versus control groups in which it wasn't promised), level of psychopathology (e.	studies across target behaviours or generalise the results of the review. Second, most of the studies contained relatively small sample sizes, with 95% of the studies containing less than 15 subjects per group and only 55% of the studies containing at least 10 subjects per group. Third, only 85% of the studies used non-clinical populations. Finally, there were inconsistencies in how self-regulation components were utilised and defined in studies. For example, some studies purporting to use self-monitoring as the sole intervention also included explicit feedback and goal-setting. CRD commentary. The review focuses on a well defined question. Inclusion and exclusion criteria were appropriate. The primary studies were combined appropriately. The search terms and dates of the databases searched were not provided. In addition, only published studies were included, leading to a potential publication bias. An analysis of internal and external validity was performed, but quality criteria such as blinding of randomisation and concealment of randomisation were not assessed. Some details of the primary studies were provided, but only for those which examined self-regulatory interventions compared to control groups were included. Details such as age, sex, level of psychopathology, length of treatment, follow up times, type of assessment, target behaviours, and treatment modality were not provided. In addition, the authors did not state what measurement tools were used to measure changes in participants' problem behaviours. The conclusions follow from the results, but both should be interpreted with caution, due the limitations noted by the authors (see "Author's Conclusions") and those stated here. What are the implications of the review? The authors state that there is a need to conduct large-scale controlled studies of the effectiveness of self-regulatory interventions on clinical populations and to assess their impact. Such research should systematically assemble and disassemble interventions in which self-regulatory components are the primary interventions

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	G. outpatient versus college), type of assessment (self report versus behavioural) and length of treatment (1-4 weeks, 5-8 weeks, and greater than 8 weeks). Sub-group (external validity) analyses were performed separately for the target behaviours (habit disturbances, depression, anxiety, and health related behaviours) and for treatment modality (therapist assisted versus self-administered and interventions utilising individual, group and mail-contact only formats).	
Williams D, McBride AJ. The drug treatment of alcohol withdrawal symptoms: a systematic review. Alcohol and Alcoholism 1998;33(2):103-15.	A computer-assisted and cross-reference literature search identified trials of therapy for alcohol withdrawal symptoms. Those with a randomized, double-blind placebo-controlled design were systematically assessed for quality of methodology. Fourteen studies were identified investigating 12 different drugs.	The quality of methodological design, even among this highly selected group of published studies, was often poor. Study populations were generally under-defined, most studies excluded severely ill patients, control groups were poorly matched, and the use of additional medication may have confounded results in some studies. Twelve different rating scales were used to assess severity of symptoms. All 12 compounds investigated were reported to be superior to placebo, but this has only been replicated for benzodiazepines and chlormethiazole. Further research using better methods is required to allow comparison of different drugs in the treatment of alcohol withdrawal symptoms. On the evidence available, a long-acting benzodiazepine should be the drug of first choice.
Marsch, LA. The efficacy of methadone maintenance interventions in reducing illicit opiate use, HIV risk behavior and criminality: a meta analysis. Addiction 1998;93(4):515-32.	Meta-analytic statistical procedures are used to determine the effectiveness of methadone maintenance treatment (MMT) on illicit opiate use (11 studies), HIV-risk behaviors (8 studies) and criminal activities (24 studies).	There was a consistent, statistically significant relationship between MMT and the reduction of illicit opiate use, HIV-risk behaviors and drug and property-related criminal behaviors. The effectiveness of MMT was most apparent in its ability to reduce drug-related criminal behaviors. MMT had a moderate effect in reducing illicit opiate use and drug and property-related criminal behaviors, and a small to moderate effect in reducing HIV-risk behaviors. MMT's effectiveness was evident across a variety of contexts, cultural and ethnic groups, and study designs.
Tolan P, Guerra N. Youth Violence: What Works. Boulder, CO: University of Colorado, Boulder Center for the Study and Prevention of Violence. 1998.	Review of programs for violent youth.	The authors advise that the value of this is limited, because it indicates that most approaches for addressing juvenile violence have not been well evaluated, so that the effects shown must be qualified and enthusiasm tempered. The review shows that there are effective programs at each level of intervention, although the majority of evaluated programs target individual- level influences, because this level is the easiest to evaluate. At the individual level, there is support for the use of cognitive- behavioral multidimensional programs, particularly those that combine generic problem-solving skills (a structured method for resolving interpersonal

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		conflicts) with other cognitive skills (e.g., perspective-taking and moral reasoning). Further, programs that provide for extensions into real-life skills and situations are apparently more effective than others, and behavior modification in real-life settings has shown promise. There is some evidence that individual analytic and supportive psychotherapy can work if it is part of a larger structured program; however, the overall evidence argues against its use. it is less effective than other approaches and may have harmful effects. Similarly, intensive casework has been evaluated numerous times and has failed to show a positive effect; at times, negative effects have been shown. Biomedical approaches have produced equivocal results, and apparently are indicated only for extremely violent youths.
Wing J, Marriott S, Palmer C, Thomas V. Management of imminent violence: clinical practice guidelines to support mental health services. Occasional Paper 1998;(OP41):1-111.	Author's objective. To develop clinical practice guidelines intended to assist health practitioners, managers, service users and 'informal' careers in making decisions about the most appropriate actions needed in mental health care settings where violence by a user is imminent or actually occurring. Type of intervention. Management, prevention. Specific interventions included in the review. All interventions aimed at preventing or dealing with imminent violence, including environmental interventions (providing calming features, a secure environment, activities, staff training, management protocols, policies etc); restraining and seclusion interventions (leather cuffs, strait jacket, seclusion rooms etc), pharmacological interventions (tranquillisers, antipsychotics etc) and short-term prediction interventions (screening scales, clinical assessment etc). Interventions including medium to long term prediction, causation, or management of violence were excluded. Participants included in the review. Adult users of mental health services. The following were excluded from the review: the elderly, people with learning disorders, people with problems due primarily to personality disorders or substance abuse,	Results of the review Environmental interventions (n=17 studies, all descriptive studies): Although the studies were relevant, all were descriptive and none had a fully controlled design. Varied methods of data collection, measurement and analysis made it impossible to aggregate the results and so no strongly evidence-based conclusions could be drawn. However, there was weak quantitative evidence that training and experience reduces injuries to staff, although it is not clear whether overall incidents of violence (ie patient-to-patient) are reduced. Material in several papers also suggested that overcrowding is a potent cause of irritability on wards and that wards with trained and experienced staff working well together with good leadership (ie high morale wards) tend to be less violent. Restraint and seclusion (n=16 studies, 6 cohort and 10 descriptive studies): Few of the papers gave examples of how restraint or seclusion were administered. The definition and practice of restraint also differed between countries and changes over time. The majority of the papers were from the USA where the term 'restraints' can mean the use of leather cuffs and belt fastened with various degrees of security. It can also mean a 'camisole' or 'straitjacket'. Only two papers were relevant to the UK and they were not rigorous, so no strongly evidence-based conclusions can be drawn. Variations between the legal systems of different countries should be considered when interpreting the results. Medication (n=19 studies, 4 RCTs, 7 controlled, 1 review of controlled studies, 2 cohort and 5 descriptive studies): Only one trial satisfied all the design criteria specified and only one other was specifically randomised and double-blind. Many provided no evidence for claims of randomisation or that clinicians were blind. Thus it was not possible to draw strong evidence-based conclusions from these studies. Several references did however suggest that if rapid tranquilization is indicated because psychosocial methods have failed or are insufficient or inappropriate, then

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	people receiving domicilliary visits and those attending general practice surgeries. Outcomes assessed in the review. Intervention effectiveness and safety was assessed. Effectiveness was measured in a number of ways including: number of violent/aggressive incidences, rate of injury (including patient-to-patient and patient-to-staff), mean violent incident rate, mean number of incidences of seclusion/restraint been used, and patient attitudes (assessed via questionnaire). Violent incidences committed by people other than mental health service users were excluded. Measures of safety included: number of hallucinatory experiences whilst on medication, drug related adverse events, patient injury rate. Study designs of evaluations included in the review. RCTs, controlled trials, cohort studies, descriptive studies, meta-analyses and reviews were included. Economic evaluations were excluded. What sources were searched to identify primary studies? Reviewers working with a member of the Work Group conducted their own searches and a skilled librarian searched the following electronic databases: EMBASE (1986-1996), PsycLIT (1974-1997), MEDLINE (1966-1997), Cochrane Library (1997; Issue 3). The searches were combined and additional articles identified through manually searching the reference lists of retrieved articles. Experts in the field were also consulted to identify further references and to ensure the completeness of the reference list. Criteria on which the validity (or quality) of studies was assessed. Study design, clarity of hypothesis, size and adequacy of sampling methods, drop-out rates, appropriate use of measurement tools, statistical methods, and evidence of a clear and disinterested	benzodiazepines alone, or an antipsychotic alone can be used with a reasonable degree of safety for managing violent behaviour. There was no evidence that a combination of several medications, or that the use of doses above those recommended in the British National Formulary, produce better results. Short-term prediction (n=17 studies, 14 cohort and 3 descriptive studies): Many of the papers provided data that could be compared in terms of the sensitivity and specificity of prediction. Several of the papers however pointed to difficulties that hindered the interpretation of the results, such as wide variations in settings, patient sampling and characteristics etc. Many of the studies also used data from records of uncertain accuracy. Designs that included violence at or near admission as a predictor of violence later on ran into a constant risk of contamination. Consequently, the studies did not provide a clear consensus on items that would be clinically useful for short-term prediction across a variety of clinical settings. A review of non-research information was also presented including: assessment of national guidance documents, canvassed views and priorities of mental health service users/carers, and a review of information obtained through discussion groups with mental health service nurses. Was any cost information reported? No. Author's conclusions. The review has been thorough. We consider that the guidelines provide an up-to-date and dispassionate account of the evidence currently available and that it deserves to be read widely and acted upon, particularly in light of the Department of Health's recent guidance on reducing the incidence of violence to health service staff. CRD commentary. This is a clear and detailed review based on a thorough search of the literature, both published and unpublished. Clear inclusion/exclusion criteria are provided and the methods used to assess the relevance and quality of studies clearly stated. However, the nature of the review question dictates that the majority of the evidence comes from descriptive studies and not from more rigorous studies such as RCTs and controlled studies. Heterogeneity is also evident throughout the groups of studies and the authors highlight this. In view of these limitations the use of a narrative summary of results is appropriate and the authors conclusions would appear to be valid. What are the implications of the review? Practice implications: A series of 18 guidelines for practice are provided under the general headings of 'ward design and organisation', 'anticipating and preventing violence', and 'medication in the context of violence'. The authors state that the guidelines 'should be seen as a companion to the Department of Health's guidance, the Health and Safety Executive's guidance on managing and assessing violence to staff and the Royal College of Psychiatrists' Council

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	presentation. In addition controlled studies were also assessed in terms of randomisation, clinician and patient blinding, sample size and follow-up rate. How were decisions on the relevance of primary studies made? Relevance was assessed by individual reviewers and then consensus decisions reached by discussion with the Research Team and members of the Work Group. How were judgements of validity (or quality) made? Validity was assessed by individual reviewers and then consensus decisions reached by discussion with the Research Team and members of the Work Group. Only well designed studies were included. How was the data extracted from primary studies? Not stated. Number of studies included in the review. 68 studies (4 RCTs, 11 controlled, 22 cohort, 34 descriptive and 1 other study). How were the studies combined? The studies were divided into the four intervention groups (environmental, restraint and seclusion, medication, short-term prediction) and discussed using a descriptive narrative. How were differences between studies investigated? Differences between studies were discussed but no formal assessment of heterogeneity was performed.	Report on the design of psychiatric facilities'. Research implications: The authors state that 'controlled studies of the use of atypical and short-acting depot neuroleptics in this context are needed'. Also 'it is strongly recommended that a review of the evidence and probably a revision of this report, should be made within five years'.
Higgins ST. The influence of alternative reinforcers on cocaine use and abuse: a brief review. Pharamacology, Biochemistry and Behavior 1997;57(3):419-27.	Review of experimental studies conducted with human and non-human participants.	Increasing availability of alternative, non-drug reinforcers can significantly disrupt the acquisition and maintenance of cocaine use and abuse.
Wilk AI, Jensen NM. Meta-analysis of randomized control trials addressing brief interventions in heavy alcohol drinkers. Journal of General Internal Medicine 1997;12(5):274-83.	To assess the effectiveness of brief interventions in heavy drinkers by analyzing the outcome data and methodologic quality. DESIGN: (1) Qualitative analysis of randomized control trials (RCTs) using criteria from Chalmers' scoring system; (2) calculating and combining odds ratios (ORs) of RCTs	Twelve RCTs met all inclusion criteria, with an average quality score of 0.49 + or - 0.17. This was comparable to published average scores in other areas of research (0.42 + or - 0.16). Outcome data from RCTs were pooled, and a combined OR was close to 2 (1.91; 95% confidence interval 1.61-2.27) in favor of brief alcohol interventions over no intervention. This was consistent across gender, intensity of intervention, type of clinical setting, and higher-quality clinical trials. CONCLUSIONS: Heavy drinkers who

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	using the One-Step (Peto) and the Mantel-Haenszel methods. STUDY SELECTION AND ANALYSIS: A EDLINE and PsycLIT search identified RCTs testing brief interventions in heavy alcohol drinkers. Brief interventions were less than 1 hour and incorporated simple motivational counseling techniques much like outpatient smoking cessation programs. By a single-reviewer, non-blinded format, eligible studies were selected for adult subjects, sample sizes greater than 30, a randomized control design, and incorporation of brief alcohol interventions. Methodologic quality was assessed using an established scoring system developed by Chalmers and colleagues. Outcome data were combined by the One-Step (Peto) method; confidence limits and chi 2 test for heterogeneity were calculated.	received a brief intervention were twice as likely to moderate their drinking 6 to 12 months after an intervention when compared with heavy drinkers who received no intervention. Brief intervention is a low-cost, effective preventive measure for heavy drinkers in outpatient settings.
Stanton MD, Shadish WR. Outcome, attrition, and family-couples treatment for drug abuse: a meta-analysis and review of the controlled, comparative studies. Psychological Bulletin 1997;122(2):170-91.	This review synthesizes drug abuse outcome studies that included a family-couples therapy treatment condition. The meta-analytic evidence includes 1,571 cases involving an estimated 3,500 patients and family members.	Evidence favors family therapy over (a) individual counseling or therapy, (b) peer group therapy, and (c) family psychoeducation. Family therapy is as effective for adults as for adolescents and appears to be a cost-effective adjunct to methadone maintenance. Because family therapy frequently had higher treatment retention rates than did non-family therapy modalities, it was modestly penalized in studies that excluded treatment dropouts from their analyses, as family therapy apparently had retained a higher proportion of poorer prognosis cases. Re-analysis, with dropouts regarded as failures, generally offset this artifact. Two statistical effect size measures to contend with attrition (dropout d and total attrition d) are offered for future researchers and policy makers.
Glanz M, Klawansky S, McAullife W, Chalmers T. Methadone vs. L-alpha-acetylmethadol (LAAM) in the treatment of opiate addiction: a meta-analysis of the randomized, controlled trials. American Journal on Addictions 1997;6(4):339-49.	The studies were located through a search of MEDLINE and a review of bibliographies of retrieved articles and pertinent review articles, The search spanned 1966-96. All studies were conducted in standard outpatient opiate addiction treatment clinics. Most participants were men from lower socioeconomic strata.	Results revealed a statistically significant risk difference that favored methadone for retention in treatment and for discontinuation of treatment because of side effects. The risk difference for illicit drug use favored LAAM, but the difference was not significant. A small treatment difference in favor of methadone was also noted. Findings indicated that LAAM is a relatively effective alternative in the treatment of opiate addiction, given its potential practical and operational benefits in comparison to methadone in certain situations

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Harris GT, Rice ME. Risk appraisal and management of violent behavior. Psychiatric-Services 1997;48(9):1168-76.	A review analyzes research published in the last decade on the prediction, management and treatment of violent persons.	Well-controlled studies have shown the effectiveness of behavior therapy and of behavioral staff training programs in reducing violence by patients in institutions, chronic psychiatric patients, and other populations. Otherwise, little is known about which psychotherapeutic or pharmacological treatments reduce violent recidivism under what circumstances. Recent work on the neurophysiology of aggression holds exciting promise but does not yet provide a scientific basis for prescriptive treatment. The most exciting and promising avenues for research on the management of violence lie in the joining of biology and psychology.
Bates BC, English DJ, Kouidou-Giles S. Residential treatment and its alternatives: a review of the literature. Child and Youth Care Forum 1997;26(1):7-52.	This review summarizes the literature for residential treatment, family preservation services, treatment foster care, and individualized services. Characteristics of each model are reviewed, as are methodological limitations of outcome studies and treatment effectiveness with children.	Although residential treatment is often viewed negatively, empirical evidence does not suggest differential levels of effectiveness compared to nonresidential alternatives. The results of some nonresidential outcome studies are promising, but efficacy claims should be viewed critically, due to the absence of methodologically rigorous evaluations for both residential and nonresidential approaches. Treatment effectiveness for both residential and nonresidential programs continues to be hampered by the use of small, nonrandom samples, failure use comparison or control groups, poorly defined subjective outcome criteria, the use of nonstandardized assessment tools, and the failure to explicate and link treatment components to outcomes.
Mayo-Smith MF. Pharmacological management of alcohol withdrawal. A meta-analysis and evidence-based practice guideline. JAMA 1997;278(2):144-51.	To provide an evidence-based practice guideline on the pharmacological management of alcohol withdrawal. DATA SOURCES: English-language articles published before July 1, 1995, identified through MEDLINE search on "substance withdrawal--ethyl alcohol" and review of references from identified articles. STUDY SELECTION: Articles with original data on human subjects. DATA ABSTRACTION: Structured review to determine study design, sample size, interventions used, and outcomes of withdrawal severity, delirium, seizures, completion of withdrawal, entry into rehabilitation, adverse effects, and costs. Data from prospective controlled trials with methodologically sound end points corresponding to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, were abstracted by 2 independent	Benzodiazepines reduce withdrawal severity, reduce incidence of delirium (-4.9 cases per 100 patients; 95% confidence interval, -9.0 to -0.7; P=.04), and reduce seizures (-7.7 seizures per 100 patients; 95% confidence interval, -12.0 to -3.5; P=.003). Individualizing therapy with withdrawal scales results in administration of significantly less medication and shorter treatment (P<.001). beta-Blockers, clonidine, and carbamazepine ameliorate withdrawal severity, but evidence is inadequate to determine their effect on delirium and seizures. Phenothiazines ameliorate withdrawal but are less effective than benzodiazepines in reducing delirium (P=.002) or seizures (P<.001). CONCLUSIONS: benzodiazepines are suitable agents for alcohol withdrawal, with choice among different agents guided by duration of action, rapidity of onset, and cost. Dosage should be individualized, based on withdrawal severity measured by withdrawal scales, comorbid illness, and history of withdrawal seizures. beta-Blockers, clonidine, carbamazepine, and neuroleptics may be used as adjunctive therapy but are not recommended as monotherapy.

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	reviewers and underwent systematic review.	
Gendreau P, Paparozzi M, Little T, Goddard M. Does "punishing smarter" work? An assessment of the new generation of alternative sanctions in probation. Forum in Corrections Research 1997;5:31-4.	They provide a brief report on a systematic review of 'get tough' or harsh sanctions on criminal recidivism. They defined 'get tough' strategies as any programs that had, as its primary emphasis, the punishment of offenders. These included: intensive supervision programs, scared straight, restitution, incarceration, boot camp, electronic monitoring, drug testing, arrest, and fines.	The recidivism rates were compared for three sets of studies: (a) spent more vs. less time in prison; (b) were incarcerated vs. those who remained in the community; and (c) intermediate sanctions vs. regular probation or parole. Over 100 studies were found (N=103) were found with control groups, yielding 376 effect sizes. The results showed that get tough strategies are ineffective and largely increase crime. For example, prisoners who spent more time in prison recidivated at a slightly higher rate (4%). Get tough strategies particularly backfire with low risk offenders, increasing their rate of recidivism by 7%. Only ISP programs that added counseling and treatment reduced crime (5%). Note that the 13 effect sizes from an unknown number of Scared Straight programs typically increased recidivism by 7%.
Malec TS, Malec EA, Dongier M. Efficacy of buspirone in alcohol dependence: a review. Alcoholism: Clinical and Experimental Research 1996;20(5):853-8.	The five published controlled studies on the effects of buspirone in alcoholism treatment are reviewed. They have been conducted mostly in alcoholics with comorbid anxiety.	Significant differences in favor of the medication were observed in several psychopathological measures (anxiety, depression, hostility, interpersonal sensitivity, and global psychopathology). In only two studies were alcohol craving and consumption found influenced. Systematic review showed positive effects of buspirone on treatment retention, as well as on anxiety. It can be concluded that the main effect of buspirone in the treatment of alcoholism is not on ethanol consumption per se, but on associated psychopathological symptoms. A favorable safety profile and a lack of interaction with alcohol make buspirone a useful pharmacological adjunct in the treatment of alcoholism.
Bourke ML, Donohue B. Assessment and treatment of juvenile sex offenders: an empirical review. Journal of Child Sexual Abuse 1996;5(1):47-70.	A review evaluates empirical support for the assessment and treatment methods currently used with juvenile sex offenders.	The heterogeneous nature of juvenile sex offenders and the failure of most measures to assess reliability and validity with this population make it difficult to generalize findings. Standardized assessment and treatment methods for use with prepubescent children are conspicuously absent in the literature. Suggestions for future investigations are offered.
Pearson FS, Lipton DS, Cleland CM. Some preliminary findings from the CDATE project. Presentation at the American Society of Criminology, Chicago, Illinois, November, 1996	Systematic review of 508 published and unpublished reports.	Two-thirds of their sample reported outcomes favoring treatment over control on crime or substance abuse outcomes. This was true of both adult and juvenile studies. When examining effect size, Pearson, et al. (1996) reported small, positive effects for treatment over controls; however, the weighted effect for treatment programs with adults was considerably smaller than that reported for juveniles (d=.035 for adults; d=.125 for juveniles).

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		They also found a design effect, i.e., that randomized designs had smaller effects than quasi-experimental ones.
Batel P. The treatment of alcoholism in France. Drug and Alcohol Dependence 1995;39(1): 15-21.	To determine the most appropriate form of pharmacotherapy for treating alcohol dependence, a systematic review of randomized controlled studies published between 1960-2993 was performed.	Results show that several pharmacotherapeutic agents had demonstrated safety and efficacy on different periods of follow-up, including acamprosate (long term), naltrexone (intermediate term), fluoxetine and citalopram (short term). Continued research is needed to identify the most appropriate patients to receive treatment with specific forms of pharmacotherapy.
Pearson F, Lipton D, Cleland C, O'Kane J. Meta-analysis on the effectiveness of correctional treatment: another approach and extension of the time frame to 1994—A progress report. Presentation at the American Society of Criminology Annual Meeting, Boston, Massachusetts, November 15th. 1995.	Preliminary analysis of 43 studies published between 1989-1994 (47 effect sizes included).	Pearson, et al. (1995) could not replicate the Andrews, et al. (1990) finding for appropriate correctional service with this new sample of studies. They found a substantively smaller phi (.19) than Andrews, et al. (1990) found (.69) for 'better' services. Pearson, et al. speculated that this conflict may be the result of coding unreliability between the two meta-analytic studies.
Agosti V. The efficacy of treatments in reducing alcohol-consumption: a meta-analysis. International Journal of the Addictions 1995;30(8):1067-77.	Systematic review was used to assess the relative efficacy of various treatments in reducing alcohol consumption over the short-term, 6 months, and 12 months. All the treatments were administered in well-controlled studies.	In the short-term and 1-year follow-up studies, patients in the experimental group drank much less than the control group. However, between group consumption differences were negligible in the 6-month studies. When the studies were pooled, regardless of the follow-up assessment periods, the experimental group drank significantly less than the control group. These results suggest that, in general, patients who received experimental treatments consumed much less alcohol than patients in the control groups.
Alexander CN, Robinson P, Rainforth M. Treating and preventing alcohol, nicotine, and drug abuse through transcendental meditation: A review and statistical meta-analysis: Errata. Alcoholism Treatment Quarterly 1995;13(4):97.	A qualitative review and statistical systematic review of 19 studies summarize the effect of TM on alcohol, cigarette, and illicit drug use and compare the outcomes of TM with relaxation and standard treatments.	Transcendental Meditation (TM) program provides a holistic, natural, and effective treatment that impacts social, environmental, physiological, psychological, and spiritual factors that can influence addictive behavior.

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Suss HM. The effectiveness of the treatment of alcoholics: results of a meta-analysis. Psychologische Rundschau 1995;46(4):245-66.	A systematic review of 23 experimental and 21 non-experimental prospective studies is given.	Different general success rates for total abstinence and improvement of drinking behavior are presented depending on the method of calculation (handling of treatment dropouts and follow-up dropouts). The stability over time of the success rates are evaluated. The effect sizes of the experimental studies are presented. Particular outcome issues include: comparing behavioral treatment, standard treatment package, disulfiram and minimal treatment, inpatient vs. outpatient, duration and variety of treatment. The significance of patient characteristics are analyzed, aspects of the experimental and clinical settings and in which country the study was conducted. The differing health structures in different countries may have an effect on the combined issue of generalizability of success rates and effect sizes.
Hall GC, Nagayama. Sexual offender recidivism revisited: a meta-analysis of recent treatment studies. Journal of Consulting and Clinical Psychology 1995;63(5): 802-9.	A systematic review examined 12 studies of sex offender treatment (N=1,313).	A small but robust overall effect size emerged for treatment versus comparison conditions. The overall recidivism rate for treated sex offenders was .19, versus .27 for untreated sex offenders. Treatment effect sizes across studies, however, were heterogeneous. Effect sizes were larger in studies that had higher base rates of recidivism, had follow-up periods longer than 5 years, included outpatients, and involved cognitive-behavioral or hormonal treatments. These treatments were significantly more effective than behavioral treatments, but were not significantly different from each other.
Wells-Parker E, Bangert-Drowns R, McMillen R et al. Final results from a meta-analysis of remedial interventions with drink/drive offenders. Addiction 1995;90:907-26.	A systematic review of the efficacy of remediation with drunk-driving offenders is based on 215 independent evaluations. Study characteristics were coded using scales and protocols developed by expert panels.	Better methodological quality, as indicated by group equivalence, was associated with smaller effect size and less variation in effect size. The average effect of remediation on recidivism was an 8 to 9% reduction. A similar effect size emerged for alcohol-involved crashes. Combinations of modalities incorporating education, psychotherapy/counseling, and follow-up contact/probation were more effective than other modes for reducing recidivism. Treatment effects were probably underestimated in the literature.
Agosti V. The efficacy of controlled trials of alcohol misuse treatments in maintaining abstinence: A meta-analysis. International Journal of the Addictions 1994;29(6):759-69.	Systematic review was used to establish the efficacy of various controlled alcohol misuse treatments in maintaining abstinence over short-term, 6 months, and 12 month follow-ups. The literature was surveyed for studies (1974-1992) that had a control group, used a significant other report and/or laboratory testing to validate the patient's report of alcohol use, measured abstinence rates, and randomized patients to treatments. 15 studies met the criteria.	Diverse treatments for alcohol misuse did not demonstrate significant differences in abstinence outcomes.

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Antonowicz DH, Ross RR. Essential components of successful rehabilitation programs for offenders. International Journal of Offender Therapy and Comparative Criminology 1994;38(2):97-104.	They conducted a systematic review of correctional treatment programs for juveniles or adults. They found 44 rigorous evaluations using randomization or a comparison group design cited in prior reviews or published in professional journals, during 1970-1991, that reported some outcome measure of crime in the community. They describe their search methods as examining previous reviews and searching criminological, sociological, psychological and substance abuse journals.	This report listed six factors that seemed to predict success (success measured as chi-square on outcomes, E v C). They state that "one of our major findings was that there is not a large number of published, rigorously controlled studies" (p.98). They note that "Twenty effective programs in 21 years indicates that effective programs are truly exceptional" (p. 98). They also note the reporting problems in the journals, including inadequate description of the programs, clients, staff and so on. The six characteristics associated with program efficacy: (1) sound conceptual model; (2) multifaceted programming; (3) targeting criminogenic needs; (4) responsivity principle; (5) role-playing and modeling; and (6) social cognitive skills training. No details on analyses or strength of associations were found in the abbreviated journal report. They also conclude discouragingly enough about the research, "given the distressingly poor quality of research and reporting of research, it is not yet possible to adequately test most of these suggestions" (p.102). But some programs obviously do work, with magnitudes of effect ranging from a 25 to 90% reduction in crime!
Lamas X, Farre M, Moreno V, Cami J. Effects of morphine in post-addict humans: a meta-analysis. Drug and Alcohol Dependence 1994;36(2):147-52.	Performed a systematic review of dose response data to determine whether there was a relationship between doses of the prototypic opioid agonist morphine and the magnitude of effects on subjective, behavioral, and physiological variables commonly used in the assessment of opioids. Data about heterogeneity between studies and variations in the dose-response functions were also analyzed. 33 studies published between 1964 and 1991 were examined.	Measurements of subjective and physiological effects increased as a function of the dose of morphine and, therefore, were useful predictors of morphine-like effects. However, the differences between variables and the degree of heterogeneity found across studies showed that the concurrent assessment of several indexes is required when evaluating the effects of morphine in nondependent humans.
Rasmussen DW, Benson BL. Intermediate sanctions: a policy analysis based on program evaluations. Report prepared for The Collins Center for Public Policy. 1994.	A review of recent evaluations of day fines, shock incarceration, intensive probation supervision, electronic monitoring and house arrest, and day reporting.	The promise of these sanctions is compromised by institutional structure, conflicting goals and lack of coordination and accountability; inadequate knowledge about targeted program participants; and insufficient cost-effectiveness analysis. Combined, these studies reveal only what such sanctions cannot do, rather than what they can accomplish.

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Tolan P, Guerra N. What works in reducing adolescent violence: an empirical review of the field. Boulder, CO: Center for the Study and Prevention of Violence, University of Colorado. 1994.	A review assesses research on the effects of programs intended to reduce adolescent violence. Programs are reviewed within each of 4 intervention categories that reflect risk factors for violence: individual factors, close interpersonal relations, proximal social contexts, and broader societal macrosystems within a biopsychological model.	Limited program evaluation is available to assess the effects of these approaches, and the most popular programs may not be those evaluated. While effective programs exist at each level of intervention, those assessed typically target individual-level influences: there is some support for cognitive-behavioral multidimensional programs, those that provide real life skills, and behavior modification. Increasingly popular mentoring and manhood development programs have not been adequately studied. Proximal interpersonal systems programs such as family-targeted interventions are effective. In this category, peer relation intervention was less effective. Interventions in proximal social settings, although not sufficiently evaluated, reported some success for increased parental involvement in schools, increasing youths' motivation to do well in school, and opportunities for prosocial roles. Community organization programs have been minimally evaluated. Milieu or token programs offered at residential institutions seem to improve youths' behavior while incarcerated, but are not promising in the long-term. Finally, there were no tests of societal-level influences. A more solid empirical base is necessary to effectively address adolescent violence.
Sowers WE, Daley DC. Compulsory treatment of substance use disorders. Criminal Behaviour and Mental Health 1993;3(4):403-15.	Review of current literature. Compulsory treatment refers to (1) civil commitment and (2) the provision of treatment as an alternative to incarceration	There is evidence that compulsory treatment is effective in reducing substance abuse.
Quinsey VL, Harris GT, Rice ME et al. Assessing treatment efficacy in outcome studies of sex offenders. Journal of Interpersonal Violence 1993;8(4):512-23.	A review critiques the literature on sex offender treatment.	Effectiveness of treatment in reducing recidivism has not yet been scientifically demonstrated. More well-controlled outcome research is needed that can be evaluated with meta-analytic techniques.
McLaren K. Reducing reoffending: what works now. Wellington, NZ: Penal Division, New Zealand Department of Justice. 1992.	A review of the international literature assesses correctional interventions aimed at reducing criminal recidivism, with an emphasis on New Zealand.	There is statistically rigorous evidence for the existence of a small but significant group of effective interventions. About 25-30% of interventions evaluated to date have done so in a statistically reliable way. No single category of intervention--such as work or education--has been found effective in all or even most cases, but some characteristics are shared across types of effective interventions. Sixteen principles from those interventions are outlined. The principles apply to many types of correctional interventions, whether in the community or in residential settings. The most important are based on a social learning model, which suggests that many criminal ways of thinking and behaving are learned, and that offenders can learn new attitudes and behaviors that result in less reoffending. Relations between staff and offenders in effective interventions are characterized by

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		empathy, trust and open communication. Offenders are trained in practical, personal and social problem-solving skills, and involved in planning interventions. When offenders are assigned to interventions that suit their predominant style of learning, they are more likely to benefit. Deterrent interventions, which seek to prevent future offending by exposing offenders to harsh or rigorous regimes, have rarely resulted in reduced reoffending. Interventions based on a "medical model" are less likely to be effective.
Lipsey MW. Juvenile delinquency treatment: a meta-analytic inquiry into the variability of effects. In Thomas A. Cook, et al. (eds.) Meta-Analysis for Explanation: A Casebook. New York, NY: Russell Sage Foundation: 1992;83-127.	A systematic review examines variability in delinquency treatment effects found in the research literature. The analysis included 443 studies conducted since 1950 in English-speaking countries.	While treatment program effects were positive overall, there was a larger than expected degree of variability in outcomes. The research methods as well as the treatment influenced the effects of treatment. Multiple regression revealed that method variables contributed a large share of the variability in treatment outcomes, but that treatment characteristics also had a large, independent impact on effect size. Pre-treatment equivalence of treatment and control groups used in the study accounted for the most variance: while use of random assignment had no relationship, specific areas of nonequivalence did matter. Other important method clusters included sample size, type of control group, and the nature of measures of delinquency outcome. The treatment modality and the nature of the treatment provider demonstrated the strongest relationship with effect size, independent of study method. The more structured and focused treatments, such as behavioral and skill-oriented approaches, as well as multimodal treatments, were most effective. Interestingly, subject characteristics were unrelated to treatment effects, and the modest relationships between amount or intensity of treatment and outcomes were confounded. In conclusion, the wide variability in treatment effects implies that whether delinquency treatment is deemed effective depends upon which areas of the research literature are examined.
Roberts AR, Camasso MJ. The effect of juvenile offender treatment programs on recidivism: a meta-analysis of 46 studies. Notre Dame Journal of Law, Ethics and Public Policy 1991;5(2):421- 41.	They conducted a systematic review of evaluations of juvenile offender treatment. Methods are explicit. They did a hand search of 23 major criminology, justice and psychology journals, covering the literature from 1980-1990. Only studies that included some type of control or comparison were included, i.e. randomized experiment, quasi-experiment, statistical controls, matched comparison, or pre/post.	They report that juvenile offender treatment typically has small, positive effects. The largest effects, according to the authors, are for family therapy (ES=.55) and group treatment strategies (ES=.81). Roberts and Camasso note that the evaluations comprising the group treatment category are weak and they question the findings. Interesting that the effect sizes for vocational/educational programs (ES=.40) and drug/alcohol counseling (.44) - both higher than the average effect size - are not mentioned. They also find that studies with smaller samples (<50 in each group) report larger effect sizes. Effect size also decreases dramatically with length of follow-up (ES=.22 for studies with follow-ups of more than 12 months compared to an ES of .60 for studies with follow-ups of less than six months). The long on description, short on evaluation problem is noted again when they write,

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		"Despite the fact that hundreds of studies have been published on the effectiveness of different types of juvenile offender treatment programs during the past decade, the majority of them are descriptive and anecdotal, with small samples and weak research designs"(p. 437). They conclude that the only treatment modality that is clearly effective is family therapy, based on effect size and quality of studies in the category, concluding that "..it is important to recommend to juvenile justice administrators that they replicate family counseling programs in their respective jurisdiction" (p.438).
Ter Riet G, Kleijnen J, Knipschild P. A meta-analysis of studies into the effect of acupuncture on addiction. British Journal of General Practice 1990;40:379-82.	A literature search revealed 22 controlled clinical studies on the efficacy of acupuncture in three fields of addiction: cigarette smoking (15), heroin (five), and alcohol (two). These studies were reviewed using a list of 18 predefined criteria of good methodology. A maximum of 100 points for study design could be earned, divided over four categories: comparability of prognosis; adequate intervention; adequate effect measurement; and good data presentation.	The study design was generally poor. No study earned more than 75 points and 12 studies (55%) earned less than 50 points. For smoking cessation, the number of studies with negative outcomes exceeded by far the number with positive outcomes. Taking the quality of the studies into account this negative picture becomes even stronger. For heroin and alcohol addiction controlled clinical research is both scarce and of low quality. Claims that acupuncture is efficacious as a therapy for these addictions are thus not supported by results from sound clinical research.
Izzo RL, Ross RR. Meta-analysis of rehabilitation programs for juvenile delinquents: a brief report. Criminal Justice and Behavior 1990;17(1): 134-42.	A systematic review examines 46 studies of intervention programs for delinquents, concentrating specifically on the intervention variable of program conceptualization. Of the studies reviewed, 16 reported 2 or more appropriate comparisons, for a total of 68 effect-size measures.	Support emerged for a cognitive model of offender rehabilitation. Attending to how the offender thinks may be at least as important as concentrating on how he or she feels or behaves. It may be also be valuable to teach offenders to think logically, objectively and rationally without overgeneralizing, distorting the facts or externalizing the blame
Andrews DA et al. Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. Criminology 1990;28(3): 369-404.	A content and systematic review hypothesizes that the delivery of appropriate correctional service reflects 3 psychological principles: delivery of service to higher-risk cases; targeting of criminogenic needs; and use of styles and modes of treatment (e.g., cognitive and behavioral) that are matched with client need and learning styles. These principles were applied to 80 studies of juvenile and adult correctional treatment, which yielded 154 phi coefficients that summarized the magnitude and direction of the impact of treatment on	The effect of appropriate correctional service (mean phi=.30) was significantly greater than that of unspecified correctional service (.13), and both were more effective than inappropriate service (-.06) and nonservice criminal sanctioning (-.07). Service was reported effective: (a) in both juvenile and adult corrections; (b) in studies published before and after 1980; (c) in randomized and nonrandomized designs; and (d) in diversionary, community, and residential programs (albeit, attenuated in residential settings).

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	recidivism.	
Bandoroff S. Wilderness adventure therapy for delinquent and pre-delinquent youth: a review of the literature 1989.	The review itself includes 25 empirical studies presented according to the type of research design employed.	The findings are inconsistent, but a number of areas demonstrate relatively clear results. Evidence supports the claims that wilderness-adventure therapy leads to improved self-perceptions, increase of social adjustment, and reduced recidivism. The findings are less conclusive regarding locus of control, problem solving ability, behavior change, and duration of the effects. It is concluded that WAT appears to be a viable alternative for the treatment of delinquent youth
Furby L, Weinrott MR, Blackshaw L. Sex offender recidivism: a review. Psychological Bulletin 1989;105(1):3-30.	They provide a systematic review of recidivism rates for sex offenders. They describe their search efforts as a "considerable effort to locate both published and unpublished studies" (p. 10). They examined books, articles, conference papers already familiar to them, as well as searches of Psychological and Social Abstracts, DIALOG PsychInfo, Sociological Abstracts, and the Criminal Justice Periodicals Index. They circulated their list to researchers and authorities in the field to account for studies that were overlooked. Their inclusion criteria included: (1) offenders were Convicted or committed to a treatment facility because of a sex crime, but not homosexuality; (2) data on follow-up in the community presented in the report; (3) male offenders; (4) data included official criminal justice records; (5) samples of 10 or more participants; and a (6) specified follow-up period	Furby et al. do not use meta-analytic techniques because: (1) the large number of studies in which the sample selection procedure was inadequately described; (2) enormous variability in samples across studies; (3) large number of studies for which the recidivism measures was inadequately defined; (4) the variability within many studies in length of follow-up periods for different men. All of these factors make it difficult to establish comparability of studies, which is necessary for the combining of their results to be meaningful. (p. 21). They do conclude from the qualitative analysis that "we can at least say with confidence that there is no evidence that treatment effectiveness reduces sex offender recidivism" (p.25). They state that "methodological shortcomings are present in virtually all studies, making the results from any single study both hard to interpret.." (p. 27).
Whitehead JT, Lab SP. A meta-analysis of juvenile correctional treatment. Journal of Research in Crime and Delinquency 1989;26 (3):276-295.	A systematic review of research published between 1975 and 1984	Interventions appear to have little positive impact on recidivism, and many appear to exacerbate the problem. The present analysis could even be considered overly lenient in its interpretation of the findings. It appears that the earlier evaluations that claim that nothing works are close to the conclusion to be drawn from more recent evaluations of juvenile treatments.

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Basta JM, Davidson II WS. Treatment of juvenile offenders: study outcomes since 1980. Behavioral Sciences and the Law 1988;6(3):355-84.	They conducted a systematic review of outcome studies from 1980-1987. They used the following search methods to find their studies: (1) computer Searches of ERIC and Psychological Abstracts; (2) examination of prior reviews; and (3) examination of actual study documents. They also define their search terms as "juvenile delinquents, treatment, intervention, outcome, rehabilitation, and community services." Their eligibility criteria were that the study had to treat adjudicated youths in the sample. A total of 37 studies were retrieved. They categorize their treatments into the following categories: behavioral, counseling-therapy, diversion, deterrence, and wilderness experience.	They conclude that overall, most treatments showed at least one positive outcome. Behavioral treatments were effective, as were counseling and therapy approaches. Mixed results were found for diversion, but they note that better controlled studies were more likely to find positive effects. Deterrence and wilderness approaches were not effective. Their final statement is" ..the question of whether anything works for treating juvenile offenders must be answered with a qualified "yes" (p. 375). Nonetheless, they add "the conclusions drawn, and the answers that might resolve these issues, lie in the future implementation of well-designed and well-controlled studies" (p. 375).
Lab SP, Whitehead JT. Analysis of juvenile correctional treatment. Crime and Delinquency 1988;34(1):60-83.	The impact of treatment on recidivism was the primary consideration in a simple ballot-box analysis of reports published in professional journals.	The results indicated that juvenile correctional treatment fared no better than in earlier reviews. In general, at least half of the studies reported negative or no impact on recidivism and many of the positive findings were based on dubious, subjective evaluations.
Wilson TG. Chemical aversion conditioning as a treatment for alcoholism: a re-analysis. Behaviour Research and Therapy 1987;25(6):503-16.	A systematic review of CAC studies is presented along with other analyses.	It is argued that the original justification for using drug-induced nausea in treating alcoholism has been undermined by alternative strategies (e.g., electrical aversion conditioning, covert sensitization through imagery) that are at least as effective. The intrusiveness and public acceptability of CAC and alternative therapies are discussed. It is noted that CAC is not a cost-effective treatment because of the hospitalization and direct physician involvement necessary.
Gottschalk R et al. Community-based interventions. In Herbert C. Quay (ed.) Handbook of Juvenile Delinquency. New York, NY: John Wiley and Sons. 1987:266-89.	A systematic review of the literature published after 1975 on community-based interventions with juvenile offenders reviews 90 studies involving over ll,000 subjects.	Treatment in community settings did not have a large effect on outcomes. If a strong treatment is used and care is taken during treatment to ensure that it is actually being implemented as designed, then more positive effects may emerge
Gendreau P, Ross RR. Revivification of Rehabilitation: evidence from the 1980s. Justice Quarterly 1987;4(3):349-407.	These evaluations had to employ some type of control, and must have had a six-month follow-up measure of crime in the community. research published during 1981-1987	Although no final number of studies they reviewed is provided, they similarly conclude that some treatment programs work across a variety of settings, with diverse types of offenders. They state (1987:395) that it "is downright ridiculous to say 'Nothing works'. The principles underlying effective rehabilitation generalize across far too many intervention strategies

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		and offender samples to be dismissed as trivial." Their view that something works was offered in several other literature surveys during this time frame (e.g., Cullen and Gendreau, 1989; Basta and Davidson, 1988; van Voorhis, 1987; Palmer, 1983). However, a careful reading of both the earlier "pessimistic" reviews and these later syntheses indicates a difference on emphasis, rather than substantive content.
Losel F, Koferl P, Weber F. Meta-evaluation of social therapy. [original title Meta-evaluation der sozialtherapie]. Stuttgart, Germany: Ferdinand Enke Verlag. 1987.	A systematic review synthesizes empirical studies from several nations on the effectiveness of rehabilitation programs in correctional facilities. Effectiveness is measured in relation to recidivism, as well as personality and behavioral change.	Inmates in prisons with rehabilitation therapy had moderately lower rates of recidivism than those in prisons without such programs. There was no evidence of clear differences in effectiveness between programs with a strong psychotherapeutic orientation and others emphasizing socialization.
Goldstein AP, Pentz MA. Psychological skill training and the aggressive adolescent. School Psychology Review 1984;13(3):311-23.	An analysis of 30 evaluation-orientated studies of skills training with delinquent or aggressive adolescents.	The research review demonstrates the effectiveness of social skills training with different settings, types of Ss, and target skills.
Winterdyk MA, Griffiths C. Wilderness experiences programs: reforming delinquents or beating around the bush? Juvenile and Family Court Journal 1984;35(3):35-44.	Analysis of 10 published evaluations.	Those studies using a control group to compare program and non-program differences in psychological scales provide mixed support for the efficacy of wilderness experiences. Studies focusing on recidivism have also provided inconsistent results. The majority of studies failed to use any measure or used only a short-term follow-up period (less than six months). The available data raise serious questions about the efficacy of wilderness education.
Davidson WS, Gottschalk R, Gensheimer L, Mayer J. Interventions with juvenile delinquents: a meta-analysis of treatment efficacy. Unpublished manuscript, Psychology Department, Michigan State University 1984.	Using a computerized search of Psychological Abstracts and a mail campaign with prominent research investigators, they were able to locate 91 juvenile treatment studies published or available between 1967-1983.	While the investigators took pains to cautiously present their results, they reported that treated subjects performed an average .35 SDs better on all outcomes (e.g, recidivism, attitudinal, etc.) than control subjects in 58 comparison group designs. For recidivism outcomes only, experimental subjects performed .32 SDs better than untreated controls, a finding which translates into a 16% reduction in recidivism rates (eg. Lipsey, 1988). It is interesting to note that experimental subjects performed .75 SDs better than control group subjects in the methodologically inferior pre/post designs, causing some later systematic review to dismiss such designs from their samples (eg. Lipsey, 1992a). The most promising interventions, when all research designs were included in the analysis, were academic and vocational rehabilitation programs (eg. Lipsey, 1988).

CRIME: Treatment and control relevant to crime, drugs and alcohol

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Gensheimer LK et al. Diverting youth from the juvenile justice system: a meta-analysis of intervention efficacy. In J. Apter and Arnold P. Goldstein (eds.) Youth Violence: Programs and Prospects. Elmsford, NY: Pergamon Press. 1986;39-57.	A review assesses the efficacy of diversion interventions with juvenile delinquents. Published and unpublished literature on diversion interventions from 1967 through 1983 are analyzed; included are only outcome studies of officially delinquent youth.	Overall, findings did not provide substantial evidence for the efficacy of diversion programs. It was impossible, however, to determine how far into the system those youths went before they were diverted. The older the subject, the less likely for intervention to have a positive effect. Interventions typically took place in community nonresidential settings, with length of intervention ranging from 4 to 52 weeks. The data substantiate the ambiguity and diversity of diversion programs. The practice of referring subjects to other community resources/programs (service brokerage) was the most common intervention used. Group therapy was also frequently employed. Other interventions used in over 1/3 of the studies were academic, vocational, and advocacy training. Behavioral techniques were used in slightly over 10% of the programs.
Mayer JP et al. Social learning treatment within juvenile justice: a meta-analysis of impact in the natural environment. In Steven J. Apter and Arnold P. Goldstein (eds.). Youth Violence: Programs and Prospects, Elmsford, NY: Pergamon Press. 1986:24-38.	A review analyzes information from 39 studies reporting behavioral interventions within the juvenile justice system. The typical study involved an adjudicated male sample in a residential setting; treatment involved token economies, modeling, contracting, or some other application of social learning theory. Both "vote count" and "effect size" methods of research accumulation were employed in assessing recidivism, behavioral, and attitudinal outcomes.	The "vote count" results agreed with past reviews suggesting that behavioral approaches were for the most part highly effective. The "effect size" method presented a more mixed picture. The literature suffered from serious methodological shortcomings and findings must therefore be strictly scrutinized.
Blumstein A et al. Research on sentencing: the search for reform. National Research Council Panel on Sentencing Research. Washington, D.C.: National Academy Press. 1983.	Research on the effects of sentencing reforms.	The extent of compliance with reforms has varied with a) the level of organizational or political support for the reform, b) the existence of statutory or administrative authority supporting the procedural requirement, and c) the existence of mechanisms for monitoring and enforcement. There have been modest changes in sentencing outcomes, particularly some increases in prison use, as a result of sentencing reforms. Increases in sentencing severity were typically found in cases that might or might not have resulted in short prison terms in the past. However, the substantial increases in prison populations in sentencing reform jurisdictions continued preexisting trends and were not substantially caused by these sentencing reforms.
Genevie L et al. Trends in the effectiveness of correctional intervention. Washington, DC: U.S. National Institute of Justice. 1983.	A statistical synthesis of the literature encompasses 555 reports and includes information on over 10,000 groups of adult and 2,100 groups of juvenile offenders, representing more than 2 million people.	Findings suggest that adult probationers and parolees return to crime at about the same rate. However, juvenile groups that were incarcerated have consistently higher rates of recidivism than groups sentenced to probation. Innovative treatment strategies showed little success; in fact, groups administered such treatment had higher rates of recidivism than those not

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		treated. For adults who had been incarcerated, short-term resource interventions such as financial aid and job placement appeared most promising for reducing recidivism. Similar trends emerged for juveniles; both job training and work study programs were associated with lower rates of recidivism.
Henderson M, Hollin CA. A critical review of social skills training with young offenders. Criminal Justice and Behavior 1983;10(3):316-41.	A review of 15 studies on the use of social skills training with delinquent populations	The findings do not yet provide unequivocal support for the usefulness of such training in reducing criminal behavior among delinquents. Failure to show consistent generalization and durability of training effects must be taken into account when discussing the efficacy of such treatment.
Orsagh T, White AD. Economic status and crime: implications for offender rehabilitation. Journal of Criminal Law and Criminology 1981;72(3):1055-71.	Within larger review, includes studies evaluating the effectiveness of programs designed to improve economic viability.	The programmatic literature provides only glimmers of hope that this may occur, mostly among a large number of insignificant program effects
Reker GT, Cote JE, Peacock EJ. Juvenile diversion - conceptual issues and program effectiveness. Canadian Journal of Criminology 1980;22(1):36-50.	A summary of empirical evaluation studies of juvenile diversion since 1976.	Few negative effects for diversion projects. However, methodological problems plague studies.
Hudson J, Galaway B, Novack S. National assessment of adult restitution programs. Final report. Duluth, Minnesota: University of Minnesota, School of Social Development. 1980.	The literature review identified 336 articles, books, and reports on community service, monetary restitution, or both; 85 percent had been published since 1970. Forty-three research studies were identified, all dating from 1975.	The extent to which generalizations can be made from the results of the studies is limited. At best, some tentative judgments can be made about trends and findings from the body of evaluative work: (1) The studies dealing with community service projects show that a large number of persons can be handled at relatively low cost, with relatively few in-project failures, resulting in the performance of large amounts of work for community agencies. The indirect costs of such projects, however, are open to legitimate question. One of the most consistent findings in the body of evaluation work is that restitution projects and programs established to divert offenders from custodial confinement generally do not fulfill this mission. The apparent inability of diversion projects to divert a substantial number of offenders from more severe penalties and their tendency to increase the degree of social control exercised over offenders raise disturbing questions. Instead of helping reduce rates of incarceration as intended, such projects may increase the number of persons under custodial confinement. The evaluative studies consistently show that most property offenses result in relatively small losses, the amount of restitution that is obligated is also relatively small, the amount actually paid is smaller yet, and

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		the largest proportion of victims are likely to be business firms. (4) Several of the evaluative studies show, somewhat surprisingly, that restitution is most frequently ordered in conjunction with a fine. (5) The non-evaluative studies dealing with attitudes toward the use of financial restitution or community service show quite clearly that such sanctions are endorsed by criminal justice officials and lay citizens.
Gendreau P, Ross RR. Effective correctional treatment: Bibliotherapy for cynics. Crime and Delinquency 1979;25(4):463-89.	In their first review, they accumulated 95 treatment peer-reviewed, published evaluations from the years 1973-1978 (e.g., Gendreau and Ross, 1979). These evaluations had to employ some type of control, and must have had a six month follow-up measure of crime in the community.	Although there was some overlap with Greenberg's (1977) earlier review, they concluded that several intervention programs were successful with offender populations.[2] One of their observations in this early review was that multi-method approaches seem to be more successful than programs relying on one treatment modality (1979:485).
Ward DA. Use of legal coercion in the treatment of alcoholism. A methodological review. Journal of Drug Issues 1979;9(3):387-98.	Review of research.	The evaluation of research studies shows there is no scientific base of evidence to support the notion that legal coercion is effective in treating alcoholics. Although most studies do conclude coercion works, such conclusions are unwarranted given the problems in the research designs.
Eskridge CW, Carlson EW. The use of volunteers in probation: a national synthesis. Journal of Offender Counseling, Services and Rehabilitation 1979;2:175-89.	A review of 38 project evaluations.	No clear evidence that volunteer programs are any more or any less successful than other correctional programs. However, such conclusions suggest that volunteer projects should be undertaken with extreme caution, for they appear to be fraught with theoretical, operational, and administrative pitfalls. There is some concern whether long-term improvements in behavior can be brought about in involving individual probationers in a volunteer program. Such involvement may have only a short-term impact upon individuals' behavior patterns.
Romig DA. Justice for Our Children. Lexington, MA: Lexington Books. 1978.	Romig (1978) reviewed 179 juvenile intervention program evaluations using randomized or matched control designs. He provides annotations similar to Lipton et al. 1975 that grade evaluations on the quality of the evidence.	Romig found little evidence for a single effective treatment approach with juvenile offenders.

[2] Although Greenberg (1977) and Gendreau and Ross (1979) cover much similar ground, their conclusions are quite disparate, highlighting the need for a more replicable and overt method of synthesizing studies.

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Banks J, Silver TR, Rardin RL. Past and present findings in intensive adult probation. 1977.	Intensive or special projects were considered. All projects dealt with adult offenders.	The review indicates that caseload reduction alone does not significantly reduce recidivism of adult probationers.
Gottfredson DM, Finckenauer JO, Rauh C. Probation on trial. Newark, NJ: Rutgers University School of Criminal Justice 1977.	A review is made of 104 selected studies of adult probation conducted in the United States since 1950.	Participation in Alcoholics Anonymous has reportedly, although not invariably, been associated with success. Evidence on the effects of reduced caseload size is mixed: More intensive supervision may result in more technical violations but fewer new convictions. Concerning types of treatment, group counseling and therapy methods are found to be effective with sex offenders, "contract" probation is useful in completion of a probation plan, and probationer unemployment may be reduced by a program of "vocational upgrading." Other programs having had some success include a methadone maintenance project, a behavior modification program for adult drug offenders, and a specialized program for alcoholic offenders.
Greenberg DF. The corrrectional effects of corrections. A survey of evaluations. In David F. Greenberg (ed.) Corrections and Punishment. Beverly Hills, CA: Sage. 1977;5: 111-48.	He conducted an exhaustive and possibly systematic review of research on the effects of Juvenile and adult correctional treatment. In a footnote, he lists the inclusion criteria as (1) studies conducted in the United States; (2) through 1975; (3) studies contained a meaningful number of subjects to be meaningful; (4) program involved persons in contact with criminal justice system from police contact stage through parole or prison release; (5) included some control or comparison group; and (6) included a measure of recidivism. Search techniques involved "searching relevant journals and relevant abstracting journals, and unpublished reports either obtained by author or from secondary data cited in Lipton et al. (1975) book and other sources. Annotations of studies are presented under each of the following categories: diversion, probation intensity, imprisonment, probation with non-residential programs, programs in conventional institutions, unconventional institutions, parole, and	Greenberg concludes that "..many correctional dispositions are failing to reduce recidivism, and it thus confirms the general thrust of the Lipton, Martinson and Wilks survey, which ended in 1967..Much of what is now done in the name of "corrections" may serve other functions, but the prevention of return to crime is not one of them. Here and there a few favorable results alleviate the monotony, but most of these results are modest and are obtained through evaluations seriously lacking in rigor" (p. 140-141). Greenberg relies on statistical significance as the barometer for success.

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	programs after release.	
Martinson R, Wilks J. Knowledge in criminal justice planning: a preliminary report. New York: The Center for Knowledge in Criminal Justice Planning, City University of New York. 1976.	The present project was designed as a Knowledge survey and was meant to build upon and improve the procedures developed in the previous work to synthesize existing research findings. The project began with the recognition that there is no standard methodology for carrying out such a survey and that there is considerable dispute among professionals as to how to proceed. This preliminary report summarizes what has been accomplished regarding the retrieval of all relevant research. The search produced 3,300 documents. The initial data analysis focused on 3005 recidivism rates derived from only 128 of these documents.	The data appear to show that the general recidivism rate in the United States in the last several decades is below the one-third rate previously estimated by Daniel Glaser. The mean recidivism rate in the 1970's (23.26) was lower than it was in the 1960's (33.17). The mean recidivism rate for imprisonment plus parole (25.35) is lower than for those discharged without parole supervision (31.55). Reduced-custody residential establishments have a high rate (41.67) when introduced before a sentence of imprisonment, but a lower rate (22.07) when introduced following incarceration (halfway houses). The mean recidivism rate for standard processing of offenders (24.22) does not differ from the rate for "standard plus special treatment" (24.73).
Lipton D, Martinson R, Wilks J. The Effectiveness of Correctional Treatment. New York: Praeger. 1975.	They provide a possibly systematic review of correctional treatment evaluations published or available between 1945-1968. Martinson (1974) published his famous review in the Public Interest based on this work. Standard search procedures were used over a six-month period, including bibliographies, abstracting services, and handsearching. Their eligibility criteria included: (1) study represents an evaluation of a treatment method applied to criminal offenders; (2) completed 1945 or later; (3) included empirical data with some control or comparison group (including pre-post or comparison with base expectancy rates); and (4) at least one of the outcomes: recidivism, institutional adjustment, educational achievement, vocational adjustment, personality and attitude change, drug and alcohol readdiction or cost benefits. Studies	Their conclusion based on the evidence is that there is little evidence that correctional efforts have impacted recidivism. Not one of the categories are considered effective. Higher standards for research efforts are urged, as is greater cooperation between researchers and practitioners.

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	were categorized into the following treatment categories: (a) probation; (b) imprisonment; (c) parole; (d) casework and individualized counseling; (e) skill development; (f) individual psychotherapy; (g) group methods; (h) milieu therapy; (i) partial physical custody; (j) medical methods; and (k) leisure time activities. Remarkably, the authors find 231 evaluations, and they annotate and rank them according to methodological rigor. A research design that used a probability sample and then randomized them received a "1A" rating. They rate randomized experiments that draw on a non-probability sample as "2A." Surprisingly, matched designs are also rated as "2A."	
National Center for State Courts. An evaluation of policy related research on the effectiveness of pretrial release programs. Denver CO: National Center for State Courts. 1975.	Approximately 300 references to bail, pretrial release, and related topics were located, and copies of more than 2000 documents were obtained and screened by the project staff. This volume discusses over forty of these documents including virtually all of the most important empirical studies in the field published by mid-1974.	The relative effectiveness of the traditional surety bail system and the various alternative forms of pretrial release has not yet been satisfactorily measured according to criteria such as failure-to-appear rates, re-arrest rates, and economic costs. With respect to failure-to-app- ear (FTA) rates, where there is some fragmentary data on the comparative performance of the traditional bail system and the various alternatives to it, there is no distinct pattern of lower FTA rates for any particular form of release.
Rovner RP. Pretrial intervention strategies: an evaluation of policy-related research and policymaker perceptions. Washington DC: American Bar Association, National Pretrial Intervention Service Center. 1974.	A review of evaluation findings of fifteen demonstration programs.	Evaluation research conducted by the programs focused primarily upon documenting participant change on employment and recidivism variables, system change in the adjudication process, and cost-benefits of the programs. Among the conclusions reached in the analysis of research reports are the following: Several pretrial intervention programs were responsible for positive changes in the employment status, wage, and skill levels of alleged offenders during program participation; several programs validly demonstrated a decrease in participant recidivism during program participation; and an individual's in-program and post-program success is influenced by his pre-program characteristics.
Martinson R. What works? Questions and answers about prison reform. Public Interest 1974;35:22-54.	Analysis of 231 studies that evaluated correctional treatment methods between 1945 and 1967 to determine what works in correction.	Supplied no evidence of success or effectiveness of educational programs for juvenile or adult inmates and of programs of individual or group counseling. Youths who participate in milieu therapy programs such as California's Marshall Program at least do no worse than their counterparts in regular institutions; special programs, moreover, may cost less. Strictly medical treatment to change behavior also had little effect on recidivism in

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		general. Length of sentence had no clear relationship to recidivism. Studies of probation with intensive supervision indicate that specially treated youthful probationers were less recidivistic; some major studies e.g., the Warren studies in California present a much bleaker picture of the possibilities of intensive supervision with special treatment. The results are ambiguous with intensive supervision of adult offenders. No sure way of reducing recidivism through rehabilitation has been found.
Slaikeu KA. Evaluation studies on group treatment of juvenile and adult offenders in correctional institutions. A review of the literature. Journal of Research in Crime and Delinquency 1973;87-100.	He conducted a possibly systematic review of 23 evaluations of group counseling for incarcerated juveniles or adults. His criteria for inclusion were:(1) the report went beyond impressionistic findings to produce numerical tabulation of results; and (2) conducted in an institution. Searches included use of an existing bibliography of evaluations and Psychological Abstracts (1968-1970).	Rather than reporting data on effects, Slaikeu finds that the research is generally so poor that claims of success can not be made, only that it can not be said that group treatment does not work. He writes: “The major conclusion drawn from the review is that even though the evaluative studies report a variety of positive results, still, as a whole they fall short of the criteria of scientific research, especially regarding replication. This makes it impossible to conclude that group treatment in correctional Institutions is an effective rehabilitation mode" (p. 88). He finds 2/3 of the studies had a control group (though he likely means control or comparison group), and less than 1/5 follow-up in the community. Only 1/3 of the studies revealed enough information about the statistical data and analyses to permit the reader to critically evaluate the results and possibly replicate them.
Logan CH. Evaluation research in crime and delinquency: a reappraisal. The Journal of Criminal Law, Criminology and Police Science 1972;63(3):378-87.	He reviewed 100 correctional reports to determine the effectiveness of correctional treatment in another possibly eligible systematic review. He assesses whether any of them meet all seven of his minimum criteria for an "adequate scientific test" (p.378). These criteria are: (1) adequate definition of the program or set of techniques being tested; (2) program or techniques must be capable of routinization; (3) treatment and control groups, preferably through randomization; (4) evidence that the treatment group did in fact receive the treatment; (5) some "before and after" measurement and comparison between groups on behavioral measures; (6) definition of success and failure that is valid and reliably measured and are ordinarily agreed upon as reflecting success or failure of the treatment; and (7) follow-up in the community. Logan describes his search as more a matter of	Logan finds that none of the 100 reports met all seven minimum requirements for adequacy. Twenty-three (23%) of the studies included randomization. Logan writes (p.380) that: "..there is not yet one single study of correctional or preventive effectiveness that will satisfy the most minimal standards of scientific design." Seventy percent of the studies reported fair to good results; only 16% were failures and the rest were unclassifiable. Logan reports a small correlation: the strength of claimed success decreased as the number of criteria for scientific adequacy were met. Logan does not recommend more experiments, but statistically controlled studies as experimental designs seem so difficult to carry out in correctional settings.

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	"acquisition than selection," relying on books, articles, reports, or studies available or borrowed through Indiana University Library" (p.379). Inclusion criteria were broad and included any evaluation of any program designed to prevent or respond to crime or delinquency.	
Shireman CH, Mann KB, Larsen C, Young T. Findings from experiments in treatment in the correctional institution. Social Service Review 1972;46(1):38-59.	They present a possibly systematic review in analysis of institutional treatment programs for juveniles or adults. They describe their inclusion criteria as: (1) completed 1959-1969; (2) produced reports available to researchers; (3) carried out in the United States; and (4) tested treatment for institutionalized adults or juveniles. They select high-quality research, particularly experiments.	They note that "..research to date has not finally demonstrated the superior effectiveness of any of the forms of institutional treatment subjected to examination" (p. 54). They tentatively suggest that milieu therapy, group counseling, short-term psychiatric care and provision of plastic surgery showed some success in a particularly well-done evaluation. Successful programs, according to Shireman et al., seemed to change the nature of relationships between clients and staff and others. They also note there were more failures than successes (using the criterion of statistical significance) for each of these programs. They write that "While there is thus encouraging indication that achieving treatment goals is not forever impossible, knowledge of precisely how and for whom that may best be achieved remains rudimentary" (p.55). Shireman et al. caution about simple reliance upon aggregate experimental results as treatment will work for some and not for others.
Adams S. Caseload research. Federal Probation 1967;31(4):48-57.	Studies are reviewed from the California Department of Corrections, Los Angeles County Probation Department, California Youth Authority and Federal Probation and Parole.	Most of these studies have determine that, despite preliminary indications of superior performance by experiment participants during the early phases of the reduced caseloads programs, these indications eventually vanished. When additional emphasis is placed on treatment and rehabilitation and the additional time experienced by correctional personnel is put to good use, small caseloads do seem to have a significant effect on correctional program success.
Bailey WC. Correctional outcome: An evaluation of 100 reports. The Journal of Criminal Law, Criminology and Police Science 1966;57(2):153-60.	He conducted a possible systematic review of 100 evaluation reports generally published between 1940-1960 of correctional programs, including either juveniles or adults. Bailey's inclusion criteria: (1) report based on empirical data; (2) treatment dependent upon the manipulation of some interpersonal relations as the independent variable; and (3) outcome of behavior subject to legal sanction.	Bailey found that only 10% of reports found harmful or null effects, 38% found some improvement, 37% reported a statistically significant improvement for treatment, and 5% of studies reported outcomes irrelevant to treatment (this does not add up to 100%, what happened to other 10%?). The number of evaluations reporting some positive findings decreases with rigor of design (88%, 84%, 60%); harmful or null findings increased with rigor (4%, 12%, 23%). Bailey concluded, curiously, despite 60% of positive findings for more rigorous evaluation: "But, when one recalls that these results, in terms of success or failure of the treatment used, are based upon the conclusions of the authors themselves, then the implications of correctional treatment become discouraging. On the basis of this sample of

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		outcome reports with all of its limitations, evidence supporting the efficacy of treatment is slight, inconsistent and of questionable reliability" (1966, p.157). No attempt was made to examine specific types of interventions and claims of efficacy.

CRIME: The efficiency of the criminal justice system

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Godkin MD, Onyskiw JE. A systematic overview of interventions to reduce physical restraint use in long-term care settings. Online Journal of Knowledge Synthesis for Nursing 1999;6(6).	Review empirical evidence regarding effectiveness of interventions.	Most effective programs included an educational component, restraint removal, and interventions individualized to residents' specific needs were successful in decreasing restraint use.
Pratt-Travis C and Maahs J. Are private prisons more cost-effective than public prisons? A meta-analysis of evaluation research studies. Crime and Delinquency 1999;45(3):358-71.	A systematic review was conducted of 33 cost-effectiveness evaluations of private and public prisons as reported in 24 independent studies.	The private institutions were no more cost-effective than public facilities.
West MM. Meta-analysis of studies assessing the efficacy of projective techniques in discriminating child sexual abuse. Child Abuse and Neglect. 1998;22(11):1151-66.	12 studies assessing the efficacy of projective techniques to discriminate between sexually abused children and nonsexually abused children	Projective techniques have the ability to discriminate between children who have been sexually abused and those who were not abused sexually.
Schmidt FL, Viswesvaran V, Ones DS. Validity of integrity tests for predicting drug and alcohol abuse: a meta-analysis. In William J. Bukoski (ed.). Meta-Analysis of Drug Abuse Prevention Programs. Rockville, MD: US Dept of Health and Human Services, National Institute on Drug Abuse. 1997:69-95.	Systematic review of studies.	For both drugs and alcohol, the findings show that integrity tests correlated substantially (0.34 to 0.51) with admissions of abuse in student and employee samples. In samples of job applicants, however, the mean validity was lower (0.21) for drug abuse; validity for applicants was high for alcohol abuse, but only one study was found. All meta-analyses showed that validity was generalizable. Based on these analyses, the authors conclude that the operational validity of integrity tests for predicting drug and alcohol abuse in the workplace is probably about 0.30.
Salekin RT, Rogers R, Sewell KW. A review and meta-analysis of the Psychopathy Checklist and Psychopathy Checklist--Revised: Predictive validity of dangerousness. Clinical Psychology Science and Practice. 1996;3(3):203-15.	Reports a systematic review of 18 studies that investigate the relationship between the PCL/PCL-R and violent and nonviolent recidivism.	Results show that both the PCL and the PCL-R had moderate to strong effect sizes and appear to be good predictors of violence and general recidivism.

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Lyons P, Doueck HJ, Wodarski JS. Risk assessment for child protective services: a review of the empirical literature instrument performance. Social Work Research 1996;20(3):143-55.	Reviews the empirical literature on 10 risk-assessment models in an effort to examine the psychometric properties of existing risk assessment models, including their reliability and validity, as well as to examine the outcomes of implementing these models.	It is concluded that although each model contains generally sound psychometric properties, there is still a need for further model development and for process and outcome evaluation of model implementation
Cutler BL, Penrod SD. Mistaken identification: the eyewitness, psychology, and the law. New York, NY: Cambridge University Press. 1995.	A review summarizes empirical research on the adequacy of procedural safeguards to protect defendants from erroneous conviction resulting from mistaken eyewitness identification	Traditional safeguards--such as the presence of counsel at lineups, cross-examination and judges' instructions - are ineffective against mistaken eyewitness identification. Expert psychological testimony on eyewitness memory, intended to educate the jury about how memory processes work and how eyewitness testimony should be evaluated, shows greater promise of protection against mistaken identification leading to erroneous convictions.
Lalumiere ML, Quinsey QL. Discriminability of rapists from non-sex offenders using phallometric measures: A meta-analysis. Criminal Justice and Behavior 1994;21(1):150-75.	Eleven primary and five secondary phallometric studies that involved 415 rapists and 192 non-sex offenders were examined with the use of meta-analytic techniques	Study effect sizes averaged 0.82 (95 percent confidence interval 0.16 to 1.49). Only stimulus set was a statistically significant moderator of effect size; stimulus sets that contained more graphic rape descriptions produced better discrimination between rapists and non-sex offenders. There was a trend for stimulus sets that contained more exemplars of rape descriptions to achieve better discrimination between the two groups. Also, rapists responded more to rape than to consenting sex cues in nine of the 16 data sets- and in all eight of those that used the more effective stimulus sets. Study results support the use of phallometric assessment to identify treatment needs and assess the risk of recidivism among identified rapists, provided that appropriate stimulus sets and scoring procedures are used. The findings do not preclude differences in motives between rapist subtypes.
Kircher JC, Horowitz SW, Raskin DC. Meta-analysis of mock crime studies of the control question polygraph technique. Polygraph 1989;18(1):1-14.	Reviewed 18 studies.	A systematic review revealed that approximately 24 percent of the variance in detection rates could be attributed to sampling error, and detection rates were correlated with types of Subjects (r = .61), Incentives (r = .73), and Decision Policies (r = .67). The highest diagnostic accuracies were obtained from nonstudent subject samples, when both guilty and innocent subjects were offered monetary incentives to convince the examiner of their innocence, and when conventional field methods were used for interpreting the physiological recordings and diagnosing truth and deception.
McMurtry SL. Secondary prevention of child maltreatment: a review. Social Work 1985;30(1): 42-8.	Summarizes the published research on secondary prevention of child maltreatment, emphasizing attempts to identify parents at risk of abusing or neglecting their children. Major types of primary prevention programs are reviewed; these include social reforms such as	The accuracy of predictive measures used in screening procedures is assessed in terms of sensitivity (or ability of the screening procedure to identify correctly all at-risk respondents) and specificity (or ability to include in this group only those who truly belong). Key issues in secondary prevention research are addressed: (1) accuracy of screening instruments, (2) use of individual screening, and (3) the possibilities of generating screening

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	legislation to protect children's rights, social programs to assist families, and intensive educational interventions aimed at a variety of audiences.	procedures for broad applications and of formulating useful and feasible treatment programs from screening results. It is concluded that although accurate identification of at-risk parents may eventually be possible, more research is needed to establish identifying criteria and to determine effective means of intervention to prevent abuse.
Cohen J. The incapacitative effect of imprisonment: a critical review of the literature. Deterrence and incapacitation: estimating the effects of criminal sanctions on crime rates. Panel on Research on Deterrent and Incapacitative Effects Report. Washington, D.C.: National Academy of Sciences. 1978;187-243.	Five recent studies of models that estimate the incapacitative effect of imprisonment are reviewed.	Of these, three conclude that the potential increases in crime associated with a reduction in the present use of prison are minimal. The remaining two indicate that the potential gains in reducing crime that would result from expanding the use of prison are sizable. Research on incapacitation, including the five studies reviewed, suffers from various methodological deficiencies.
Peters C. Research in the field of volunteers in courts and corrections: what exists and what is needed. Journal of Voluntary Action Research 1973;2(3):21-34.	Peters (1973) conducted a possibly systematic review in her work for the National Information Center on Volunteerism in Boulder, Colorado (USA). She used the Center's extensive files and examined "any study which approaches a problem in the field in an organized manner, through relatively reliable and valid techniques, and is presented in a written form is included in the population of studies for this analysis" (p.21). Her review is a survey of the literature and content analysis of type of reports. She finds 73completed and 68 incomplete studies that were nonetheless included in her review. Her broad categories include: managerial questions, screening, placement and matching; orientation and training; volunteer incentive and support; administration; volunteer coordination; impact on clients; impact on staff; impact on other service-centered agencies; impact on volunteers themselves; impact on victims; historical research; and general program evaluation.	Peters finds nine evaluations that tested for volunteer effects on client recidivism; all were positive but none used rigorous method; larger and more consistent effects reported on attitude.

CRIME: Broad crime and justice reviews covering more than one area

CITATION	*REVIEW DETAILS*	*FINDINGS*
Sherman LW, Gottfredson D, MacKenzie D et al. Preventing crime: what works, what doesn't, what's promising. Report to the Congress. Washington, DC: U.S. Office of Justice Programs. 1997	500 evalutions were analyzed. Types of programs were deemed to "work" if at least 2 methodologically rigorous studies reported statistically significant crime prevention effects; they were deemed "promising" if at least 1 acceptable study reported prevention effects. Types of programs were categorized as "not working" if at least 2 methodologically sound studies reported "no effect."	
Petrosino A. What works revisited again: A meta-analysis of randomized experiments in delinquency prevention, rehabilitation and deterrence. Doctoral dissertation, Rutgers University (New Jersey, USA). Ann Arbor, MI: University Microfilms, Inc. 1997.	150 randomized experiments, systematic search and data extraction	Finds that estimates of program impact changed depending on synthesis technique used; juvenile programs and small-sample studies most effective most robust findings (despite technique used).

Appendix 1: Search process

The following databases were searched for reviews of cancer, cardiovascular diseases, accidents and mental health from a public health angle, using a range of keywords.

Health Technology Assessment database (CRD, http://www.york.ac.uk/)
TRIP index (index to reviews, guidelines and evidence summaries: http://www.ceres.uwcm.ac.uk/)
NCCHTA web site (http://www.hta.nhsweb.nhs.uk/)
National Research Register
HSTAT (US web site providing access to AHCPR publications and other US review and guideline material. http://text.nlm.nih.gov/)
US Preventive Taskforce guidelines (http://text.nlm.nih.gov/)
Canadian Preventive Taskforce guidelines (http://www.ctfphc.org/)
Health Management Information Consortium (UK health management databases)
Econlit
Sociological Abstracts
ASSIA

Details of the results and searches for each are listed below. Where possible searches have been limited to the most recent year. However, most web interfaces do not offer date restriction so the material presented covers all dates.

Health Technology Assessment database (CRD web site 10/1/2000)

The CRD web version of this databases is more up to date than the version on The Cochrane Library. Search results have been printed out with fullest information available. The search was date limited.

TRIP index (web-based index to reviews, guidelines and evidence summaries, searched 10/1/2000 for cancer and cardiovascular topics and 24/1/2000 for accidents and mental health)

The search interface only allows single word searches or very simple combinations (e.g. cancer not smoking) which have simple exclusions to eliminate previously identified records. The search therefore involved many individual searches. TRIP automatically truncates terms. The search was not date limited. The following search phrases were used for the topics, but not all produced results:

Appendix 1: Search process

Cancer

Cancer
Neoplasms not cancer
Sarcoma not cancer
Leukemia not cancer
Leukaemia not cancer
Cigarette not cancer
Smoking not cancer
Diet not cancer
Fruit not cancer
Vegetables not cancer
Melanoma not cancer
Unemploy not cancer
Lifestyle not cancer
Deprivation not cancer
Social not cancer
Stress not cancer
Radon not cancer
Asbestos not cancer
Pollut not cancer
Ozone not cancer
Sunburn not cancer
Sex not cancer
Alcohol not cancer
Drinking not cancer

Cardiovascular diseases

Heart
Smoke
Smoking not heart
stroke not heart
cardiovascular not heart
mi not heart
myocardial not heart
smoking not heart
cigarette not smoking
Unemploy
Jobless
Exclusion
Acitivity or exercise or fitness
Lifestyle
Cycl or walk
employ
Stress or workplace
Diet or food or nutrition
Obesity not heart
Obese not heart
Relaxation
Coronary not heart
Cardiac not heart
Resuscitation
Blood and pressure
Hypertension not pressure

Accidents

Accident prevention
Accident awareness
Accidents
Safety awareness
Safety + job
Safety + work
Safety + occupation
Safety standard
Social exclusion
Public risk
Awareness of risk
Risk assessment
Traffic accident
Road accident
Road safety
Vehicle safety
Cycling
Cycle training

Appendix 1: Search process

Cyclist education
Cycle proficiency
Cyclist protection
Bicycle proficiency
Pedestrian education
Pedestrian training
Walking
Speed limit
Speeding
Speed management
Building safety
Water safety
School travel
School transport
Ecological transport
Traffic calming
Safe play
Safe area
Home safety
Hazardous site
Safety belt
Seatbelt
Seat-belt
Seat belt

Mental health

Mental health
Mental ill
Mental disorder
Homeless
Housing
Job
Employ
Unemploy
Volunteer
Bereave
Grief
Coping
Support group
Self-help
Support network
Social support
Social welfare
Bully
Crime
Criminal
Violen
Prison
Homicide + media
Suicide + media
Suicide
Dyslexi
Learning + difficult
Mental + exercis
Physical + activ
Drug abuse
Drug misuse
Alcoholism
Alcohol abuse
Alcohol misuse
Substance misuse
Substance abuse
Addict
Misuse + detect
Abuse + detect
Drug + test
Child care
Child abuse
School
Single parent
Sole parent
Lone parent
Parenting
Parent skill
Stigma
Black or ethnic
refugee
Inequity
Social exclusion
Social isolation
Stress + work
Stress + job
Stress + occupation
smok

Appendix 1: Search process

NCCHTA web site (searched 10/1/2000)

This web site lists all projects funded by the UK Health Technology Assessment Programme. The search was not date limited.

National Research Register CD-ROM (1999 Issue 2 and 2000 Issue 1).

This records UK health and health-related research. The search strategies are listed below in full.

Cardiovascular diseases and cancer

1. CARDIOVASCULAR-DISEASES*:ME
2. (HEART next DISEASE*)
3. STROKE
4. (CEREBROVASCULAR next ACCIDENT*)
5. ((SMOKING or CIGARETTE*) or TOBACCO) or SMOKE)
6. SMOKING*:ME
7. ((UNEMPLOY* or JOBLESS*) OR (SOCIAL next EXCLUSION))
8. (((PHYSICAL next ACTIVITY) or EXERCISE) OR FITNESS)
9. EXERCISE*:ME
10. ((CYCLING or WALKING) or STRESS)
11. (((LIFESTYLE* or DIET) or FOOD) or NUTRITION)
12. (HEALTHY next SCHOOL*)
13. (HEALTHY next WORKPLACE*)
14. (HEALTHY next LIVING)
15. ((RELAXATION or CORONARY) or MYOCARDIAL)
16. STROKES
17. RESUSCITATION
18. (BLOOD next PRESSURE)
19. ((((((((((((((#1 or #2) or #3) or #4) or #5) or #6) or #7) or #8) or #9) or #10) or #11) or #12) or #13) or #14) or #15) or #16) or #17) or #18)
20. REVIEW-LITERATURE*:ME
21. GUIDELINES*:ME
22. META-ANALYSIS*:ME
23. EVIDENCE-BASED-MEDICINE*:ME
24. ((REVIEW* or OVERVIEW*) or GUIDELINE*)
25. (((#20 or #21) or #22) or #23) or #24)
26. (#19 and #25)
27. ((REVIEW*:TI or OVERVIEW*:TI) or GUIDELINE*:TI)
28. ((REVIEW*:MT or OVERVIEW*:MT) or GUIDELINE*:MT)
29. (((((#20:MT or #21:MT) or #22:MT) or #23:MT) or #28:MT) or #29:MT)
30. (#19:MT and #30:MT)
31. NEOPLASMS*:ME
32. (((((CANCER* or SARCOMA*) or NEOPLASMS) or CARCINOMA*) or SEMINOMA) or MELANOMA*)
33. (LEUKAEMIA or LEUKEMIA)

Appendix 1: Search process

34. ((((ASBESTO or RADON) or OZONE) or SUNBURN) or SEX)

35. ((((((((((((#5 or #6) or #7) or #8) or #9) or #10) or #11) or #12) or #13) or #14) or #15) or #32) or #33) or #34) or #35)
36. (#36 and #30)

Accidents

1. ACCIDENT-PREVENTION*:ME
2. (ACCIDENT* next PREVENTION)
3. (ACCIDENT* next AWARENESS)
4. (SAFETY next AWARENESS)
5. (SAFETY next PRACTICE*)
6. (SAFETY next WORK*)
7. (SAFETY next JOB*)
8. (SAFETY next OCCUPATION*)
9. OCCUPATIONAL-HEALTH*:ME
10. (SOCIAL next EXCLUSION)
11. (SOCIALLY next EXCLUDED)
12. (AWARE* next RISK*)
13. (PUBLIC next RISK)
14. (TRAFFIC next SAFETY)
15. (ROAD next SAFETY)
16. (VEHICLE next SAFETY)
17. (SAFETY next STANDARD*)
18. (TRAFFIC next ACCIDENT*)
19. (ROAD next ACCIDENT*)
20. ACCIDENTS-TRAFFIC*:ME
21. CYCLING
22. WALKING
23. (CYCLE next TRAINING)
24. (CYCLIST next EDUCATION)
25. (CYCLE next PROFICIENCY)
26. (CYCLE next TEST)
27. (CYCLIST next PROTECTION)
28. (BICYCLE next PROFICIENCY)
29. (BICYCLE next TEST)
30. (PEDESTRIAN next EDUCATION)
31. (PEDESTRIAN next TRAINING)
32. (SPEED next LIMIT*)
33. SPEEDING
34. (SPEED next MANAGEMENT)
35. (BUILDING next SAFETY)
36. (WATER next SAFETY)
37. (SCHOOL next TRAVEL)
38. (SCHOOL next TRANSPORT*)
39. (ECOLOGICAL* next TRANSPORT*)
40. (TRAFFIC next CALMING)
41. (SAFE next PLAY)
42. (SAFE next AREA*)
43. (HOME next SAFETY)
44. ACCIDENTS-HOME*:ME
45. (HAZARDOUS next SITE*)
46. (SAFETY next BELT*)
47. (SEAT next BELT*)
48. SEAT-BELTS*:ME
49. SEATBELT*
50. (CYCLE next HELMET*)

Appendix 1: Search process

51. (BICYCLE next HELMET*)
52. DRINK-DRIVE*
53. (DRINK next DRIVE*)
54. (ALCOHOL and ACCIDENT*)
55. (TRADING next STANDARD*)
56. ((HEALTHY next DIET) and ACCIDENT*)
57. (PHYSICAL* next ACTIV*)
58. ACCIDENT*
59. (#57 and #58)
60. (PARENT* next SKILL*)
61. EYESIGHT
62. EYE-SIGHT
63. (EYE next SIGHT)
64. (MEDICATION* next REVIEW*)
65. EYETEST*
66. EYE-TEST*
67. (EYE next TEST*)
68. FALLER*
69. (FALL* and OLDER*)
70. (FALL* and ELDER*)
71. (FIRST next AID)
72. FIRST-AID
73. FIRSTAID
74. (BASIC next RESUSCITATION)
75. (((((((((#1 or #2) or #3) or #4) or #5) or #6) or #7) or #8) or #9) or #10)
76. (((((((((#11 or #12) or #13) or #14) or #15) or #16) or #17) or #18) or #19) or #20)
77. (((((((((#21 or #22) or #23) or #24) or #25) or #26) or #27) or #28) or #29) or #30)
78. (((((((((#30 or #31) or #32) or #33) or #34) or #35) or #36) or #37) or #38) or #39)
79. (((((((((#40 or #41) or #42) or #43) or #44) or #45) or #46) or #47) or #48) or #49)
80. (((((((#50 or #51) or #52) or #53) or #54) or #55) or #56) or #59)
81. (((((((((#60 or #61) or #62) or #63) or #64) or #65) or #66) or #67) or #68) or #69)
82. (((((((((#70 or #71) or #72) or #73) or #74) or #75) or #76) or #77) or #78) or #79)
83. ((#80 or #81) or #82)
84. REVIEW-LITERATURE*:ME
85. GUIDELINES*:ME
86. META-ANALYSIS*:ME
87. (REVIEW* OR OVERVIEW* OR META-ANAL* OR METAANAL* OR GUIDELINE*
88. META NEXT ANAL*
89. (#87 OR #88)
90. (#83 AND #89)
91. (#83 AND #89)

Mental health

1. MENTAL-HEALTH*:ME
2. MENTAL-DISORDERS*:ME
3. (MENTAL next HEALTH)
4. (MENTAL* next ILL*)
5. (MENTAL* next DISORDER*)
6. HOMELESS*
7. HOMELESS-PERSONS*:ME
8. PUBLIC-HOUSING*:ME

Appendix 1: Search process

9. (SUPPORTED next HOUSING)
10. (HOUSING next ASSOCIATION*)
11. JOB*
12. EMPLOY*
13. UNEMPLOY*
14. VOLUNTEER*
15. ALCOHOLI*
16. (ALCOHOL next ABUSE*)
17. (ALCOHOL next MISUSE*)
18. (DRUG next ABUSE*)
19. (DRUG next MISUSE*)
20. (SUBSTANCE next ABUSE*)
21. (SUBSTANCE next MISUSE*)
22. ALCOHOLISM*:ME
23. SUBSTANCE-RELATED-DISORDERS*:ME
24. ADDICT*
25. (GLUE next SNIFF*)
26. ((((((((((#15 or #16) or #17) or #18) or #19) or #20) or #21) or #22) or #23) or #24) or #25)
27. ((MISUSE* or ABUSE*) next DETECT*)
28. SUBSTANCE-ABUSE-DETECTION*:ME
29. (DRUG next TEST*)
30. ((TREATMENT* or THERAP*) or REHABILITAT*)
31. (#26 and #30)
32. SUBSTANCE-ABUSE-TREATMENT-CENTERS*:ME
33. GRIEF
34. BEREAVE*
35. (COPING next BEHAVIOR*)
36. (COPING next BEHAVIOUR*)
37. (COPING next MECHANISM*)
38. INEQUITY
39. (SOCIAL next ISOLATION)
40. (SOCIAL next EXCLUSION)
41. BEREAVEMENT*:ME
42. ADAPTATION-PSYCHOLOGICAL*:ME
43. SOCIAL-ISOLATION*:ME
44. CRIME
45. CRIMINAL*
46. BULLY*
47. VIOLEN*
48. CRIME*:ME
49. SELF-HELP
50. (SUPPORT next GROUP*)
51. (SUPPORT next NETWORK*)
52. (SOCIAL next SUPPORT)
53. (SOCIAL next WELFARE)
54. SELF-HELP-GROUPS*:ME
55. SOCIAL-WELFARE*:ME
56. SOCIAL-SUPPORT*:ME
57. EDUCATION
58. (FINANCIAL next PROBLEM*)
59. (FINANCIAL next DIFFICULT*)
60. (TRANSPORT next POLIC*)
61. (CHILD next ABUSE*)
62. AT-RISK
63. (CHILD* next CARE)
64. (LEAVING next CARE)
65. (COMMUNITY next SAFETY)
66. (SINGLE next PARENT*)
67. (SOLE next PARENT*)
68. (LONE next PARENT*)
69. PARENTING*
70. (PARENT* next SKILL*)
71. PARENTING*:ME
72. (HEALTHY next PRISON*)
73. (HEALTHY next SCHOOL*)

Appendix 1: Search process

74. (HEALTHY next DIET*)
75. ((HOMICIDE* or MURDER*) or SUICIDE*)
76. MEDIA*
77. (#75 and #76)
78. STIGMA*
79. REFUGEE*
80. REFUGEES*:ME
81. ((BLACK or BLACKS) or ETHNIC*)
82. ETHNIC-GROUPS*:ME
83. (SMOKER* or SMOKING)
84. SMOKING*:ME
85. STRESS
86. STRESS*:ME
87. (OCCUPATION* or WORKPLACE*)
88. (WORK next PLACE*)
89. WORKPLACE*:ME
90. (((#11 or #87) or #88) or #89)
91. (#85 or #86)
92. (#90 and #91)
93. DYSLEX*
94. (LEARNING next DIFFICULT*)
95. LEARNING-DISORDERS*:ME
96. EXERCIS*
97. (PHYSICAL next ACTIV*)
98. (((((((#1 or #2) or #3) or #4) or #5) or #6) or #7) or #8) or #9) or #10)
99. (((((((((#11 or #12) or #13) or #14) or #15) or #16) or #17) or #18) or #19) or #20)
100. (((((#20 or #21) or #22) or #23) or #24) or #25)
101. (((((((((#27 or #28) or #29) or #30) or #31) or #32) or #33) or #34) or #35) or #36)
102. (((((((((#37 or #38) or #39) or #40) or #41) or #42) or #43) or #44) or #45) or #46)
103. (((((((((#47 or #48) or #49) or #50) or #51) or #52) or #53) or #54) or #55) or #56)
104. (((((((((#57 or #58) or #59) or #60) or #61) or #62) or #63) or #64) or #65) or #66)
105. (((((((#67 or #68) or #69) or #70) or #71) or #72) or #73) or #74)
106. (((((((#77 or #78) or #79) or #80) or #81) or #82) or #83) or #84)
107. (((((((((#92 or #93) or #94) or #95) or #96) or #97) or #98) or #99) or #100) or #101)
108. (((((#102 or #103) or #104) or #105) or #106) or #107)
109. REVIEW-LITERATURE*:ME
110. GUIDELINES*:ME
111. META-ANALYSIS*:ME
112. EVIDENCE-BASED-MEDICINE*:ME
113. ((((REVIEW or OVERVIEW*) or META-ANAL*) or METAANAL*) or GUIDELINE*)
114. (META next ANAL*)
115. ((((((#109 or #110) or #111) or #112) or #113) or #114)
116. (#108 and #115)

HSTAT (US web site providing access to AHCPR publications and other US review and guideline material, searched 10/1/2000 for cancer/cardiovascular, 25/1/2000 for accidents and 19/1/2000 for mental health)

The search interface to HSTAT is quite basic and allows only one line strategies, which were not date limited. The search lines used were:

Appendix 1: Search process

Cancer

Neoplasms or cancer or sarcoma or carcinoma or leukemia
Smoking or cigarettes or tobacco
Diet or fruit or vegetables
Employment or unemployment
Social exclusion
Stress
Radon
Asbestos
Pollution or pollutants
Sunburn or ozone
Obesity or obese or weight
Drinking or alcohol
Exercise or activity or fitness

Cardiovascular diseases

Heart or cardiac or myocardial or stroke or cerebrovascular
Smoking or cigarettes or tobacco
Diet or fruit or vegetables
Employment or unemployment
Social exclusion
Stress
Obesity or obese or weight
Exercise or activity or fitness
Cardiovascular or coronary or pressure
Cycling or walking
Relaxation or lifestyle

Accidents

Accident* prevent*
Accident* awareness
Safety awareness
Safety + job*
Safety + work*
Safety + occupation*
Safety standard*
Social exclusion
Public risk*
Awareness of risk*
Traffic accident*
Road accident*
Road safety
Vehicle safety
Cycling + accident*
Cycle training
Cyclist education
Cycle proficiency
Cyclist protection
Bicycle proficiency
Pedestrian education
Pedestrian training
Walking + accident*
Speed limit*
Speeding
Speed management
Building safety
Water safety
School travel*
School transport*
Ecological* transport*
Traffic calming
Safe play*
Safe area*
Home safety
Hazardous site*
Safety belt*
Seatbelt*
Seat belt*

Appendix 1: Search process

Cycle helmet*
Bicycle helmet*
Drink drive*
Alcohol + accident*
Trading standard*
Healthy diet* + accident*
Physical* activ* + diet*
Parent* skill*
Eyesight
Eye sight*
Medication review*
Eye test*
Eyetest*
Faller*
Fall* + elder*
Fall* + older*
Firstaid
First aid
Basic resuscitation

Mental health

Mental health
Mental* ill*
Mental* disorder*
Alcohol or alcoholic or alcoholism or drug or drugs or addiction
Employment or unemployment or volunteer
Homeless or homelessness or housing
Bereave* or grief or coping
Exclusion or isolation or inequity
Crime or criminal or bully* or violen*
Self-help or support or welfare
Education
Financial difficult*
Transport polic*
Child abuse*
At-risk
Child* care*
Community safety
Single parent*
Lone parent*
Sole parent*
Parenting
Parent* skill*
Healthy prison*
Healthy school*
Healthy diet*
Homicide* and media
Murder* and media
Suicide* and media
Stigma* or refugee* or black* or ethnic*
Smoker* or smoking
Stress
Dyslexi*
Learning difficult*
Exercis*
Physical* activ*

US Preventive Taskforce guidelines (web site searched 10/1/2000)

All guidelines were printed out. The search was not date limited.

Appendix 1: Search process

Canadian Preventive Taskforce guidelines (web site searched 10/1/2000)

The full list of guidelines was printed out. The search was not date limited.

Health Management Information Consortium CD-ROM (UK health management databases). Silverplatter version (the update version was unclear but it was possibly 1999/Q3) (searched 24/1/00 and 17/1/00).

Cancer

1. cancer* or neoplasms or sarcoma or carcinoma or melanoma or leukemia or leukaemia
2. smoking or smoke or cigarette* or tobacco
3. fruit or vegetables or diet or food or nutrition
4. jobless* or unemploy*
5. social exclusion or socially excluded
6. healthy lifestyle*
7. deprived or deprivation
8. social networks
9. social support
10. stress or relaxation
11. radon or asbestos or pollut* or ozone
12. sunburn or sunbathing
13. high risk behav*
14. risky behav*
15. healthy workplace*
16. healthy school*
17. weight or obesity or obese
18. safe sex
19. safer sex
20. drinking or alcohol
21. physical activity or exercise or fitness
22. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10
23. #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21
24. #22 or #23
25. (review* or overview* or metaanal* or meta-anal* or metanal* or meta analy* or guideline*) in ti,ab,de
26. #24 near #25
27. #26 and (UD>"199812")

Cardiovascular diseases

1. heart
2. cardiac
3. myocardial
4. stroke
5. cerebrovascular
6. heart or cardiac or myocardial or stroke or cerebrovascular
7. cardiovascular or coronary or blood pressure
8. smoking or cigarette* or tobacco or smoke

Appendix 1: Search process

9. jobless* or unemploy* or social exclusion or socially excluded
10. physical activity or fitness or exercise or cycling or walking
11. stress
12. healthy workplace*
13. diet or food or nutrition
14. healthy school*
15. healthy living
16. healthier living
17. healthy lifestyle*
18. health improvement
19. relaxation
20. waiting times
21. rescuscitation
22. cpr
23. blood pressure
24. #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23
25. (review* or overview* or metaanal* or meta analy* or meta-analy*) in ti,ab,de
26. guideline*
27. #25 or #26
28. #24 and #27
29. #28 and (UD > "199812")
30. "Heart-Diseases" in DE
31. "Smoking-" in DE
32. "Unemployment-" in DE
33. "Poverty-" in DE
34. "Low-Income-Areas" in DE
35. "Social-Inequality" in DE
36. "Physical-Fitness" in DE
37. "Fitness-" in DE
38. "Diet-" in DE
39. explode "Nutrition"
40. explode "Stress"
41. #30 or #31 or #32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40
42. #41 or #24
43. #42 and #27
44. #43 and (UD > "199812")
45. education or training or employment
46. #45 and #27
47. (education or training or employment) in ti,ab,de
48. #47 and #27
49. #48 and (UD > "199812")
50. #47 near #27
51. #50 and (UD>"199812")

Accidents

1 (accident near prevention) in ti,ab,de,nt
2. (safety near awareness) in ti,ab,de,nt
3. (accident* near awareness) in ti,ab,de,nt
4. (safety near job*) in ti,ab,de,nt
5. (safe ty near work*) in ti,ab,de,nt
6. (safety near occupation*) in ti,ab,de,nt
7. (safety standard*) in ti,ab,de,nt
8. social exclusion in ti,ab,de,nt

Appendix 1: Search process

9. (public near risk*) in ti,ab,de,nt
10. (awareness near risk*) in ti,ab,de,nt
11. traffic accident* in ti,ab,de,nt
12. road accident* in ti,ab,de,nt
13. road safety in ti,ab,de,nt
14. vehicle safety in ti,ab,de,nt
15. cycling in ti,ab,de,nt
16. cycle training in ti,ab,de,nt
17. cyclist education in ti,ab,de,nt
18. cycl* proficiency test* in ti,ab,de,nt
19. bicycl* proficiency test* in ti,ab,de,nt
20. pedestrian education in ti,ab,de,nt
21. pedestrian training in ti,ab,de,nt
22. walking in ti,ab,de,nt
23. speed limit* in ti,ab,de,nt
24. speeding in ti,ab,de,nt
25. speed management in ti,ab,de,nt
26. building safety standard* in ti,ab,de,nt
27. water safety in ti,ab,de,nt
28. school travel* in ti,ab,de,nt
29. school transport* in ti,ab,de,nt
30. ecological* transport* in ti,ab,de,nt
31. traffic calming in ti,ab,de,nt
32. safe play in ti,ab,de,nt
33. safe area in ti,ab,de,nt
34. home safety in ti,ab,de,nt
35. hazardous site* in ti,ab,de,nt
36. safety belt* in ti,ab,de,nt
37. seatbelt* in ti,ab,de,nt
38. seat belt* in ti,ab,de,nt
39. seat-belt* in ti,ab,de,nt
40. cycle helmet* in ti,ab,de,nt
41. bicycle helmet* in ti,ab,de,nt
42. drink-drive* in ti,ab,de,nt
43. drink drive* in ti,ab,de,nt
44. (alcohol and accident*) in ti,ab,de,nt
45. trading standard* in ti,ab,de,nt
46. ((healthy diet*) and accident*) in ti,ab,de,nt
47. ((physical* activ*) and accident*) in ti,ab,de,nt
48. parent* skill* in ti,ab,de,nt
49. eyesight in ti,ab,de,nt
50. eye sight in ti,ab,de,nt
51. eye-sight in ti,ab,de,nt
52. medication* review* in ti,ab,de,nt
53. eye-test* in ti,ab,de,nt
54. eyetest* in ti,ab,de,nt
55. eye test* in ti,ab,de,nt
56. faller* in ti,ab,de,nt
57. (fall* and older*) in ti,ab,de,nt
58. (fall* and elder*) in ti,ab,de,nt
59. firstaid in ti,ab,de,nt
60. first aid in ti,ab,de,nt
61. first-aid in ti,ab,de,nt
62. basic resuscitation in ti,ab,de,nt
63. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20
64. #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #34 or #33 or #35 or #36 or #37 or #38 or #39 or #40
65. #41 or #42 or #43 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64
66. (review* or overview* or guideline* or meta-anal* or metaanal* or meta anal*) in ti,ab,de,nt
67. #65 and #66

Appendix 1: Search process

68. #67 and (PY = 1999-2000)

Mental health

1. mental health in ti,ab,de,nt
2. mental* ill* in ti,ab,de,nt
3. mental* disorder* in ti,ab,de,nt
4. supported housing in ti,ab,de,nt
5. homeless* in ti,ab,de,nt
6. housing association* in ti,ab,de,nt
7. job* in ti,ab,de,nt
8. employ* in ti,ab,de,nt
9. unemploy* in ti,ab,de,nt
10. volunteer* in ti,ab,de,nt
11. alcoholi* in ti,ab,de,nt
12. alcohol abuse* in ti,ab,de,nt
13. alcohol misuse* in ti,ab,de,nt
14. drug misuse* in ti,ab,de,nt
15. drug abuse* in ti,ab,de,nt
16. substance abuse* in ti,ab,de,nt
17. substance misuse* in ti,ab,de,nt
18. addict* in ti,ab,de,nt
19. glue sniff* in ti,ab,de,nt
20. (misuse or abuse) near (detect* in ti,ab,de,nt)
21. drug test* in ti,ab,de,nt
22. (treatment or therap* or rehabilitat*) in ti,ab,de,nt
23. #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19
24. #23 and #22
25. bereave* in ti,ab,de,nt
26. grief in ti,ab,de,nt
27. coping behavior* in ti,ab,de
28. coping behaviour* in ti,ab,de
29. coping mechanism* in ti,ab,de
30. social exclusion in ti,ab,de
31. social isolation in ti,ab,de
32. inequity in ti,ab,de
33. crime in ti,ab,de
34. criminal in ti,ab,de
35. bully* in ti,ab,de
36. violen* in ti,ab,de
37. self-help in ti,ab,de
38. support group* in ti,ab,de
39. social support in ti,ab,de
40. social welfare in ti,ab,de
41. support network* in ti,ab,de
42. education in ti,ab,de
43. financial* problem* in ti,ab,de
44. financial* difficult* in ti,ab,de,nt
45. transport polic* in ti,ab,de,nt
46. child abuse* in ti,ab,de,nt
47. at-risk in ti,ab,de,nt
48. child* care in ti,ab,de,nt
49. leaving care in ti,ab,de,nt
50. community safety in ti,ab,de,nt
51. single parent* in ti,ab,de,nt
52. sole parent* in ti,ab,de,nt
53. lone parent* in ti,ab,de,nt
54. parenting in ti,ab,de,nt
55. parent* skill* in ti,ab,de,nt

Appendix 1: Search process

56. (healthy near prison*) in ti,ab,de,nt
57. (health near school*) in ti,ab,de,nt
58. healthy diet* in ti,ab,de,nt
59. (homicide* or murder*) in ti,ab,de,nt
60. suicide* in ti,ab,de,nt
61. media in ti,ab,de,nt
62. #59 or #60
63. #62 and #61
64. stigma* in ti,ab,de,nt
65. refugee* in ti,ab,de,nt
66. (black or blacks) in ti,ab,de,nt
67. ethnic* in ti,ab,de,nt
68. (smoke or smoking or smoker*) in ti,ab,de,nt
69. stress in ti,ab,de,nt
70. (job* or occupation*) in ti,ab,de,nt
71. workplace* in ti,ab,de,nt
72. work place* in ti,ab,de,nt
73. #70 or #71 or #72
74. #69 and #73
75. dyslexi* in ti,ab,de,nt
76. learning difficult* in ti,ab,de,nt
77. exercis* in ti,ab,de,nt
78. physical activ* in ti,ab,de,nt
79. #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21
80. #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40
81. #41 or #42 or #43 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58
82. #63 or #64 or #65 or #66 or #67 or #68 or #74 or #75 or #76 or #77 or #78
83. #79 or #80 or #81 or #82
84. #1 or #2 or #3
85. (review* or overview* or metaanal* or meta-anal* or meta anal* or guideline*) in ti,ab,de,nt
86. #83 or #84
87. #86 and #85
88. #87 and (PY = 1999-2000)

The search was limited to material added during the last year.

Econlit (Silverplatter Version, 1999/12 update, searched 24/1/2000 and 17/1/2000).

Cancer

1. cancer* or neoplasms or sarcoma or carcinoma or melanoma or leukemia or leukaemia
2. smoking or smoke or cigarette* or tobacco
3. fruit or vegetables or diet or food or nutrition
4. jobless* or unemploy*
5. social exclusion or socially excluded
6. healthy lifestyle*
7. deprived or deprivation
8. social networks
9. social support
10. stress or relaxation
11. radon or asbestos or pollut* or ozone
12. sunburn or sunbathing
13. high risk behav*

Appendix 1: Search process

14. risky behav*
15. healthy workplace*
16. healthy school*
17. weight or obesity or obese
18. safe sex
19. safer sex
20. drinking or alcohol
21. physical activity or exercise or fitness
22. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10
23. #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21
24. #22 or #23
25. (review* or overview* or metaanal* or meta-anal* or metanal* or meta analy* or guideline*) in ti,ab,de
26. #24 near #25
27. #26 and (UD>"199812")

Cardiovascular diseases

1. heart
2. cardiac
3. myocardial
4. stroke
5. cerebrovascular
6. heart or cardiac or myocardial or stroke or cerebrovascular
7. cardiovascular or coronary or blood pressure
8. smoking or cigarette* or tobacco or smoke
9. jobless* or unemploy* or social exclusion or socially excluded
10. physical activity or fitness or exercise or cycling or walking
11. stress
12. healthy workplace*
13. diet or food or nutrition
14. healthy school*
15. healthy living
16. healthier living
17. healthy lifestyle*
18. health improvement
19. relaxation
20. waiting times
21. rescuscitation
22. cpr
23. blood pressure
24. #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23
25. (review* or overview* or metaanal* or meta analy* or meta-analy*) in ti,ab,de
26. guideline*
27. #25 or #26
28. #24 and #27
29. #28 and (UD > "199812")

Accidents

1 (accident near prevention) in ti,ab,de
2. (safety near awareness) in ti,ab,de
3. (accident* near awareness) in ti,ab,de
4. (safety near job*) in ti,ab,de

Appendix 1: Search process

5. (safety near work*) in ti,ab,de
6. (safety near occupation*) in ti,ab,de
7. (safety standard*) in ti,ab,de
8. social exclusion in ti,ab,de
9. (public near risk*) in ti,ab,de
10. (awareness near risk*) in ti,ab,de
11. traffic accident* in ti,ab,de
12. road accident* in ti,ab,de
13. road safety in ti,ab,de
14. vehicle safety in ti,ab,de
15. cycling in ti,ab,de
16. cycle training in ti,ab,de
17. cyclist education in ti,ab,de
18. cycl* proficiency test* in ti,ab,de
19. bicycl* proficiency test* in ti,ab,de
20. pedestrian education in ti,ab,de
21. pedestrian training in ti,ab,de
22. walking in ti,ab,de
23. speed limit* in ti,ab,de
24. speeding in ti,ab,de
25. speed management in ti,ab,de
26. building safety standard* in ti,ab,de
27. water safety in ti,ab,de
28. school travel* in ti,ab,de
29. school transport* in ti,ab,de
30. ecological* transport* in ti,ab,de
31. traffic calming in ti,ab,de
32. safe play in ti,ab,de
33. safe area in ti,ab,de
34. home safety in ti,ab,de
35. hazardous site* in ti,ab,de
36. safety belt* in ti,ab,de
37. seatbelt* in ti,ab,de
38. seat belt* in ti,ab,de
39. seat-belt* in ti,ab,de
40. cycle helmet* in ti,ab,de
41. bicycle helmet* in ti,ab,de
42. drink-drive* in ti,ab,de
43. drink drive* in ti,ab,de
44. (alcohol and accident*) in ti,ab,de
45. trading standard* in ti,ab,de
46. ((healthy diet*) and accident*) in ti,ab,de
47. ((physical* activ*) and accident*) in ti,ab,de
48. parent* skill* in ti,ab,de
49. eyesight in ti,ab,de
50. eye sight in ti,ab,de
51. eye-sight in ti,ab,de
52. medication* review* in ti,ab,de
53. eye-test* in ti,ab,de
54. eyetest* in ti,ab,de
55. eye test* in ti,ab,de
56. faller* in ti,ab,de
57. (fall* and older*) in ti,ab,de
58. (fall* and elder*) in ti,ab,de
59. firstaid in ti,ab,de
60. first aid in ti,ab,de
61. first-aid in ti,ab,de
62. basic resuscitation in ti,ab,de
63. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20
64. #21 or #22 or #23 or #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #34 or #33 or #35 or #36 or #37 or #38 or #39 or #40

Appendix 1: Search process

65. #41 or #42 or #43 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59 or #60 or #61 or #62 or #63 or #64
66. (review* or overview* or guideline* or meta-anal* or metaanal* or meta anal*) in ti,ab,de
67. #65 and #66
68. UD > "199812"
69. #67 and (UD > "199812")

Mental health

This search used the same strategy as that for Health Management Information Consortium above. The search was limited to material added during the last year.

Sociological Abstracts (Silverplatter version, 1999/12 update, searched 24/1/00).

Cancer

1. cancer* or neoplasms or sarcoma or carcinoma or melanoma or leukemia or leukaemia
2. smoking or smoke or cigarette* or tobacco
3. fruit or vegetables or diet or food or nutrition
4. jobless* or unemploy*
5. social exclusion or socially excluded
6. healthy lifestyle*
7. deprived or deprivation
8. social networks
9. social support
10. stress or relaxation
11. radon or asbestos or pollut* or ozone
12. sunburn or sunbathing
13. high risk behav*
14. risky behav*
15. healthy workplace*
16. healthy school*
17. weight or obesity or obese
18. safe sex
19. safer sex
20. drinking or alcohol
21. physical activity or exercise or fitness
22. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10
23. #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21
24. #22 or #23
25. (review* or overview* or metaanal* or meta-anal* or metanal* or meta analy* or guideline*) in ti,ab,de
26. #24 near #25
27. #26 and (UD>"199812")

Appendix 1: Search process

Cardiovascular diseases

1. heart
2. cardiac
3. myocardial
4. stroke
5. cerebrovascular
6. heart or cardiac or myocardial or stroke or cerebrovascular
7. cardiovascular or coronary or blood pressure
8. smoking or cigarette* or tobacco or smoke
9. jobless* or unemploy* or social exclusion or socially excluded
10. physical activity or fitness or exercise or cycling or walking
11. stress
12. healthy workplace*
13. diet or food or nutrition
14. healthy school*
15. healthy living
16. healthier living
17. healthy lifestyle*
18. health improvement
19. relaxation
20. waiting times
21. rescuscitation
22. cpr
23. blood pressure
24. #6 or #7 or #8 or #9 or #10 or #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21 or #22 or #23
25. (review* or overview* or metaanal* or meta analy* or meta-analy*) in ti,ab,de
26. guideline*
27. #25 or #26
28. #24 and #27
29. #28 and (UD > "199812")
30. "Heart-Diseases" in DE
31. "Smoking-" in DE
32. "Unemployment-" in DE
33. "Poverty-" in DE
34. "Low-Income-Areas" in DE
35. "Social-Inequality" in DE
36. "Physical-Fitness" in DE
37. "Fitness-" in DE
38. "Diet-" in DE
39. explode "Nutrition"
40. explode "Stress"
41. #30 or #31 or #32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40
42. #41 or #24
43. #42 and #27
44. #43 and (UD > "199812")
45. education or training or employment
46. #45 and #27
47. (education or training or employment) in ti,ab,de
48. #47 and #27
49. #48 and (UD > "199812")

Appendix 1: Search process

Accidents

The same strategy was used as when searching Econlit.

Mental health

1. mental health in ti,ab,de,nt
2. mental ill* in ti,ab,de,nt
3. mental disorder* in ti,ab,de,nt
4. homeless* in ti,ab,de,nt
5. supported housing in ti,ab,de,nt
6 housing association in ti,ab,de,nt
7. job* in ti,ab,de,nt
8. employ* in ti,ab,de,nt
9. unemploy* in ti,ab,de,nt
10. volunteer* in ti,ab,de,nt
11. alcoholi* in ti,ab,de,nt
12. alcohol abuse* in ti,ab,de,nt
13. alcohol misuse* in ti,ab,de,nt
14. drug misuse* in ti,ab,de,nt
15. drug abuse* in ti,ab,de,nt
16. sub stance abuse* in ti,ab,de,nt
17. substance misuse* in ti,ab,de,nt
18. glue sniff* in ti,ab,de,nt
19. addict* in ti,ab,de,nt
20. ((misuse* or abuse*) near (detect*)) in ti,ab,de,nt
21. drug test* in ti,ab,de,nt
22. (treatment* or therap* or rehabilitat*) in ti,ab,de,nt
23. #11 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19
24. #22 and #23
25. bereave* in ti,ab,de,nt
26. grief in ti,ab,de,nt
27. coping behavior* in ti,ab,de,nt
28. coping behaviour* in ti,ab,de,nt
29. coping mechanism* in ti,ab,de,nt
30. social exclusion in ti,ab,de,nt
31. social isolation in ti,ab,de,nt
32. social* isolat* in ti,ab,de,nt
33. social* exclud* in ti,ab,de,nt
34. crime in ti,ab,de,nt
35. criminal* in ti,ab,de,nt
36. bully* in ti,ab,de,nt
37. violen* in ti,ab,de,nt
38. self-help in ti,ab,de,nt
39. social* support* in ti,ab,de,nt
40. social welfare in ti,ab,de,nt
41. support group* in ti,ab,de,nt
42. support network* in ti,ab,de,nt
43. education in ti,ab,de,nt
44. financial problem* in ti,ab,de,nt
45. financial difficult* in ti,ab,de,nt
46. transport polic* in ti,ab,de,nt
47. child* abuse* in ti,ab,de,nt
48. at-risk in ti,ab,de,nt
49. child* care in ti,ab,de,nt
50. leaving care in ti,ab,de,nt
51. community safety in ti,ab,de,nt
52. single parent* in ti,ab,de,nt
53. sole parent* in ti,ab,de,nt

Appendix 1: Search process

54. lone parent* in ti,ab,de,nt
55. parenting in ti,ab,de,nt
56. parent* skill* in ti,ab,de,nt
57. healthy prison* in ti,ab,de,nt
58. healthy school* in ti,ab,de,nt
59. healthy diet* in ti,ab,de,nt
60. (homicid* or murder* or suidic*) in ti,ab,de,nt
61. media in ti,ab,de,nt
62. #60 and #61
63. stigma* in ti,ab,de,nt
64. refugee* in ti,ab,de,nt
65. (black or blacks or ethnic*) in ti,ab,de,nt
66. (smoke* or smoking) in ti,ab,de,nt
67. stress in ti,ab,de,nt
68. (job* or occupation* or workplace* or work place*) in ti,ab,de,nt
69. #67 and #68
70. dyslexi* in ti,ab,de,nt
71. learning difficult* in ti,ab,de,nt
72. exercis* in ti,ab,de,nt
73. physical* activ* in ti,ab,de,nt
74. #1 or #2 or #3 or #4 or #5 or #6 or #7 or #8 or #9 or #10 or #12 or #13 or #14 or #15 or #16 or #17 or #18 or #19 or #20 or #21
75. #24 or #25 or #26 or #27 or #28 or #29 or #30 or #31 or #32 or #33 or #34 or #35 or #36 or #37 or #38 or #39 or #40 or #41 or #42 or #43 or #44 or #45 or #46 or #47 or #48 or #49 or #50 or #51 or #52 or #53 or #54 or #55 or #56 or #57 or #58 or #59
76. #62 or #63 or #64 or #65 or #66 or #69 or #70 or #71 or #72 or #73
77. #74 or #75 or #76
78. (review* or overview* or meta-anal* or metaanal* or meta anal* or guideline*) in ti,ab,de,nt
79. #78 near #77
80. #79 and (UD > "199812")

The search was limited to material added during the last year.

ASSIA (searched on Datastar online, 14/1/2000)

Cardiovascular diseases and cancer

1. HEART ADJ DISEASE OR STROKE OR STROKES OR CORONARY OR CARDIOVASCULAR
2. MYOCARDIAL OR HEART ADJ ATTACK$ OR CERBROVASCULAR ADJ ACCIDENT$ OR ANGIOPLASTY
3. RESUSCITATION OR BLOOD ADJ PRESSURE
4. REVIEW$ OR OVERVIEW$ OR METAANAL$ OR META-ANAL$ OR METANAL$
5. (1 OR 2 OR 3) AND 4
6. CEREBROVASCULAR
7. (1 OR 2 OR 3 OR 6) AND 4

Appendix 1: Search process

8. ..LIMIT 7 YR=1998
9. ..LIMIT 7 YR=1999
10. 8 OR 9
11. CANCER$ OR NEOPLASMS OR CARCINOMA$ OR SARCOMA$ OR MELANOMA$ OR LEUKEMIA OR LEUKAEMIA
12. RADON OR ASBESTOS$ OR POLLUT$ OR OZONE Or SUNBURN
13. RISK NEAR BEHAV$
14. DRINKING OR ALCOHOL$
15. SAFER ADJ SEX OR UNPROTECTED ADJ SEX OR CONDOM$ OR SEXUAL ADJ HEALTH
16. (REVIEW$ OR OVERVIEW$ OR METAANAL$ OR META-ANAL$ OR METANAL$).TI,AB.
17. (11 OR 12 OR 13 OR 14 OR 15) AND 16

The search was limited to material published in 1998 and 1999.

Accidents

Accidents were searched on the cd-rom version of ASSIA (1999/Q4 update, searched 24.1.00)

1. ft = accident* prevention or ft = safety awareness or ft = accident* awareness
2. ft = safety near3 job* or ft = safety near3 work* or ft = safety near3 occupation*
3. ft = safety standard* or ft = social exclusion or ft = social* exclud*
4. ft = public near3 risk* or ft = awareness near3 risk* or ft = traffic accident*
5. ft = road accident* or ft = road safety or ft = vehicle safety
6. ft = cycling or ft = cycle training or ft = cyclist education
7. ft = cycle proficiency or ft = cycle test* or ft = bicycle proficiency or ft = bicycle test*
8. ft = pedestrian education or ft = pedestrian training or ft = walking or ft = speed limit*
9. ft = speeding or ft = speed management or ft = building safety or ft = water safety
10. ft = school travel* or ft = school transport* or ft = ecological* transport* or ft = traffic calming
11. ft = safe play or ft = safe area or ft = home safety or ft = hazardous site*
12. ft = safety belt* or ft = seatbelt* or ft = seat-belt* or ft = seat belt*
13. ft = cycle helmet* or ft = bicycle helmet* or ft = drink-drive* or ft = drink drive*
14. ft = alcohol near4 accident* or ft = trading standard* or ft = parent* skill*
15. ft = health diet near accident* or ft = physical* activ* near diet*

Appendix 1: Search process

16. ft = eyesight or ft = eye sight or ft = eye-sight or ft = eye-test
17. ft = eye test* or ft = medication* review* or ft = eyetest* or ft = faller*
18. ft = fall* near4 elder* or ft = fall* near4 older* or ft = firstaid or ft = first aid
19. ft = first aid or ft = basic resuscitation
20. ft = review* or ft = overview* or ft = guideline* or ft = meta-anal* or ft = metaanal* or ft = meta anal*
21. cs = 1 or cs = 2 or cs = 3 or cs = 4 or cs = 5 or cs = 6 or cs = 7 or cs = 8 or cs = 9 or cs = 10
22. cs = 11 or cs = 12 or cs = 13 or cs = 14 or cs = 15 or cs = 16 or cs = 17 or cs = 18 or cs = 19
23. cs = 21 or cs = 22
24. cs = 23 and cs = 20
25. da = 1999
26. cs = 25 and cs = 24

Mental health

Mental health topics were searched on the cd-rom version of ASSIA (1999/Q4 update, searched 17/1/2000)

1. ft = mental health or ft = mental* ill* or ft = mental* disorder*
2. ft = supported housing or ft = housing association* or ft = homeless*
3. ft = job* or ft = unemploy* or ft = employ* or ft = volunteer*
4. ft = alcoholi* or ft = alcohol abuse* or ft = alcohol misuse* or ft = drug abuse*
5. ft = drug misuse* or ft = substance misuse* or ft = substance abuse* or ft = addict* or ft = glue sniff*
6. ft = abuse detect* or ft = misuse detect* or ft = drug test*
7. cs = 4 or cs = 5
8. ft = treatment or ft = rehabilitat* or ft = therap*
9. cs = 7 and cs = 8
10. ft = bereave* or ft = grief or ft = coping behavior* or ft = coping behaviour* or ft = coping mechanism*
11. ft = exclusion or ft = isolation or ft = inequity or ft = crime or ft = criminal* or ft = bully* or ft = violen*
12. ft = self-help or ft = social support or ft = support group* or ft = social welfare or ft = support network*
13. ft = education or ft = financial problem* or ft = financial difficult* or ft = transport polic*
14. ft = child* abuse* or ft = child* care or ft = at-risk or ft = leaving care or ft = community safety
15. ft = single parent* or ft = sole parent* or ft = lone parent* or ft = parenting or ft = parent* skill*
16. ft = healthy prison* or ft = healthy school* or ft = healthy diet* or ft = exercis*
17. ft = homicide* or ft = murder* or ft = suicide*
18. ft = media

Appendix 1: Search process

19. cs = 17 and cs = 18
20. ft = stigma* or ft = refugee* or ft = black* or ft = ethnic* or ft = smoker* or ft = smoking
21. ft = workplace* or ft = work place* or ft = job* or ft = occupation*
22. ft = stress*
23. cs = 21 and cs = 22
24. ft = dyslexi* or ft = learning difficult* or ft = exercis* or ft = physical activ*
25. ft = review* or ft = overview* or ft = metaanal* or ft = meta-anal* or ft = meta anal* or ft = guideline*
26. cs = 1 or cs = 2 or cs = 3 or cs = 4 or cs = 5 or cs = 6 or cs = 10 or cs = 11 or cs = 12 or cs = 13
27. cs = 14 or cs = 15 or cs = 16 or cs = 19 or cs = 20 or cs = 23 or cs = 24 or cs = 26
28. cs = 27 and cs = 25
29. da = 1999
30. cs = 28 and cs = 29

Searches for reviews relating to employment, education and social inequality were undertaken. Broader issues of reducing social inequalities and how they may effectively impact upon health are difficult to retrieve because:

- There are a large number of potential interventions
- Inequality and changes in inequality are described in many different ways
- Few of the databases searched support subject indexing that captures the concept of systematic review
- Outside of the field of medicine, psychology and education systematic reviews are relatively few
- Reviews tend to have very little description of the methodology used, in the abstract, which means that retrieval cannot be usefully focused onto reviews which may be systematic.

The searches found some potentially interesting studies which were not included in this version of the document because of lack of time, but are available for consideration in any future updates.

Appendix 2: References to all systematic reviews cited in this report

1. Abbot NC, Stead LF, White AR, Barnes J, Ernst E. Hypnotherapy for smoking cessation [Cochrane Review]. In: The Cochrane Library, Issue 1, 2000. Oxford: Update Software. {Substantively amended: 18 February 1998} [Ca]
2. Abel EM. Psychosocial treatments for battered women: a review of empirical research. Research on Social Work Practice 2000;10(1):55-77. [S]
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