

# Evidence-based social services

Toolkit for planning  
& evaluating social services

*Social  
innovation*



The content of this report and its toolkit consists of a guidance on what type of knowledge is required for planning and evaluating services accompanied by two questionnaires; the first aids practitioners when planning services, while the second questionnaire aids practitioners in their evaluation of local social services. The toolkit also includes a review of international evidence-based social work databases that may be useful for practitioners when planning services.

The European Social Network (ESN) has been working on aspects related to evidence-based policy and practice in public social services since 2012. This toolkit was tested with senior practitioners and applied researchers at a joint meeting on evidence-based practice in London in October 2015 and their feedback was integrated into this final report.

Knowledge  
to action

# Evidence-based social services

Toolkit for planning  
& evaluating social services

Better  
outcomes  
for users

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## Introductory letter

In 2014, the European Social Network (ESN) launched a new strand of its work focused on evidence-based practice in social services. This component of ESN's work programme consists of a panel of applied researchers and senior practitioners, who meet in a variety of formats. The input of applied researchers and social service's directors results in a series of outputs exploring challenges and opportunities for evidence-based practice.

As a follow up to the panel's first meeting, which took place in November 2014, we published a paper that discussed the evidence-based policy and practice phenomenon in social services in selected European countries. The paper defined the concepts of evidence and impact and assessed what sort of impact may be relevant and for whom. It reviewed two case studies from Denmark and the Netherlands, which served as the basis for addressing a number of challenges and suggesting possible ways to move forward.

Throughout 2015, ESN has continued this work with a review of international databases that gather evidence-based practice in the field of social work and an assessment of how useful the information they contain may be for senior social work practitioners. This has helped us to formulate a proposal around what type of information should be collected to plan and evaluate social services programmes.

As a result of this work, we are now launching this toolkit consisting of a guidance on what type of knowledge is required for commissioning services accompanied by two questionnaires; the first questionnaire includes what questions may be useful to think of when planning services, the second questionnaire looks at what questions are useful when evaluating your services. The toolkit also includes a review of international evidence-based social work databases or evidence hubs that may be useful for practitioners when they search for evidence-based practice that could guide their service planning and evaluation. We tested various parts of the toolkit with senior practitioners and applied researchers at a joint meeting in London in October 2015 and integrated their feedback in the final output, which we gladly present now.



John Halloran

**ESN CEO**

## About this toolkit

This toolkit has been written by Alfonso Lara Montero, Policy Director, from the European Social Network's Secretariat and Ann Buchanan, Researcher, from the University of Oxford. The toolkit consists of a guidance on what type of knowledge is required for planning and evaluating services accompanied by two questionnaires; the first questionnaire includes those questions that practitioners may want to think of when planning services, the second questionnaire looks at what questions are useful when evaluating local social services.

The toolkit also includes a review of international evidence-based social work databases that may be useful for practitioners when they search for evidence-based practice that could guide their service planning and evaluation. We tested various parts of the toolkit with senior practitioners and applied researchers at a joint meeting in London in October 2015 and integrated their feedback in the final output, which we gladly present now.

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## Background

Five years after the start of the financial and economic crisis, in February 2013, the European Commission called on Member States to prioritise social investment in order to modernise their social welfare states. Within the current budget constraints, the Commission invited Member States to shift their social policy focus towards **investment** in human capital and social cohesion so that they can progress towards the objectives of the Europe 2020 Strategy<sup>1</sup>.

The EC gave guidance to Member States on more efficient and effective social policies in response to the significant challenges they face. Recognising the budget constraints posed by the crisis and the demographic challenges posed by population ageing, social policies need to be both adequate and fiscally sustainable. There is a need to innovate socially using the available resources more efficiently and effectively and engaging critically with a combination of approaches such as universalism, targeting and conditionality when designing policies. **Social innovation** is essential, especially in times of crisis, and policy approaches need to be tested so that policy-making becomes evidence-based and effective approaches are scaled up across Europe.

Therefore, the modernisation of public social services is placing an increasing emphasis on **evidence** with regard to **decision-making, service contracting and delivery, and evaluation**. The European Commission recognised in the 2013 Social Investment Package (SIP)<sup>2</sup> the need to test social policies and services to favour the most effective. The SIP argues that effective and quality social services are a public investment, hence public social services play a key role in achieving the Europe 2020 objectives. In difficult economic times, the imperative to spend public money efficiently is even higher and not withstanding political choices and demands, the value of informed decision-making drawing on evidence in all its component parts has gained a new momentum. The European Commission is also increasingly prominent in supporting research and innovation grounded on evidence-based knowledge sharing<sup>3</sup>.

Programme evaluation has thus become increasingly important. The European Social Network (ESN) has published a number of relevant papers<sup>4</sup>. It has become clear from ESN's work with key personnel across Europe that: *“Public authorities struggle to gather accurate data on what works, for what groups, at what cost, and with what effects. Decision-makers*

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<sup>1</sup> European Commission (2015): Europe 2020 in a nutshell. Available at: [http://ec.europa.eu/europe2020/europe-2020-in-a-nutshell/index\\_en.htm](http://ec.europa.eu/europe2020/europe-2020-in-a-nutshell/index_en.htm)

<sup>2</sup> European Commission (2013): Communication from the Commission to the European Parliament, the Council, the European Economic and Social Committee and the Committee of the Regions. Towards Social Investment for Growth and Cohesion – including implementing the European Social Fund 2014-2020, Brussels, 20.2.2013. Available at: <http://ec.europa.eu/social/BlobServlet?docId=9761&langId=en>

<sup>3</sup> J-Pal Europe (2012): Social experimentation methodological guide. A methodological guide for policy makers. Available at: <http://ec.europa.eu/social/BlobServlet?docId=7102&langId=en>

<sup>4</sup> European Social Network (ESN) (2015): Public social services in crisis: challenges and responses. Available at: [http://www.esn-eu.org/userfiles/Documents/2015/2015\\_Public\\_Social\\_Services\\_in\\_Crisis\\_report\\_-\\_FINAL.pdf](http://www.esn-eu.org/userfiles/Documents/2015/2015_Public_Social_Services_in_Crisis_report_-_FINAL.pdf); European Social Network (ESN) (2014): Contemporary issues in the public management of social services in Europe. Innovation, research and evidence-based practice. Available at: <http://www.esn-eu.org/raw.php?page=files&id=970>. European Social Network (ESN) (2015): Evidence in public social services. An overview from practice and applied research. Available at: [http://www.esn-eu.org/userfiles/Documents/Publications/Practice\\_reports/Evidence\\_in\\_public\\_social\\_services.pdf](http://www.esn-eu.org/userfiles/Documents/Publications/Practice_reports/Evidence_in_public_social_services.pdf)

*and practitioners need data and effective evaluation designs that are flexible enough to be implemented in a variety of contexts.”*

Alongside these pressures, there are also **ethical** imperatives. Helping strategies for vulnerable populations should be based on best evidence. Any intervention has three possible outcomes: positive change; no change; does harm. At the very least, social workers need to ensure that their interventions **do not harm**. However, without effective evaluations they can never be sure of the outcomes. Actually, history is replete with well-meaning programmes that have caused harm to the recipients.

Two well-known examples of harm<sup>5</sup> are commonly quoted: first, the Cambridge-Somerville study when young men at risk of delinquency were linked with a supportive mentor. In a very thorough longitudinal randomised controlled trial comparing delinquents with non-delinquents, there was a highly significant finding. The only problem was that the non-delinquents had committed more crimes than the delinquents. A second example is the outcome from ‘psychological debriefing’. This was a popular therapy for people who had experienced severe trauma. The logic was that if a therapist talked through the trauma with the person this would ease the post-traumatic stress. Studies showed that far from relieving the stress, those who had undertaken the therapy had a more prolonged period of mental health difficulties.

As part of past ESN’s work in the framework of the working group on leadership, performance and innovation, directors of public social services emphasised the importance of making research and evidence **intelligible** to professionals in order to improve its use in the public sector. Most directors saw evidence as an instrument to achieve a specific aim, for instance, to improve the provision of services. *“As a purchaser of services, I need to ensure that I buy services that are of quality, efficient and effective”*, said John Powell, from the Association of Directors of Adult Social Services in England (the UK). In other cases, evidence was seen as an instrument to making the case for a particular investment. *“I need a strong evidence base in order to convince politicians of the need to invest in a certain service”*, argued Karine Lycops, from the Association of Directors of Social Services in Belgium<sup>6</sup>.

There are, however, a number of **barriers** to the implementation of Evidence Based Practice (EBP). Even in the United States, where most EBPs originate, implementation is often poor and programmes come to an end when funding dries up<sup>7</sup>. It is suggested that this is because there is little knowledge about EBP; there is confusion about what constitutes “evidence based” and concern that, in the real world, there may not be both the human and financial resources to undertake such programmes.

In Europe, some of these issues are magnified. There is an understandable **reluctance** to import programmes that have been developed in a very different social welfare context (e.g. the United States has much poorer outcomes for children than many EU countries) and

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<sup>5</sup> McCord, J. (2007 (originally published in 1978)): A thirty-year follow-up of treatment effects, crime and family: selected essays of Joan McCord. Available at: <http://books.google.com/books?id=Upu7qxbvP6IC&pg=PA13#v=onepage&q&f=false>; Wessely, S. and Deahl, M (2003): Psychological debriefing is a waste of time; *American Psychologist*, Vol. 183:1, pp. 12-14. Available at: <http://bjp.rcpsych.org/content/183/1/12>

<sup>6</sup> European Social Network (ESN) (2014): Contemporary issues in public social services: Innovation, research and evidence-based practice. Available at: <http://www.esn-eu.org/raw.php?page=files&id=970>

<sup>7</sup> Ashford, N.; Elliott, D. and Little, M. (2012): Blueprints for Europe: Promoting evidence based programmes in children’s services, *Psychosocial interventions*, Vol. 21:2, pp. 205-214. Available at: <http://www.redalyc.org/pdf/1798/179824384009.pdf>

indeed some programmes have performed badly when replicated in Europe. For example, transportation of Multi-Systemic Therapy for young offenders from the United States to Sweden yielded disappointing results, and researchers have suggested that marked differences in youth welfare systems and socio-demographic factors may have led to this outcome<sup>8</sup>.

Perhaps more important is that, although there are some efforts to develop EBP platforms (for example, the European Platform for Investing in Children, EPIC, is developing such a facility for children), there is **no pan-European source of information** for all social work target populations, and what is available may not be in all European languages. Added to this, most evidence based programmes are undertaken in group, schools or community centres, while most social workers work with individual clients and their task is to assess their individual situation and suggest an immediate route forward, but the resource may not be available within the timetable needed.

Despite these problems, some imported programmes have demonstrated **good outcomes**. Among these are [The Incredible Years](#)<sup>9</sup> which has been implemented in US, UK, Ireland, Norway, Germany, Denmark, Netherlands, Portugal and Sweden. Their claim is that for every \$1 spent there is a return of \$1.20. [The Nurse Family Partnership](#)<sup>10</sup> that supports mothers at risk of abusing their children, is another such programme. It claims to have a \$3.15 return for every \$1 spent. In a cash-strapped environment, it is important to know what the costs/benefits are. However, at present there is very **limited information** on the **costs** and **benefits** of social services programmes in international databases.

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<sup>8</sup> Gardner, F.; Montgomery, P.; and Knerr, W. (2015): Transporting evidence-based parenting programs for child problem behavior (Age 3-10) between countries: systemic review and meta-analysis, *Journal of Clinical Child Psychology and Psychiatry*, 1, pp. 1-14. Available at: <http://67.199.123.90/library/wp-paper.asp?nMode=1&nLibraryID=723>

<sup>9</sup> Gardner, F.; Montgomery, P.; and Knerr, W. (2015): Transporting evidence-based parenting programs for child problem behavior (Age 3-10) between countries: systemic review and meta-analysis, *Journal of Clinical Child Psychology and Psychiatry*, Vol. 1, pp. 1-14. Available at: <http://67.199.123.90/library/wp-paper.asp?nMode=1&nLibraryID=723>

<sup>10</sup> Olds, D.; Holmberg, J.; Donelan-McCall, N.; Luckey, D.; Knudtson, M.; and Robinson, J. (2014): Effects of home visits by paraprofessionals and by nurses on children: follow-up of a randomized trial at ages 6 and 9 years, *JAMA Pediatr.*; Vol. 168:2, pp. 114-21. Available at: <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC4217160/>

Monitoring  
and  
evaluation

Knowledge required  
for planning and  
evaluating services



# Knowledge required for planning and evaluating services

## Introducing the Knowledge to Action Cycle

There is a range of “evidence” or “knowledge” needed to develop initiatives or programmes that work for service users. First, there is a requirement for **basic research** so that **risk and protective factors** can be identified. There is also a need for information about the **extent** of the problem, in order to plan ahead and develop resources for particular groups as well as to focus valuable **resources** to the problems and areas most in need.

The process of identifying and applying knowledge in practice is called “**Knowledge to Action Cycle**” (see figure 1). In the Knowledge to Action Cycle, the starting point is to **identify** the problem, select and review which **knowledge** we have about the problem. It is at this stage that information from the reviewed databases (see pages 37-42) may be most helpful. As can be seen in figure 1, the second stage is to **adapt** knowledge to the local context. Research suggests that when developing evidence-based practice, in addition to the various types of evidence, **awareness** of the social **context, needs and wishes** of the local community, and the **stakeholders** are a key component of successful programmes<sup>11</sup>.

Although some of the better known evidence-based programmes, such as “The Incredible Years” and “Triple P” parenting programmes from Australia<sup>12</sup> have been trialled in many countries, some of the evidence-based programmes reported in the databases, particularly from the UK and the US, may not travel well. As demonstrated earlier with multi-systemic therapy, this may be because of **cultural factors**; for instance, attitudes to children and family may be very different across countries. It may also be down to **different national policies and legislation**, but most importantly to the fact that **different systems of support**, such as health and social services have different structures.

Some of these evidence-based programmes may have to be tailored to local conditions. The dilemma here is that without “**implementation fidelity**” – that is faithfully following the original procedures, the programme may not be the same and may have very different results. It is important therefore that the adapted interventions are evaluated in their own context. However, US sites such as [SAMHSA](#)<sup>13</sup> and [Colorado Blueprints](#)<sup>14</sup> are increasingly trialling programmes in international settings, and it would be a mistake to dismiss the knowledge and support they give just because they come from the USA.

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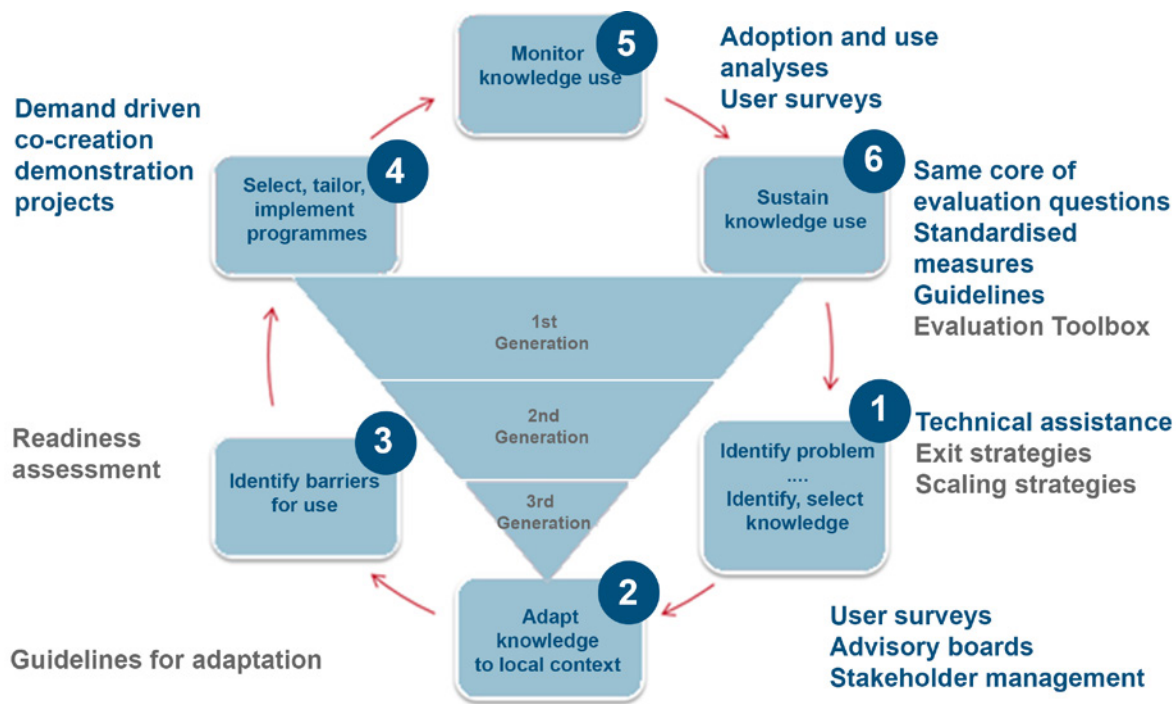
<sup>11</sup> Gambrill, E. (2006): Evidence-based social work; in: Buchanan, A.: *Evidence-based social policy and practice. A new ideology or a human rights imperative?*, pp. 328-340.

<sup>12</sup> The Incredible Years: The Incredible Years Parenting Programme. Parents, teachers, and children training series. Available at: <http://incredibleyears.com/>. Triple P International: Triple P - Positive parenting program. Available at: <http://www.triplep-parenting.uk.net/>

<sup>13</sup> Substance Abuse and Mental Health Services Administration: National registry of evidence-based programs and practices. Available at: <http://www.nrepp.samhsa.gov/Search.aspx>

<sup>14</sup> University of Colorado Boulder, Center for the Study and Prevention of Violence: Blueprints for healthy development. Available at: <http://www.blueprintsprograms.com/>

Figure 1: The Knowledge-To-Action Cycle<sup>15</sup>



## Identifying and assessing various types of knowledge

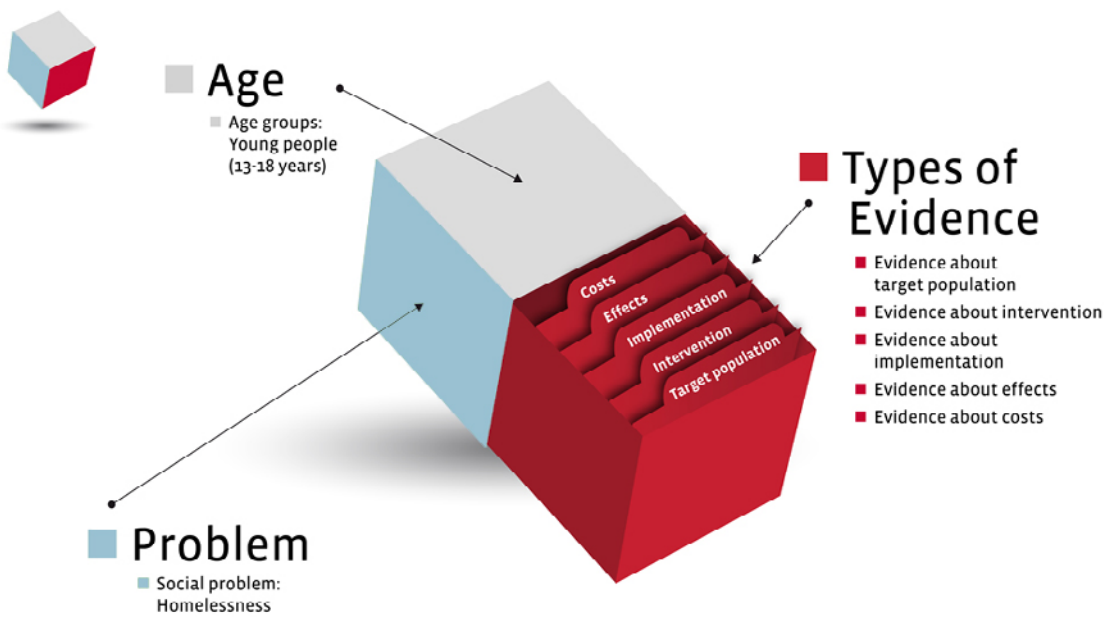
As highlighted in the beginning of this section, there is a range of “evidence” or “knowledge” needed to develop initiatives or programmes that work for service users. Previous work undertaken by Nielsen, Grünberger, and Pedersen identified five types of evidence. This part of the toolkit assesses the extent to which these five types of evidence may be available in social work databases and examines each type of evidence through the development of questions that decision-makers, social services directors and practitioners may want to ask when they develop evidence-based programmes.

The five types of evidence that were identified to inform evidence-based programmes are:

1. Evidence about the target population
2. Evidence about the potential programme
3. Evidence about how the programme should be/is implemented
4. Evidence about the possible effects
5. Evidence about the costs

<sup>15</sup> Adapted and used with permission: Graham, I. D., Logan, J.; Harrison; M. B.; Straus, S. E.; Tetroe J.; Caswell, W.; and Robinson, N. with the Alliance for Continuing Education in the Health Professions, the Society for Academic Continuing Medical Education, and the Association for Hospital Medical Education (2006): Lost in knowledge translation: Time for a map?, *Journal of Continuing Education in the Health Professions*, Vol. 26:1. Copyright © 2006. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/16557505>

Figure 2: Illustration of the logic underlying the social policy evidence base<sup>16</sup>



### 1. Evidence about the target population

Collecting evidence about the target population means looking at **who** may **benefit** from a programme; including volume, demographics and socio-economic characteristics of the target population. **Four questions** may help us collect evidence about our target population:

1. **What is the problem of concern?**
2. **What is the extent of the problem?**
3. **What risk and protective factors are associated with the problem?**
4. **Who should be partners in the programme?**

#### What is the problem of concern?

To decide what is the social problem that needs addressing, the issue will need to be **contextualised** against the norms and values, ethnic and morals and the group identity in any given community<sup>17</sup>. Different societies at different times will have different views and different awareness about what is or what is not a social problem. This information can only come from those involved in their communities. An example from the UK is the recent heightened awareness of the large numbers of children involved in sexual abuse.

<sup>16</sup> Nielsen, S.; Grünberger, P; and Pedersen, C. (2013): What types of evidence are needed for decision-makers? Knowledge management to support evidence-based social policy and programs in Denmark, *Paper presented at the American Evaluation Association Annual Conference*.

<sup>17</sup> Buchanan, A. (2000): Present issues and concerns; in: Buchanan, A.; and Hudson, B.: *Promoting Children's Emotional Well-being*.

## What is the extent of the problem?

Knowing the extent of the problem can help in **prioritising** resources and areas for intervention. **Monitoring changes in incidence** (number of new cases in a population in a given period) can be useful in giving a general indication about whether a problem is increasing or decreasing and whether a specific programme needs to be put in place to meet the needs of a community.

But knowing the extent of the problem can also help in **planning ahead** and having facilities available for specific needs. For example, if it can be estimated from current child protection cases that a number of young mothers will need a programme to prevent the risk of child abuse/neglect, this programme can be prepared and professionals ready to implement it can be trained, so that young mothers can be included in to the programme as needed.

In Europe, the **cross-European data** available from [Eurostat](#)<sup>18</sup> can be helpful for comparing countries or for comparing with local data. Information on specific problems may also be available from national data. For example, the [Appeals Board in Denmark](#)<sup>19</sup> gathers large amounts of data from the local level, including local authorities and individual casework. Another database in Germany, [INKAR](#)<sup>20</sup> provides statistical information on a wide range of social issues and has thematic maps of all the counties in Germany.

In England, maps developed by the English [Indices of Deprivation](#)<sup>21</sup> provide a relative measure of deprivation at small area level. Areas are ranked from least to most deprived on seven different dimensions of deprivation:

- income deprivation;
- employment deprivation;
- health deprivation and disability;
- education deprivation;
- crime deprivation;
- barriers to housing and services deprivation;
- living environment deprivation.

In addition, two supplementary indexes measure income deprivation: the Income Deprivation Affecting Children Index (IDACI) and the Income Deprivation Affecting Older People Index (IDAOPI). From these indexes, neighbourhood maps indicate the most deprived areas. Such maps are used by local authorities to place services in the most disadvantaged areas. For example, local maps of deprivation were used to ensure [Sure Start Families Centres](#)<sup>22</sup> were as close as possible to the communities most in need.

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<sup>18</sup> EUROSTAT. Available at: <http://ec.europa.eu/eurostat/data/database>

<sup>19</sup> Danish Appeals Board. Available at: <https://ast.dk/tal-og-undersogelser>

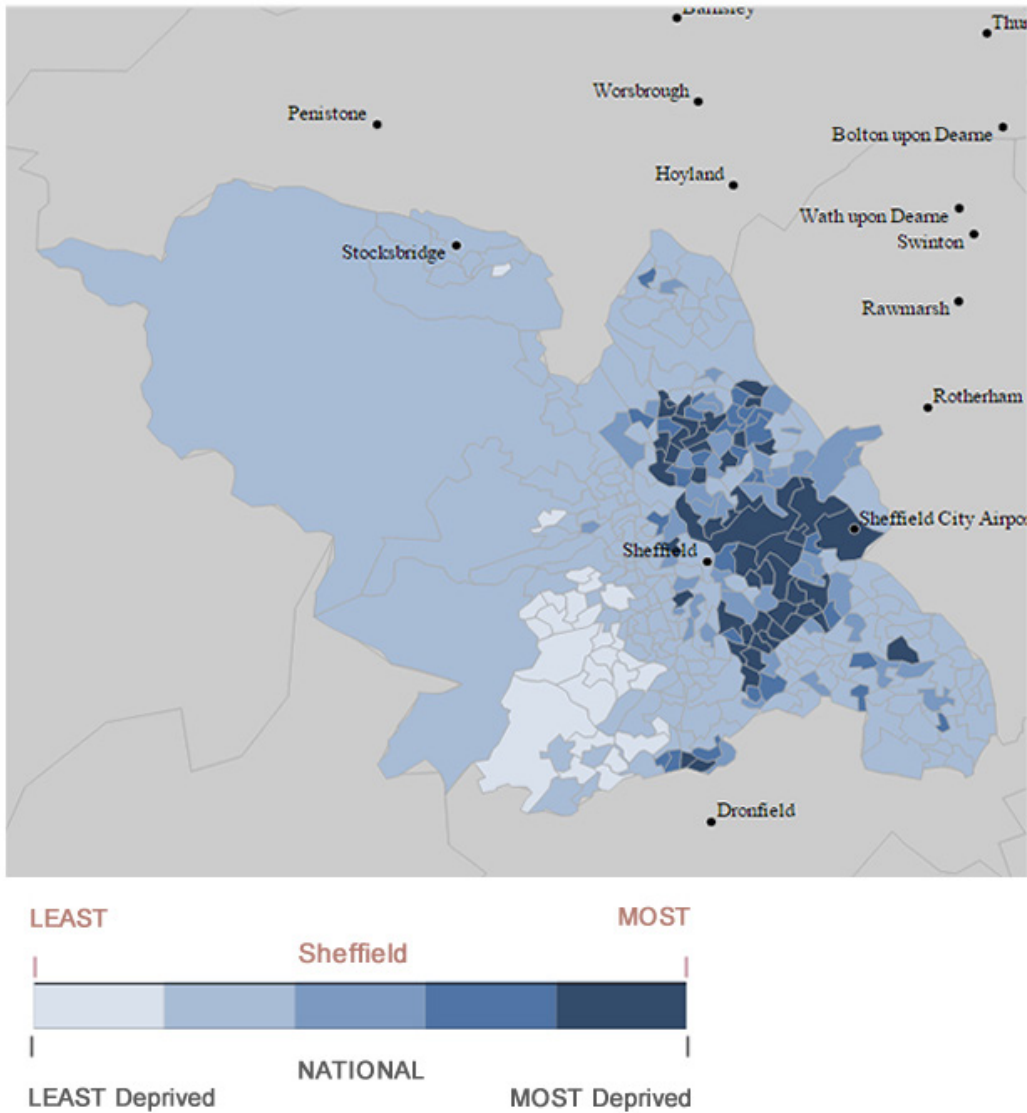
<sup>20</sup> Federal Institute for Construction, Urban and Area Research. Available at: <http://www.inkar.de>

<sup>21</sup> UK Government, Department for Communities and Local Government: Indices of Deprivation. Available at: <https://www.gov.uk/government/collections/english-indices-of-deprivation>

<sup>22</sup> UK Parliament: The development of Children's Centres. Available at: <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmchilsch/130/13006.htm>



**Figure 3: Atlas of the Indices of Deprivation 2010 for England**  
**Local maps of social deprivation – Sheffield: Index of Multiple Deprivation<sup>23</sup>**



On this map of Sheffield in the UK, the most deprived areas are navy blue and the least deprived in light blue.

**What are the risk and protective factors associated with the problem?**

Many databases across Europe have sites that give research information/overviews or research syntheses relating to particular problems/conditions. In our review, these sites are highlighted under category **‘Basic Research & Problem Overviews’**. Most of these databases have search engines where you can search a social problem, such as

<sup>23</sup> UK Office for National Statistics: Atlas of the Indices of Deprivation 2010 for England. Available at: <http://neighbourhood.statistics.gov.uk/HTMLDocs/AtlasOfDeprivation2010/index.html>, see local authority “Sheffield”

homelessness or domestic violence, and find individual research reports or research syntheses. These sites provide the information that a manager may need about the target population; for instance, who is likely to have the social problem; age; gender; ethnic background; socio-economic status, linked conditions and possible causes.

From the basic research and problem overviews, a number of factors may be identified. These factors can be classified **risk and protective factors**. Risk factors are characteristics that affect the chance of having the problem. Risk factors may be individual inherent traits, a factor under a person’s control, or a factor in their family or community. Similarly, protective factors are attributes in the person, family or community, which help people to deal with the problem. The advantage of knowing the risk and protective factors is that in your intervention you may directly target, not the people of concern but the risk factor. For example by installing cameras in areas of high vandalism, this may deter delinquents because the cameras will increase the likelihood that they will get caught.

The database SAMHSA has a useful article explaining risk and protective factors<sup>24</sup>. All recommended programmes on the Colorado Blueprints site have a section on risk and protective factors for the problem that is the focus of the programme<sup>25</sup>.

### Risk & protective factors associated with drug use amongst children and adolescents<sup>26</sup>

Risk Factors	Domain	Protective Factors
Early Aggressive Behaviour	Individual	Self-Control
Lack of Parental Supervision	Family	Parental Monitoring
Substance Abuse	Peer	Academic Competence
Drug Availability	School	Anti-drug Use Policies
Poverty	Community	Strong Neighbourhood Attachment

<sup>24</sup> Substance Abuse and Mental Health Services Administration: Practicing effective prevention. Available at: <https://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/key-features-risk-protective-factors/5>

<sup>25</sup> University of Colorado Boulder, Centre for the Study and Prevention of Violence: Blueprints for healthy development. Available at: <http://www.blueprintsprograms.com/factSheet.php?pid=ae694b0755cd5eed5886ec4d8e658bde9639331d>

<sup>26</sup> National Institute on Drug Abuse: Preventing Drug Use among Children and Adolescents. Available at: <http://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/chapter-1-risk-factors-protective-factors/what-are-risk-fact>

## Risk factors for women having a teenage birth

### Risk of having a teenage birth

#### *Risk Factors*

A woman has a high probability of being teenage mother if her own mother was also a teenage mother. The probability of being teenage mother is also significantly higher for women whose parents are unskilled or who grew up with a single parent. Teenage mothers are worse off in a number of areas than average, for example, in relation to wages, education and health.

### Who should be partners in the programme?

Involving partners, **stakeholders** and those who will be the users of the programme at an early stage is key not only for the success of the programme but also for the programme to obtain wider dissemination. Webster Stratton<sup>27</sup>, who has been successful in disseminating her parenting programmes around the world, suggests that three steps are important in ensuring success and wider dissemination:

- **First**, she speaks of developing a **taste for change**. Those involved in supporting the users under current conditions need to believe that help could be made more effective.
- **Second**, she speaks of the need to obtain **administrative and financial support** for the suggested programme.
- **Third**, Stratton highlights the need for **funding to evaluate** the programme and demonstrate that change has indeed occurred. If evaluation funding is not ring-fenced at the start, it can be hard to persuade authorities to divert much needed funding away from projects to evaluation later on.

## 2. Evidence about the programme

This concerns programmes directed towards the **social problems** of the target population and includes evidence-based practices, but may also include methods that have not been subject to rigorous impact evaluations yet, but have promising features. The question a social services director may ask her/himself to collect the best possible evidence is: **which level of intervention is likely to have the best outcome?**

Three main levels of intervention may be identified:

- **Primary prevention** aims to prevent a social problem before it ever occurs and it targets the whole population. Examples of primary prevention programmes include media campaigns for HIV/AIDS, smoking, obesity, sex/drug education in schools, health visitor services to all families of newly born babies.

<sup>27</sup> Webster Stratton, C.; and Taylor, T. (1998): Adopting and implementing empirically supported interventions. A Recipe for success; in: Buchanan, A. and B. Hudson: *Parenting, Schooling and Children's behaviour*, pp. 127-160.

- **Secondary prevention** refers to strategies used for those at risk of developing a problem. A couple of examples illustrative of secondary prevention programmes include strategies to prevent disaffected young people from offending and Family Nurse Partnership with families who are at risk of child maltreatment.
- **Tertiary prevention** refers to the limitation of long term harm for those who have experienced a social problem. Examples of tertiary prevention programmes include therapy for children who have been abused, on-going support for people with depression and training programmes for disabled people to access the labour market.

Useful information on prevention projects at various levels can be found in most evidence-based sites. The following example is of both a **primary** (targeted at the population) and a **secondary prevention programme** (targeted at those at risk) to prevent cross border trafficking in human beings. This comes from a Campbell Collaboration systematic review.

### Cross-border trafficking in human beings: Prevention and intervention strategies for reducing sexual exploitation - A Systematic Review

Policies or interventions to prevent or suppress cross border trafficking for the purpose of sexual exploitation have not been evaluated rigorously enough to determine their effect. Using different search strategies and key words in nine different languages, the authors identified 19.000 studies on trafficking that came out between January 2000 and June 2009. Literature suggests that most interventions focus on prevention through awareness raising activities. Some of the interventions aim directly at the at-risk population, victims or perpetrators, others focus more indirectly on populations, trying to create more awareness among social workers and policy makers.

Initiatives can combine several goals and activities, such as those focusing on legislation, policy development and awareness-raising. Different methods are used in awareness raising initiatives. In most cases, awareness-raising initiatives provide skills training to the targeted population, such as victims and the at-risk population. A popular instrument is the media (television, radio and posters), mainly used to raise awareness among the public.

Although, the authors were not able to state definitively which strategies worked best, the document provides useful information about strategies for limiting cross-border trafficking in human beings.

See more at: <http://www.campbellcollaboration.org/lib/project/112/>

MOVISIE, the Netherlands Centre for Social Development, led a seventh framework project for cross-country partnerships to develop **secondary prevention programmes** for those at risk of homelessness.

## The CSEYHP Project - Combating Youth Homelessness

The aim of the CSEYHP project was to gain in-depth knowledge of the life trajectories of homeless youth and those at risk of homelessness, and to explore the effectiveness of reinsertion programmes in the four participating countries.

The objectives of the CSEYHP project were fourfold:

1. To understand the life trajectories of different homeless populations in different national contexts.
2. To develop the concepts of risk and social exclusion in relation to the experience of young homeless people and to their reinsertion process.
3. To test how different methods of working contribute to the reinsertion process for young people.
4. To investigate the roles of and relationships between the young person and trusted adults, lead professionals, peer mentors and family members in the delivery of these programmes across all four countries.

See more at: <https://www.movisie.com/projects/combating-youth-homelessness>

At the level of **tertiary interventions**, there are programmes being developed in Denmark for people with mental health problems and coexisting substance abuse:

### Testing the ACT method for citizens with mental health problems and concurrent substance abuse

Assertive community treatment (ACT) is an intensive and highly integrated approach for community mental health service delivery. ACT programmes serve outpatients whose symptoms of mental illness result in serious functioning difficulties in several major areas of life, often including work, social relationships, residential independence, and physical health. In Denmark, ACT has been tested among psychiatric patients and homeless citizens. The method was implemented in two municipalities and tested among citizens who suffered from mental disorders as well as substance abuse.

See more at: [http://www.sfi.dk/view\\_all\\_projects-4843.aspx?Action=1&NewsId=4747&PID=10047#sthash.flgOPkt.dpuf](http://www.sfi.dk/view_all_projects-4843.aspx?Action=1&NewsId=4747&PID=10047#sthash.flgOPkt.dpuf)

### 3. Evidence about implementation

This type of evidence refers to the conditions known to drive or inhibit implementation, such as **organisational**, **inter-personal** and **individual factors**. This type of evidence refers broadly to the way(s) the programme is implemented; for example, selecting the relevant programme and means for its **delivery**, assessing whether the programme has been implemented elsewhere and therefore, how it should be **replicated** and finally, whether it has been **evaluated** and at which **level of evidence**.

### A social services director may want to ask:

- What type of programme is appropriate for the target population?
- What is the theoretical justification for that approach?
- What is the medium by which the programme is delivered?
- What is the length of the programme?
- Has the programme been previously evaluated?
- How should the programme be replicated?

Different databases handle these questions in different ways. Most evidence-based databases clearly specify the target population and the age group of the target population, which can be found through the databases' search engine or library facilities. Other databases also give some justification for the theoretical approach used usually in their overview. There are yet more databases that clearly specify the medium and components used to deliver the programme. In the following example, the Örebro Prevention Programme, retrieved from the European Platform for Investing in Children (EPIC), parents receive information by mail as well as attending meetings in schools (group intervention in schools).

#### Örebro Prevention Programme

Countries that have implemented the practice: [Netherlands](#), [Sweden](#)

- Age Groups: Teenagers (age 13 to 19)
- Target Groups: Children, Parents
- Years in Operation: 1995-still operating
- Type of Organization Implementing Practice: National Government

#### *Practice Overview*

The Örebro Prevention Programme (currently known as EFFEKT) works through parents and by targeting drinking among 13–16-year-olds. The 2.5-year programme, which was designed in Örebro County, Sweden, has been funded by the Swedish National Institute of Public Health. This has been part of its initiative for universal youth alcohol prevention programmes, which are to be implemented community-wide; the programme targets youths at ages during which drinking increases; it works in both urban and rural communities; it makes use of existing community resources and brings together different agencies and relevant parties.

The programme design and implementation were largely based on empirical findings demonstrating a negative correlation between levels of youth alcohol drinking and (i) the strictness levels of parental attitudes against youth alcohol consumption as well as (ii) the level of youth involvement in structured, adult-led activities. Thus, the core of the programme has been based on parents receiving information (*by mail and during parent meetings at the schools*) encouraging them to maintain strict attitudes against youth alcohol use as well as encouraging their youth's involvement in adult-led, organised activities.

See more at: [http://europa.eu/epic/practices-that-work/evidence-based-practices/practices/orebro-prevention-program\\_en.htm#chapter\\_2](http://europa.eu/epic/practices-that-work/evidence-based-practices/practices/orebro-prevention-program_en.htm#chapter_2)

A key element in implementation is to assess as to whether the programme that is being implemented may have been evaluated elsewhere and if it was, whether it was evaluated with a sound level of evidence.

Therefore, the question that a social services director may want to ask is: **Has the programme been previously evaluated? If so, can it be determined with what level of evidence?**

There are varying levels of evaluation, which are often called **the hierarchies of evidence**. These hierarchies suggest how much confidence one can have in the findings of the evaluation of a programme according to how the evaluation was undertaken. Databases use different forms of evidence hierarchies. While there is no agreement as to what constitutes the best hierarchies of evidence, figure 4 presents a synthesis from a variety of sources<sup>28</sup>.

**Figure 4: Hierarchy of evidence**



Some of the databases of evidence-based programmes give a range of ratings broadly correlating with the above. The section on evidence-based practices of the European Commission's EPIC<sup>29</sup> uses the following criteria:

<sup>28</sup> As an example on the hierarchy of evidence, see: Social Work Policy Institute: Evidence-based practice. Available at: <http://www.socialworkpolicy.org/research/evidence-based-practice-2.html>

<sup>29</sup> European Platform for Investing in Children: EPIC Evidence-based practices. Available at: [http://europa.eu/epic/practices-that-work/evidence-based-practices/evidence-criteria\\_en.htm#section1](http://europa.eu/epic/practices-that-work/evidence-based-practices/evidence-criteria_en.htm#section1)

- *Best practice*: Fulfils three categories – ‘evidence of effectiveness’, ‘transferability’ and ‘enduring impact’.
- *Promising practice*: Fulfils at least two categories: ‘evidence of effectiveness’ and at least one of the other two categories, ‘transferability’ or ‘enduring impact’.
- *Emerging practice*: Fulfils at least ‘evidence of effectiveness’.

If you are **replicating** an evidence based programme a key concern is “implementation fidelity” or “implementation with integrity”. As mentioned earlier, the programme may need to be adapted to different cultural contexts and local conditions. However, any adaptation of the programme means that it is a different programme and outcomes may differ simply because the crucial elements have not been replicated.

Some of the best known sites such as SAMHSA and Colorado Blueprints have programmes that have already been trialled in different country settings. It is expected that if **designated procedures are followed**, outcomes will be comparable. Such programmes come with an **implementation manual** detailing how the programme must be run and often insist on **training** for those undertaking the programme. Those replicating the programme are also expected to follow the **length** of the programme that is also known as the “dosage” or the number of individual sessions.

Within our databases review, we have identified a number of databases which give clear instructions about the implementation requirements and in some cases a help mechanism for queries.

#### 4. Evidence about the possible effects

This type of evidence concerns the extent to which interventions have **proved** to be effective; the effects’ ratio and size. This may also include the standardisation of outcome measurements across different evaluations/studies. The question that we would need to answer here is: **Does it work?**

For more specific questions, please see appendix 2 “How to plan a social service programme’s evaluation”. Some of the questions that would help social services directors and practitioners to collect evidence about the effects of a certain programme include:

- **What are the intended outcomes?**
- **What plans have you for evaluating your programme?** For instance, are there any standardised measures that you could use?
- **How will you measure the situation at the start of the project?** For example in a project to increase older people’s satisfaction in their residential setting, could you ask all the participants to complete a simple quality of life questionnaire?
- **What are your plans to follow up your project to see whether benefits have been sustained?**

In assessing the effects of a programme, ‘**outputs**’ are sometimes confused with ‘**outcomes**’. ‘Outputs’, for example, are the number of people who have been through the programme. ‘Outcomes’ are what happens to participants having taken part in a programme. If using a validated programme, there will be details of the outcomes. These need to be



examined carefully. For example, in a programme to reduce antisocial drinking, the outcome may be that the participants *believe* that they should reduce their drinking, but this does not mean that they *have* reduced their drinking. Although changing attitudes may be an important step on the road to reducing their alcohol consumption, it is not the same as demonstrating that they have.

If developing your own programme, it is important to include some **standardised measures** to monitor possible effects. A list of some of those that are freely available has been provided in appendix 4. Unfortunately, most of these are in English and will have to be translated into the language used. However, there are also standardised measures that have been validated in a number of languages. For example, the Strengths and Difficulties Questionnaire, which broadly measures child adjustment, is one such measure that has been translated and validated in numerous languages.

For those developing their own programmes, as demonstrated above, these measures can be useful in **evaluations** conducted ‘**before and after**’ the programme was implemented. Positive changes may indicate that the programme may deserve a more sophisticated evaluation, perhaps organised together with a partner in a research facility.

Finally, social services directors should look at whether the benefits of the programme have actually been **sustained** and have had a **longer term impact**; for instance, a follow-up evaluation has been conducted at least 2 years after the programme was implemented and a number of positive outcomes were reported.

## 5. Evidence about the costs

This type of evidence is concerned with the unit costs per output, outcome, and impact, as well as cost-benefits of (potentially) implemented programmes. Social services directors would broadly ask:

### How much does this programme cost?

There are two major costs. First, the **cost of implementing** the programme: administrative costs, personnel costs, trainers’ costs. If you are using an existing evidence-based programme, given that **implementation fidelity** is key (that is implementing the programme as designed), there a number of costs that cannot be avoided. These include the cost of buying the programme and manuals as well as a cost for training those implementing the programme. Some programmes also have a helpline for those implementing it. Most of the US programmes and some of the UK ones clearly define the costs of using an existing programme.

The second major cost will be the **cost of evaluation**. Therefore, you may want to assess as to whether there is any funding available for evaluating the programme, which could be an opportunity to partner with a local research facility/university. Funding needs to be obtained and evaluation planned before the start of the programme.

### What are the estimates of costs and benefits of running a programme?

Finally, a social services director may also want to assess what are the **estimates of costs/benefits** of running a successful project. Several sites featured in our review also

include a **cost/cost-benefit analysis**. This is an important component when managers are making judgements about where to focus resources.

If, for example, six older people are helped to stay in their own home with support for an extra year, the saving might be X compared to the cost of residential care. A director may look at what would be the cost of their community care versus their cost of residential care as well as the benefit that most people may want to stay in their own homes. In each of the listed database, there is a note as to why the site may be useful, including whether information on costs was included.

### Costs of a programme that has been replicated internationally

Although originating from the US, the following programme has been used in a large number of different settings and countries, and is a good example of the costs involved in its implementation.

#### Cognitive Processing Therapy (CPT) for Post-traumatic Stress Disorder

Treatment can be delivered in individual or group format conducted by social workers, psychologists, psychiatrists, and other mental health therapists. Treatment consists of typically 12 sessions (range 10-15) conducted once or twice weekly for 60 minutes each (90 minutes in a group setting). CPT has been implemented in all U.S. states and outside the United States in Australia, Canada, China, Democratic Republic of Congo, England, Germany, Iceland, Iraq, Peru, and Switzerland.

#### Costs

CPT Therapist Manual (includes PTSD checklist)	Free	Required
CPT Materials Manual	Free	Required
CPT Group Manual	Free	Required
3-day Workshop offered at VA or non-VA locations	\$1,000–\$5,000 per day plus trainer travel expenses. (Variable)	Required
CPT Web Training	Free	Not necessarily required
CPT Phone Consultation	\$100–\$200 per hour. Cost varies depending on length of consultation, consultant qualifications, and experience level	Required
CPT Fidelity Checklist (included in the CPT Provider Application)	Free	Required

See more at: <http://www.nrepp.samhsa.gov/ViewIntervention.aspx?id=38>

*Cost/benefit  
analysis*

**Review of international  
evidence-based social  
services databases**



# Review of international evidence-based social services databases

## Introduction

There is a wealth of information available on international websites. It was felt it would be helpful to social service managers and practitioners to bring together in one place, a list of these sites to assist them to obtain the basic knowledge they need so that they can more easily **plan** and **evaluate** their own **evidence-based social programmes**. A full list of databases is available online; for a selection, please see appendix 1 (page 37-42).

We conducted a **review** of the identified databases with the aim to find **what knowledge is included** (out of the five types of knowledge described earlier on) and assess what type of knowledge may be **helpful** in developing evidence-based social work practice. We selected 78 databases; around two thirds of them come from European countries and one third from the United States, Australia and Canada.

Most of the EU databases give research-based evidence and syntheses of the **factors** associated with specific difficulties/conditions. However, there are few sites in Europe with details of evidence-based interventions. Most databases with evidence-based programmes come from the UK in Europe and from the United States.

Although the databases with programmes from the United States should be taken into consideration, as increasingly the best programmes from the United States are now tested in Europe, it is necessary to develop more evidence-based practices in Europe that are culturally appropriate. We hope this work will contribute to this process.

## How the sites were selected

In order to identify the databases listed, four methods were used. First, we used in Google the terms 'evidence-based database' and 'evidence-based registries', which elicited a number of sites. Second, existing lists of evidence-based sites were accessed, such as the [Social Work Policy Institute](#) (US-based, linked to the National Association of Social Workers)<sup>30</sup>. Third, we drew on the authors' knowledge of such sites and information from colleagues at the Centre for Evidence Based Research at the University of Oxford; and finally, we accessed sites across Europe identified by the staff of the European Social Network (ESN).

A number of **inclusion and exclusion criteria** were defined as follows:

- Research-based basic knowledge and overviews of a target population;
- Sites giving national and local statistical information on the extent of a problem/condition;
- Sites with specific lists of evidence based programmes;
- Sites in the UK and in the United States which only gave basic research information and overviews were omitted unless specifically related to social work;
- Sites from Australia and Canada were included if it was felt they gave a different perspective to the existing sites identified.

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<sup>30</sup> Social Work Policy Institute: Evidence-based practice. Available at: <http://www.socialworkpolicy.org/research/evidence-based-practice-2.html#EVP>

- Sites from Australia and Canada were included if it was felt they gave a different perspective to the existing sites identified.

Initially over 100 sites were identified. After excluding the more medically oriented sites, the number was reduced to 78. The included databases were then grouped according to the **country** they came from, by **category** and **target population**.

The following **categories** were identified:

1. **Basic problems and research overviews:** Information on research findings relating to target populations, risk and protective factors, the extent of the problem/condition, possible causes.
2. **Systematic reviews:** Sites that follow specific procedures to link together several similar interventions for a target population and provide an overall rating on the basis of the outcomes.
3. **Multi-focused database with EBP elements:** Sites that include information on different target populations, as well as basic research and evidence-based interventions.

The following **target populations** were identified: children, youth and families; disabilities; mental health, as well as older people. These sites include evidence based programmes, research summaries and best practices for these groups.

We acknowledge that the list does not pretend to be inclusive of all such sites across Europe. There may be other sites that slipped through our search strategies that are important. However, the databases included are indicative of the type of material that is available to inform evidence-based social work policy and practice.

### **The information we found on the sites**

Most databases focused on **basic research** and **research syntheses** about different target populations. With regard to evidence-based programmes, there are some important sites in Denmark, Germany, Norway and Holland.

In addition to the UK, the United States, Australia and Canada, we identified **multi-focussed sites**, which included **evaluation** of programmes in Belgium, Denmark, Finland, Germany, Italy, Norway, Holland, Spain, Sweden, Switzerland and a website hosted by the European Commission. Although these sites all gave details of **basic research**, and most kept **practice libraries**, the **standards of evaluation** were generally lower than the sites in the UK and in the United States.

Although some medically oriented sites were later excluded, many sites were health or nursing-based and contained important information about older people's care, dementia and mental health/drugs. Where this was so, they remained in the list, since we felt that these issues were of relevance for social workers.

### **Sites with basic problems and research overviews**

When it came to sites with basic research and/or overviews of research, there were sites either specifically for social workers, or more general sites for health and social care professionals, which gave access to **basic research**, syntheses of research and statistics in

several countries. Such sites were identified in Austria, Finland, France, Germany Norway, Poland, and the UK and in the United States. Many of these sites also had examples of 'best practice'.

From these sites it is possible to find what health practitioners would call "the *aetiology*" of the condition/problem: *Who has it? When? Where? Their ages? Possible causes? What are the risk and protective factors associated with the condition/problem?* This type of information is the starting point in order to plan interventions effectively.

Also included in this category of basic research, there are sites with **statistical information** relevant to the various target groups in social work. In planning interventions and where to place resources it is helpful to understand **the extent of the problem/condition** and whether it is increasing/decreasing in a certain area. Among these, there are sites generated by the European Commission, Eurostat and the European Social Surveys<sup>31</sup>.

We also identified national sites, such as the Danish site [Appeals Board](#)<sup>32</sup>, which gathers data from local authorities on social issues, children and integration. Another site in Germany, [INKAR](#)<sup>33</sup> provides statistical information on a wide range of social issues and has thematic maps of all the regions in Germany. The UK site on the [Indices of Deprivation](#)<sup>34</sup> would also be included in this category, because it gives information on a range of deprivation categories including children, employment and income deprivation at neighbourhood level.

### Sites with systematic reviews

These reviews gather a number of studies together on a specific topic and give an opinion as to whether the general approach used by the included studies is effective in changing the problem/condition of concern. The argument is that the evidence for effectiveness is stronger when several studies are evaluated together.

One of the more useful of these sites for social practitioners is the [Campbell Collaboration](#)<sup>35</sup>. This is an international organisation based in Norway, which uses very strict procedures for including or excluding studies.

They usually include only Randomised Controlled Trials (RCTs), of which there are few in social work as they are very expensive to undertake properly. It can be frustrating, at times, after reading through the careful analyses given by the author(s) of the review, to find that they are unable to give a definitive answer as to whether the intervention is effective or ineffective. This is usually because of methodological failings in the included studies. However it is a useful source to check as they are one of the few sites, which will highlight programmes that do not work.

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<sup>31</sup> European Commission, DG Employment Social Affairs and Inclusion: Publications and documents. Available at: <http://ec.europa.eu/social/keyDocuments.jsp?advSearchKey=elder+care&mode=advancedSubmit&langId=en&policyArea=&type=0&country=0&year=0>. EUROSTAT. Available at: <http://ec.europa.eu/eurostat/web/main/home>. European Social Surveys. Available at: [http://www.europeansocialsurvey.org/about/project\\_specification.html](http://www.europeansocialsurvey.org/about/project_specification.html)

<sup>32</sup> Danish Appeals Board. Available at: <https://ast.dk/tal-og-undersogelser>

<sup>33</sup> Federal Institute for Construction, Urban and Area Research: INKAR database. Available at: <http://www.inkar.de>

<sup>34</sup> UK Government, Department for Communities and Local Government: Indices of Deprivation. Available at: <https://www.gov.uk/government/collections/english-indices-of-deprivation>

<sup>35</sup> Campbell Collaboration. Available at: <http://www.campbellcollaboration.org/>

In the UK, the [EPPI Centre](#)<sup>36</sup> at the Institute of Education focuses on educational as well as social topics and has slightly less strict criteria for including studies and a vast library of projects. [MOVISIE](#)<sup>37</sup> from the Netherlands also has a library of systematic reviews.

### Multi-focused sites with elements of evidence-based practice

These databases have been grouped together as they include not only basic research but also information on **evidence-based practices** for different target populations. The evaluation of the evidence base is often variable, and some projects have only been evaluated loosely. However, within individual countries, they are often the most useful sites for bringing together national/local information about social work practices.

Below a selection of some of these sites across Europe:

Country / Entity	Name	URL
Denmark	The Danish Social Centre for Research	<a href="http://www.sfi.dk/about_sfi-2821.aspx">www.sfi.dk/about_sfi-2821.aspx</a>
France	Agence nationale de l'évaluation et de la qualité des établissements et services sociaux et médico-sociaux: (ANESM) – Recommandations de bonnes pratiques professionnelles	<a href="http://www.anesm.sante.gouv.fr/spip.php?page=rubrique&amp;id_rubrique=10">http://www.anesm.sante.gouv.fr/spip.php?page=rubrique&amp;id_rubrique=10</a>
Finland	Mathilda Wrede Institute	<a href="http://www.fskompetenscentret.fi/mathilda_wrede_institutet/in_english">http://www.fskompetenscentret.fi/mathilda_wrede_institutet/in_english</a>
Germany	Gesis, SOWIPORT. Das Portal für die Sozialwissenschaften	<a href="http://www.thesis.org/en/institute/the-association/mission/">http://www.thesis.org/en/institute/the-association/mission/</a>
Italy	Le Buone Prassi del servizio sociale	<a href="http://www.assistentsociali.org/servizio_sociale/buone_prassi_del_servizio_sociale.htm">http://www.assistentsociali.org/servizio_sociale/buone_prassi_del_servizio_sociale.htm</a>
Poland	Baza Dobrych Praktyk database	<a href="http://www.dobrepraktyki.pl/index.php?p1=11">http://www.dobrepraktyki.pl/index.php?p1=11</a>
European Commission	Employment Social Affairs and Inclusion, publications and documents	<a href="http://ec.europa.eu/social/keyDocuments.jsp?advSearchKey=elder+care&amp;mode=advancedSubmit&amp;langId=en&amp;policyArea=&amp;type=0&amp;country=0&amp;year=0">http://ec.europa.eu/social/keyDocuments.jsp?advSearchKey=elder+care&amp;mode=advancedSubmit&amp;langId=en&amp;policyArea=&amp;type=0&amp;country=0&amp;year=0</a>
Spain	Integrated Health Models Observatory (OMIS)	<a href="http://www.omis-nh.org/">http://www.omis-nh.org/</a>
The UK	The Social Care Institute for Excellence	<a href="http://www.scie-socialcareonline.org.uk/">http://www.scie-socialcareonline.org.uk/</a>

<sup>36</sup> EPPI Centre. Available at: <http://eppi.ioe.ac.uk/cms>

<sup>37</sup> MOVISIE. Available at: <http://www.movisie.nl/>

## Sites targeted at population groups

### Children, families and youth

There were **more** sites dedicated to children, youth and families than to any other population group. Funded by the European Commission, the [European Platform for Investing in Children](#)<sup>38</sup> is an evidence-based online platform, which reviews practices submitted from across Europe according to certain standards of evidence. The website also provides information about policies that can help children and their families face the challenges that exist in the current economic climate.

In other European countries, there is information of best practice and evaluations of children's projects but they have generally been included in the multi-focused sites noted above. There are four specific sites focusing on children from Germany. Most of the remaining sites identified in the review came from the UK and the United States. The **United States'** sites have been included because of their focus on evidence-based programmes and because the quality of their evaluations is high. Some of these sites include **interventions** for children that have been **tested in Europe**, notably [Colorado blue prints](#)<sup>39</sup> and the NREPP/SAMHSA'S [National registry of evidence programmes and practices](#)<sup>40</sup>.

### People with disabilities

Despite extensive searches, **fewer** sites were found that were dedicated specifically to this group. There is information on this group in the multi-focused sites and on the more nursing/medically orientated sites. The German site Zentrum für Qualität in der Pflege (ZQP) ([Centre for Quality in Care](#)<sup>41</sup>) includes information relating to disabilities.

In the UK and in the United States, the most informative sites appear to be those run by **charities**. These sites usually have helpful information for **carers** and those with a **disability**. It is anticipated that similar charity sites may exist in other European countries, but have not been identified in this review, mostly due to language difficulties.

### People with mental health problems

There were a few more sites on this target population than for people with disabilities. Many of the sites focusing on children, youth and families have programmes for young people with minor mental health problems. Three sites specifically focusing on mental health were found. One in Germany - Deutsche Institut für angewandte Pflegeforschung ([German Institute of Applied Nursing Research](#)<sup>42</sup>). Although the main focus here is on nursing, there is helpful information on substance abuse, family counselling, children with mentally ill parents, and partners and family members of schizophrenics.

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<sup>38</sup> European Platform for Investing in Children. Available at: <http://europa.eu/epic/>

<sup>39</sup> University of Colorado Boulder, Center for the Study and Prevention of Violence: <http://www.blueprintsprograms.com>

<sup>40</sup> Substance Abuse and Mental Health Services Administration: National registry of evidence programs and practices. Available at: <http://www.nrepp.samhsa.gov/Index.aspx>

<sup>41</sup> Centre for Quality in Care. Available at: <http://www.zqp.de/>

<sup>42</sup> German Institute of Applied Nursing Research. Available at: <http://www.dip.de/datenbank-wise/informationen-zu-wise/ueber-wise/>



In the UK, the [Centre for Evidence Based Mental Health<sup>43</sup>](#) is a useful source of information. There is also an online UK journal, Evidence based Mental Health, with excellent reviews of research evaluations.

## Older people

Given the increasing prospect of an ageing population across Europe, relatively **few** sites were found that were specifically dedicated to this population group. However, four sites were found in Germany with important information on practices for older people. The Zentrum für Qualität in der Pflege ([Centre for Quality in Care<sup>44</sup>](#)), [CareLit<sup>45</sup>](#), the Deutsches Zentrum für Altersfragen ([German centre of gerontology<sup>46</sup>](#)), and the Zukunftswerkstatt Demenz ([Future workshop on dementia<sup>47</sup>](#)).

The aims of the German Centre of Gerontology are: *to increase, collect, evaluate, process and disseminate knowledge about the living arrangements of ageing and old people to use this knowledge for scientifically independent consultation regarding the challenges of ageing for society and social policy.* The site Future Workshop on Dementia includes a library facility and information on ways to access funding. Individual sites from France, Sweden, Switzerland, the UK and the United States are also included in this category.

## The information we extracted from the sites

Under each selected database, we identified the main **focus** of the site, the **type of information** provided (e.g. library or search engine), the **availability** (whether free or for pay), the **criteria** used for **evaluating** interventions, **outcomes** and **impact**, and a note on the **usefulness** or potential value of the site for those planning evidence-based programmes.

In most cases, the focus was clearly given in the opening page of the database. Where the information on the database covered many topics, a note was made of the main information of interest for social workers. Similarly where other activities were offered only those of interest for social workers and their managers were listed.

When it comes to **availability**, a surprising finding was to see how many sites gave their information **freely** and without inquiring who was accessing the material. However, some sites; for instance, the Italian site *Sistema nazionale per le linee guida (SNLG) dell' Istituto Superiore di Sanità (ISS)* do not allow social workers to sign up. It appears that this site may hold useful information for social workers but access was specifically denied.

Two excellent UK sites, the Research in Practice site for children and the Research in Practice site for adults, allow access to some parts of their sites but not to all of them. In other cases, databases are not available unless the inquirer is working in one of the local authorities/charities who have signed up and paid for membership, as this is the case with RiP (Children), a useful database on what works for troubled children.

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<sup>43</sup> Centre for Evidence Based Mental Health. Available at: <http://cebmh.warne.ox.ac.uk>

<sup>44</sup> Centre for Quality in Care. Available at: <http://www.zqp.de/index.php?pn=project>.

<sup>45</sup> CareLit. Available at: <http://www.carelit.de/cont/start/index.php>

<sup>46</sup> German Centre for Gerology. Available at: <http://www.dza.de/en/fdz.html>

<sup>47</sup> German Federal Ministry of Health: Future Workshop on Dementia. Available at: <http://www.bmg.bund.de/themen/pflege/demenz/zukunftswerkstatt-demenz/uebersicht-projekte.html>

The **standards of evidence** for effective programmes given in most European sites was low. There were sites that gave information on the quality of the evaluation, but it was confusing as to what their definition of quality meant. Almost all US sites and most UK sites broadly followed a **hierarchy of evidence** with top quality going to those programmes that had been evaluated in repeated Randomised Controlled Trials (RCTs) or Systematic Reviews, with lesser levels of confidence given to evaluations using other methodologies.

For instance, Colorado Blueprints has two levels: *model programmes* and *promising programmes*. Promising programmes clearly identify the outcomes; the population for which it is intended; have at least one RCT or 2 quasi experimental evaluations; show a significant positive change that can be attributed to the programme; there must be no harmful effects; and the programme has to be ready to be disseminated (i.e. manual available, technical assistance etc.). Model programmes must have a minimum of 2 RCTs or one high quality RCT plus one high quality quasi experimental evaluation. Positive impact must be sustained for 12 months after the end of programme<sup>48</sup>.

NREPP/SAMHSA'S [national registry of evidence programmes and practices](#)<sup>49</sup> also has high evidence standards. To be included, the programme must have produced one or more positive behavioural outcomes in mental health or substance abuse among individuals, communities, or populations. Positive behavioural outcome(s) must have been demonstrated in at least one study using an experimental or quasi-experimental design. Studies with a single group, pre-test and post-tests designs would not meet this requirement. Implementation materials, training and support resources, and quality assurance procedures have been developed and are ready for use by the public.

In the UK, websites have a variety of definitions in regards to evidence standards for their programmes. In the cases of sites like [Project Oracle](#), Children and Youth Evidence hub<sup>50</sup>, which only lists projects that have been tested in London, and the [Early Intervention Foundation](#) (EIF)<sup>51</sup>, only few programmes meet the higher standards. EIF has also a useful list comparing different evidence standards of the main national and international programmes for children.

In the EU, the [European Platform for investing in Children](#) (EPIC)<sup>52</sup>, which focuses mainly on projects that have been developed in Europe, defines its standards as *best practice*, *promising practice* and *emergent practice*. Practices are also assessed as to what extent they are transferable (i.e. have been replicated elsewhere) and whether they are enduring (i.e. there has been a follow up study after 2 years).

Our list of evidence based databases highlights the need to have some common agreement (or index of standards) and thereby a common understanding of what each standard of evidence means.

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<sup>48</sup> University of Colorado Boulder, Center for the Study and Prevention of Violence (CSPV): Blueprints for healthy development. Available at: <http://www.blueprintsprograms.com>

<sup>49</sup> Substance Abuse and Mental Health Services Administration: National registry of evidence based programs and practices. Available at: <http://www.nrepp.samhsa.gov/Search.aspx>

<sup>50</sup> Project Oracle. Available at: <http://project-oracle.com/>

<sup>51</sup> Early Intervention Foundation. Available at: <http://www.eif.org.uk/>

<sup>52</sup> European Platform for investing in Children (EPIC). Available at: <http://europa.eu/epic/>

## Costs/cost-benefit analysis

A crucial component in deciding which programme to use, is of course **the cost**. Most of the US programmes and some of the UK ones clearly define the costs of using an existing programme. These will include buying the manual or instructions and the evaluation materials. Often training the trainers is also necessary and some programmes also have a helpline for those implementing a programme. Given that in replicating a programme, **implementation fidelity** is key (that is implementing the programme as designed) these costs cannot be avoided. Of course, if the programme is adapted to suit the context and setting, it is not the same programme and similar outcomes seen in the original cannot be expected.

The other side of cost is **estimating** the possible financial benefits of a successful programme. This may be crucial in enabling funding to be released for a project and its evaluation. Many US and UK sites now include a cost/cost-benefit analysis. In a cost-benefit analysis the hypothesis may be formulated as follows: if six older people are helped to stay in their own home with support for an extra year, the saving might be X compared to the cost of residential care.

This is an important component when managers are making judgements about where to focus resources, since as we highlighted earlier on in the document, a director may look at what would be the cost of their community care versus their cost of residential care as well as the personal benefit that most people may want to stay in their own homes for as long as possible. In each of the listed databases, there is a note as to why the site may be useful, including whether information on costs was included.

## Concluding key messages

There is a range of **evidence** needed to develop evidence-based social work.

**First**, there is a requirement for basic research so that **risk and protective factors** can be identified.

**Second**, there is also a need for information about the **extent** of the problem, in order to plan ahead and develop resources for particular groups as well as to focus valuable resources to the most needy problems and areas.

**Third**, it is key to obtain knowledge about evidence-based **programmes** that have been **successful**. Those responsible for commissioning services may use a programme that has already proved its effectiveness elsewhere or develop their own version of this programme. However, this will need to be tested again as it will effectively be a different programme with different outcomes. Otherwise, they may develop their own innovative programme that is appropriate to their context and needs, and which they can feel “ownership”.

**Fourth**, looking into **evaluating** your programme a final step may be to make a partnership with a research facility so that the programme can be evaluated.

### Reviewing international evidence based social work databases

There are good sites throughout Europe relevant to evidence-based social work, but most knowledge they provide is at the level of basic information and research syntheses on different target populations.

There are fewer sites outlining programmes **that work**, and when they are available, they mostly come from the United States and the UK. Although there might be a reluctance in Europe to import these programmes, some of the better known have been tested in Europe and have demonstrated their effectiveness. However, a common trend across all sites is the considerable confusion about the **various definitions** given regarding a programme's **effectiveness**.

### A one-stop-shop database

For both, financial (making better use of resources) and ethical reasons (those in need deserve the most effective interventions), we have identified the need for an EU site that develops a **one-stop-shop database** for all social work target populations, which includes basic knowledge and research, and a register of evidence-based practices that have been generated in Europe.

Such a site needs to **bring together the various definitions** of what is an evidence-based programme, so that those responsible for designing and commissioning services can decide what is best for their setting. This site should also include a translation facility to ensure that the information is available in separate EU languages.

Designating funding for this and for quality evaluations, including **cost/cost-benefit analyses** of innovative EU projects, will be a necessary step to modernising social work and making better use of resources.

## Appendix 1

### Selection of international evidence-based social services databases by country



## Denmark

**Database category: Multi-focused database with EBP elements**

*Topics: Active inclusion; Ageing and care; Children, youth and families; Disability; Housing and homelessness; Mental health; Social services management*

<b>Name</b>	<b>The Danish National Centre for Social Research</b>
<b>Focus of work</b>	The main area is in the field of social services and welfare. The Centre has an independent department, which contributes to improving the knowledge base in regards to the effects of initiatives in the social and welfare sector. Their work includes the labour market, unemployment, equal opportunities and gender equality, integration policy, societal and employment-related aspects of health, child and youth policy, family policy, school and education, disability policy, the social housing sector, vulnerable groups, volunteer work, care for the elderly, and pensions.
<b>Type of information</b>	Publications in English from the Danish National Centre for Social Research cover mostly working papers and report abstracts, but also research publications, evaluations, data collections, and studies.
<b>Other types of activities</b>	The Centre conducts research and carries out commissioned projects in the area of public welfare policies. The Centre often works alongside other research institutions and with private consultancy firms concerning tenders and successful completion of large evaluation and elucidation projects. The Centre disseminates its research and commissioned projects to the public via its website, and by publishing reports, working papers, a quarterly magazine, press releases, and presentations.
<b>Standards of Evidence</b>	The Centre is focusing on improving implementation of commissioned projects so that they become more useable for customers/users. This is taking place through close dialogue, solid utilisation of existing knowledge, international perspective, and targeted communication.
<b>Availability</b>	Open access, free, online. A search engine for topics is available.
<b>Outcomes/ Impact</b>	Different formats take effects of social programmes into account, such as systematic reviews.
<b>Is this site useful?</b>	The combination of a broad range of topics and high-quality information makes this suite useful.
<b>Website</b>	<a href="http://www.sfi.dk">http://www.sfi.dk</a>



# European Union

**Database category: Multi-focused database with EBP elements**

*Topics: Children, youth and families*

<b>Name</b>	<b>European Platform for Investing in Children (EPIC)</b>
<b>Focus of work</b>	The European Platform for Investing in Children (EPIC), linked to the RAND corporation, is an evidence-based online platform that provides information about policies that can help children and their families facing socio-economic challenges in Europe. The European Commission funds EPIC. One of the main aspects of this work consists in a review of evidence-based practices submitted to EPIC.
<b>Type of information</b>	The information includes practices, an evidence guide, country profiles, statistics, studies and reports, as well as news about events and activities.
<b>Other types of activities</b>	EPIC also provides information about recent events, policy initiatives, and legal changes intended to support families in Europe, upcoming conferences, seminars, and meetings on policies and practices affecting children and families.
<b>Standards of Evidence</b>	<p>Evidence-based practices are assigned one out of three evidence levels. Practices are assessed on transferability and durability:</p> <ul style="list-style-type: none"> <li>• Best Practice: A “best practice” needs to have achieved at least a + in each of the three evidence categories, including “evidence of effectiveness”, “transferability” and “enduring impact.”</li> <li>• Promising Practice: A “promising practice” needs to have achieved at least a + in “evidence of effectiveness” and a + in at least one of the other two categories, “transferability” and “enduring impact.”</li> <li>• Emergent Practice: An “emergent practice” needs to have achieved at least a + in “evidence of effectiveness.” A graphical overview on evidence designations is available on the website.</li> </ul> <p>EPIC includes an inventory for practices, which have not yet been evaluated but share information on ideas.</p>
<b>Availability</b>	Open access, free, online. It is possible to browse the platform by names, policy categories, countries, and by evidence level.
<b>Outcomes/ Impact</b>	The evidence-based practices are based on reviews taking into account outcomes, for which the category “enduring impact” is an example.
<b>Is this site useful?</b>	This site presents high-quality content about evidence on interventions for children, young people, and families.
<b>Website</b>	<a href="http://europa.eu/epic/practices-that-work/evidence-based-practices/index_en.htm">http://europa.eu/epic/practices-that-work/evidence-based-practices/index_en.htm</a>



# Germany

**Database category: Basic problems and research overview**

*Topics: Ageing and care; Evidence and innovation; Social services management*

<b>Name</b>	<b>Gerostat</b>
<b>Focus of work</b>	The German Centre of Gerontology is a scientific research centre with the focus on the living arrangements, life situations, and life-styles of ageing people. The Research Data Centre provides access to the micro-data of the German Ageing Survey (DEAS) and of the German Survey on Volunteering (FWS) to scholars for non-commercial purposes and advise potential users. These cover the themes employment and retirement, economy of old age, health and social care, family and social relations and societal participation.
<b>Type of information</b>	GeroStat is an electronic information system for gerontological and demographic issues in social research, social reporting, and social policy. It provides a significant collection of statistical data, additional contextual information, and statistical reports relevant to social gerontology. The formats come in fact sheets, reports, discussion papers, and publications.
<b>Other types of activities</b>	An important task of the DZA is to report and process information and to provide advice on social policy. The target groups are public administrations at the federal and state levels, central public and non-governmental welfare agencies and those involved in social policy for the aged.
<b>Standards of Evidence</b>	The website does not address project evidence, thus no evidence standards are applied.
<b>Availability</b>	Open access, free, open. Information can be found in the library section.
<b>Outcomes/ Impact</b>	This site is more about statistical information and presents structural developments rather than looking at outcomes and impact.
<b>Is this site useful?</b>	A great source of data and further information about older people is available, which can serve as a reference point.
<b>Website</b>	<a href="https://www.gerostat.de">https://www.gerostat.de</a>



# Norway

## Database category: Systematic reviews database

Topics: Learning disability and physical disability; Social services management; Evidence and innovation

<b>Name</b>	<b>Campbell Library</b>
<b>Focus of work</b>	The Campbell Collaboration is an international research network that produces systematic reviews of the effects of social interventions in crime and justice, education, international development, and social welfare. Systematic reviews follow guidelines and standards for summarising international research on the effects of interventions.
<b>Type of information</b>	Campbell Systematic Reviews is the peer-reviewed online monograph series of systematic reviews prepared under the editorial control of the Campbell Collaboration. Campbell systematic reviews follow structured guidelines and standards for summarizing the international research evidence on the effects of interventions in crime and justice, education, international development, and social welfare.
<b>Other types of activities</b>	The Campbell Collaboration provides a meeting place for policy makers, practitioners and researchers, and stimulates the work of the organisation. The programme features a variety of presentations of completed systematic reviews and the opportunity to attend training sessions on methodology and other issues. Their portfolio includes training sessions, and they arrange stand-alone training workshops run by qualified and experienced teachers.
<b>Standards of Evidence</b>	A systematic review uses transparent procedures to find, evaluate and synthesise research. Procedures are defined in advance and studies are screened for quality. Peer review is a key part of the process, in which independent researchers control the methods and results. A systematic review must have inclusion/exclusion criteria, a search strategy, systematic coding and analysis of included studies, meta-analysis. Campbell reviews undergo both peer review and editorial review.
<b>Availability</b>	Open access, free, online. An advanced search function is available.
<b>Outcomes/ Impact</b>	The systematic reviews include effects of interventions. No formalised levels of evidence are applied.
<b>Is this site useful?</b>	This is a very comprehensive site with a great level of insight on research and interventions.
<b>Website</b>	<a href="http://www.campbellcollaboration.org/lib/">http://www.campbellcollaboration.org/lib/</a>





# United Kingdom

**Database category: Basic problems and research overview**

*Topics: Mental health; Ageing and care; Children, youth and families*

<b>Name</b>	<b>Dementia Gateway</b>
<b>Focus of work</b>	The Dementia Gateway offers a variety of information resources on dementia developed by SCIE (Social Care Institute of Excellence), others developed by external organisations. The topics are early signs and diagnosis, support after diagnosis, end of life care, getting to know the person with dementia, communicating well, difficult situations, eating well, keeping active and occupied, decision-making, partnerships with carers, young onset dementia, and environment.
<b>Type of information</b>	The Dementia Gateway contains information and resources, including videos, e-learning material and downloads, for care workers, people living with dementia, and their friends and family.
<b>Other types of activities</b>	Links are included to other websites that provide information about dementia for professionals, overviews of the evidence base behind key areas regarding dementia.
<b>Standards of Evidence</b>	Formalised standards of evidence are not applied; however, the key messages in the research overviews identify the most relevant findings.
<b>Availability</b>	Open access, free, online. All information is in English.
<b>Outcomes/ Impact</b>	Impact of dementia at different stages is considered, but is not systematically analysed.
<b>Is this site useful?</b>	The site offers useful information for people suffering dementia and their family and friends. It also offers more detailed and technical information and learning resources that can be used by carers and other professionals in the area of dementia.
<b>Website</b>	<a href="http://www.scie.org.uk/dementia/resources/index.asp">http://www.scie.org.uk/dementia/resources/index.asp</a>



# United States of America

**Database category:** *Systematic reviews database*

*Topics: Children, youth and families; Evidence and innovation*

<b>Name</b>	<b>Colorado Blueprints</b>
<b>Focus of work</b>	The Blueprints mission is to identify evidence-based prevention and intervention programmes that are effective in reducing antisocial behaviour and promoting a healthy course of youth development.
<b>Type of information</b>	Blueprints has reviewed more than 1,250 programmes. One can search by key word, or search across categories (age, programmes specifics, risk and protective factors). The site includes a matrix comparing programmes recommended by other EBP sites. Blueprints has provided training, materials, implementation support and fidelity monitoring to school districts in 16 US states, serving approximately 284,000 students.
<b>Other types of activities</b>	The Blueprints Conference brings together researchers, programme designers, community leaders and advocates, policy-makers, practitioners and funders to learn about evidence-based youth development programs. The goal of the conference is to provide information on evidence-based programmes and guidance and tools to help consumers implement these programmes successfully.
<b>Standards of Evidence</b>	<p>There are two levels: model programmes and promising programmes.</p> <ul style="list-style-type: none"> <li>• Promising programmes: the outcomes and the population for which it is intended are clearly identified. Features are at least one randomised controlled trial (RCT) or 2 quasi-experimental evaluations, a significant positive change that can be attributed to the intervention, the absence of harmful effects, and the programme is ready to disseminate (i.e. manual available, technical assistance).</li> <li>• Model programmes embrace a minimum of 2 RCTs or 1 high quality RCT plus high a quality quasi-experimental evaluation. A positive impact is sustained for 12 months after the intervention.</li> </ul>
<b>Availability</b>	Open access, free, online.
<b>Outcomes/ Impact</b>	The search function includes the possibility to look for outcomes on specific problems.
<b>Is this site useful?</b>	The site presents a high quality evidence site. Many of the projects have been replicated internationally.
<b>Website</b>	<a href="http://www.blueprintsprograms.com/">http://www.blueprintsprograms.com/</a>

## Appendix 2

### Questionnaire for planning social services

#### I. General information about the programme

1. Name of programme
2. Country
3. Region
4. Municipality
5. Responsible organisation
6. Contact details of the responsible person(s)
7. Any other partners involved (Y/N)

#### II. Evidence about the target population

*Collecting evidence about the target population means looking at who may benefit from a programme: volume, demographics and socio-economic characteristics. Knowing the extent of a given social problem can help in prioritising areas for intervention but also planning ahead and having facilities available for specific needs. Monitoring social changes (number of cases in a population in a given period) can be useful in giving an indication about whether a problem is increasing or decreasing and whether a specific programme needs to be put in place to meet the needs of a community.*

1. Who is the project for?
2. What is the age of the target population?
3. Gender (m/f/both)
4. Is this project for a particular ethnic group? If yes, please state the group.
5. What will be the level of intervention?
  - a. Primary (general population)
  - b. Secondary (those at risk)
  - c. Tertiary (those with an existing problem)

#### III. Evidence about the programme context

*In deciding what a social problem is, this will need to be contextualised against the norms and values, ethnic and morals and the group identity in any given community. Different societies at different times will have different views and different awareness about what is or what is not a social problem. This information can only come from those involved in their communities.*

1. Policy background
  - a. International
  - b. National
  - c. Regional
  - d. Local
2. What issues in social services are relevant for the programme?
3. What are the Risk and Protective Factors for the problem?
4. What organisation is responsible for the programme area?
  - a. Are the relevant staff provided with training?

#### IV. Evidence about the programme implementation

*This type of evidence refers to the conditions known to drive or inhibit implementation, such as organisational, inter-personal and individual factors. When replicating an evidence based programme a key concern is “implementation fidelity” or “implementation with integrity”. As mentioned earlier, the programme may need to be adapted to different cultural contexts and*

*local conditions. However, any adaptation of the programme means that it is a different programme and outcomes may differ simply because the crucial elements have not been replicated.*

1. What services and activities does the programme deliver?
2. Does the programme design follow a model or concept?
3. What is the status of the programme?
  - a. Is the programme based on an existing programme?
  - b. If the programme has been evaluated, can we determine with what level of evidence?
4. What is the scope of the initiative?
5. Who has the leadership and management of the initiative?
6. What is the involvement of users, families, and/or carers? How is their engagement facilitated?

#### **V. Evidence about the programme's effects**

*There are varying levels of evaluation, which are often called 'the hierarchy of evidence'. These hierarchies suggest how much confidence one can have in the evaluation. In assessing the effects of a programme, 'outputs' are sometimes confused with 'outcomes'. An example of an output is how many people participated in the programme. 'Outcomes' are what happens to participants having taken part in a programme. If using a validated programme, there will be details on outcomes, which need to be examined carefully.*

1. What are the evaluation methods of the programme?
  - a. How will you measure the situation at baseline?
  - b. Is there a local research facility/academic organisation that would advise in undertaking an evaluation?
2. What are measurable effects of the programme and what has it achieved?
  - a. Are there standardised measures which could be used to evaluate their results?
3. What are the anticipated or 'aspirational' effects of the programme?
4. Is the programme sustainable?
  - a. What are plans to follow up on your project to see whether benefits have been sustained?
5. Could the programme be transferable?

#### **VI. Evidence about the programme's resources**

*This type of evidence is concerned with the unit costs per output, outcome, and impact, as well as cost-benefits of (potentially) implemented programmes. A social services director may want to assess the estimates of costs/benefits of running a successful project. This is an important component when managers are making judgments about where to focus resources.*

1. What are the costs of running the programme?
2. On which other relevant resources does the programme rely?
3. How is the programme funded?
4. Is there funding available specifically for evaluation?
5. What are the estimates of costs and benefits for running this programme successfully?

#### **VII. Further information sources / background documents / website**

## Appendix 3

### Questionnaire for the evaluation of a social service

#### I: Initial considerations

*It is important to consider how the evaluation of your social service programme will be undertaken. Money will be wasted and learning lost unless an evaluation plan is built in from the beginning. The following is a simplified guide which suggests most of the areas you need to consider when planning the evaluation of your social service programme.*

In addition to the name and contact details of the person responsible for the programme, it is key to assess what the aims of the programme are. It is helpful here to outline the key question(s) you may want to answer.

For instance:

- *Does the programme X reduce the amount of...?*
- *Perhaps also a few secondary questions, such as for whom, when and at what cost? Are there any other benefits?*
- *When developing the questionnaires and tools, go back to the initial questions to check if they are able to give the answers you want.*

#### II: What resources are available for evaluation?

*As stated in this toolkit, there are various levels of evidence (often called the 'hierarchy' of evidence) that can be collected from evaluation studies. Basically the higher the level, the more expensive the evaluation.*

*If developing your own project and not using a programme developed elsewhere, it is generally better to start with a simple evaluation, such as a before/after design. That is measuring the extent of the problem before the intervention and then measuring again after the intervention. If results look promising, a research agency may be then able to undertake a more complex evaluation.*

*Below some of the questions you should consider at this stage.*

1. What funding/resources are available for running the intervention and for undertaking the evaluation?
2. What expertise is available to help?  
For instance, help from a research agency or an academic department is likely to improve the quality of the evaluation.
3. What staff are available to run the programme? What training will they need?
4. Where will the intervention take place?
5. Who is available to evaluate the programme?  
It is better that this person/agency is independent from those running the programme.

6. What other stakeholders are there who could be involved? Are there any people interested in the outcomes and who may contribute to cover the costs?

### III. What is the level of the programme?

*If the programme is a primary intervention, it would focus on a large group with the aim of preventing problems. If it is a secondary intervention, it would target those who are at high risk of a problem, whilst if it is a tertiary intervention, it would aim at limiting harm for those who have experienced a social problem.*

*In the case of a primary intervention; for example, advice to parents to avoid accidents at home, simple monitoring of the numbers of children presenting at hospital following accidents may be sufficient. In the case of secondary; for example, parents at risk of maltreating their children, or tertiary; for example, parents who have maltreated their children; effective evaluations will need information directly from the parents.*

*At this stage, you should consider at least the following two questions.*

1. Is there a simple primary type intervention, such as the use of media or leaflets, which would reach all those involved?
2. What would be the cost of doing this?

Though media interventions can be relatively cheap, they may not reach the population that you want.

### IV. What programme are you planning to use?

*The advantage of using an existing programme is that much of the thinking will have been done for you and evaluation tools may well come as part of the package. Therefore, it is important that you think as to whether you will replicate another programme or develop your own.*

1. Are you planning to replicate an existing evidence based programme?

For this, you will need to check costs of training, and materials, which may be available on their website.

2. Are you planning to adapt an existing evidence based programme?

Remember any adaptation means that it is a different programme and results may be different but it is helpful to use their materials as far as possible.

3. Are you planning to develop your own programme?

Make sure you have fully researched the background to the problem and found what may be the best focus for an intervention. For example, a programme to improve parenting skills and parental confidence may have also the benefit of reducing child abusive incidents.

## V. What else do you need to know for your evaluation?

*The resources available and the type of intervention will to some extent be dependent on the answers to the following questions.*

### 1. What numbers are likely to be involved in the programme?

The most common failing in evaluations is that numbers involved rarely live up to expectation, since people drop out, or fail to turn up. One way to ensure participation is by looking at providing incentives to encourage participation.

### 2. What will be the criteria for those who take part?

For example, parents living in district X who have been referred to social services with child abuse concerns.

### 3. How will you obtain the names of possible participants?

### 4. How will you inform the participants about the project?

All participants should sign a form saying that they understand the purpose of the intervention and agree to take part for the necessary number of sessions and weeks (*informed consent*).

### 5. Will I need ethical approval for the study?

If children or vulnerable adults (i.e. those with dementia or with a disability are involved) it is important to check this.

### 6. How will keep the information I obtain confidential and secure?

For instance, anonymously numbering questionnaires rather than putting names on them is safer, with one person holding a master list.

## VI. What type of evaluation?

*Depending on the type of programme, you will need to plan the type of evaluation.*

*For primary interventions, **monitoring incidence is all you need**. For example, following a media campaign focussing on domestic violence, a reduction in the number of cases reported to police for domestic violence, might indicate change.*

*For secondary and tertiary interventions the following methods are suitable:*

a) **Before/After study**. *This takes a measure of the extent of problems before an intervention and then again at the end. The disadvantage is that you may not know whether changes are due to other events. For example, with mothers at risk of abuse, the differences seen may be influenced by the arrival of a new day nursery in the area.*

b) A **'controlled' study**. *This measures the difference between two groups before and after. For example, one group of mothers received the intervention while the other group wait their turn to take part. This is better than a simple before/after study but you may never be quite*

sure that the 'waiting list' control group is the same as those undertaking the intervention (for the reasons mentioned above –participants dropping out or not turning up).

c) **Randomized controlled trial.** This is where the names of all possible participants are put into a hat and names for those taking part in the intervention are randomly picked out of the hat. Those not chosen become the control group.

d) **Mixed methods.** You may decide that you want to know more than just numbers, so you interview a random sample of those taking part in the interventions and those who have not. Their comments can be useful in understanding **why** there are the differences seen.

In order to decide what evaluation is most suitable, you should consider at least two questions.

1. What type of evaluation is possible with the resources that are available?
2. Within the limits of resources, what type of evaluation will produce the highest quality evidence?

### VII. How will you measure change?

You can develop your **own measures**. For example, a scale of 1 to 5 where 1 is "I do not feel that I have the skills" and 5 "I feel very positive about my (parenting) skills". But much better is to use 'standardised measures' that is questionnaires that have been used and validated in large studies.

When replicating programmes that have been trialled elsewhere, they will generally have their own measures which will come as part of the package when buying the programme. When adapting one of these programmes to your own context, it may be useful to look at the measures they use, translate and adapt where necessary.

Therefore, you may want to consider the following.

1. Are there standardised measures that you use for your evaluation?
2. If you are developing your own measures, how will you pilot them to test that participants understand them and they measure what you want to measure?
3. Some measures will already have validated international translations available. Have you checked whether these are available?
4. If you are translating a standardised measure, it is best first to translate it into your language and then ask someone else to translate back to the original. This way you can check if there is any change in meaning.

### VIII. What other data will you need to collect?

There are two ways to collect basic data:

1. *by questionnaire.* In developing a questionnaire, you should remember that participants have limited patience in filling in forms and their reading age may be limited. As a guide, questionnaires for most groups should not take more than 20/30 minutes to complete.



2. Collecting data by interviews, which is a more labour intensive process. Interviews as a rule, even in depth interviews should not last more than 40 minutes to 1 hour. Telephone interviews can be cheaper and quicker.

Sensitive questions need to be worded carefully. For example, participants rarely give honest answers to questions about their household income. In deprived groups, if your country has this service, a useful way to access this information, is to ask if their children have ever received 'free school meals'.

Information needs to be collected at:

a) baseline, that is the start of the project

b) end of project

c) at any follow up period decided upon to see if the results continue after the end of the programme.

You need to pilot all questionnaires to see if they provide the answers that you require.

When it comes to collecting data after the intervention, you will repeat the original standardised measure, and you may want to ask participants a question on how they felt about the programme and whether it could be improved.

When it comes to collecting additional data, consider the following questions.

1. What other information do you want to collect, about the household, income, number of children, relationships, and others?
2. What is the simplest and least intrusive way of obtaining this information? If you intend to use a questionnaire, have you piloted it with a few people to see if they understand the questions, and whether they feel the questions are acceptable?
3. Have you tested how long it takes to obtain the information?
4. When will you collect the data?

#### **IX. How will you add it all up?**

The simplest method is to take the before questionnaires of those who took part in the intervention and then compare the results with those who did not take part.

If, for example, you were assessing whether an improvement in a residential home had made any difference, you could:

- Use a quality of life measure (1 = totally satisfied with my life and 5 =totally unsatisfied)

- Measure at the beginning and then repeat it at the end to see if there have been any changes.

- Interview a few residents to try and understand what changes have made them feel better.

Standardised measures give instructions as to how their questionnaires should be added up.

*Research institutions may be helpful. If the numbers involved are large enough to do some statistical tests, it will be possible to see whether the results are better than could have occurred by chance (that is, your results are statistically significant).*

*Therefore, you should consider the following questions.*

1. Can you add up the results yourselves?
2. Are the number large enough for statistical tests?

Generally such tests need samples of more than 50 both in the group who have had the intervention, and in the control group.

3. Should you involve an outside agency?

If a research agency is involved they should be involved since the start.

4. Are the results poorer than expected?

Do not despair if that is the case. Much learning comes from having undertaken a project, but good results may not always be apparent in the short term. In the famous High scope Perry Pre School Project the real returns were not seen until 27 and 40 years later.<sup>53</sup>

## **X. So What?**

*You have undertaken the research to improve outcomes for participants. When planning your intervention you need to think from the beginning what you will do with your results. Too often good evaluations get put up on a dusty shelf and not seen again. A useful strategy is to ask those responsible for implementing service changes to write a few words in the evaluation report about how the organisation plans to make use of the findings and what actions they will actually undertake as a result.*

*Remember to ask yourself the following questions around dissemination and use of findings.*

1. Who will be responsible for disseminating the results?
2. What is the implication of the evaluation findings for other services both within your organisation and further afield?
3. Are the original stakeholders able to comment on the findings and suggest next steps?
4. How can you ensure future funding for the project?

Too often good projects get forgotten about because of lack of funding. The more noise you make about the success of your project the more likely you are to receive further funding.

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<sup>53</sup> High Scope Educational Research Foundation (2005): Lifetime effects. The high scope perry preschool study through age 40. Available at: <http://www.highscope.org/content.asp?contentid=219>

## Appendix 4

### Selection of standardised evaluation measures

When social services directors develop their own programme, it is important to include some standardised measures to monitor possible effects. A number of standardised measures have been selected by Ann Buchanan, Centre for Evidence Based Research at the University of Oxford, for the European Social Network.

This document provides social services directors and senior practitioners with a selection of standardised evaluation measures, which could be used as a baseline at the start of a project and then be reapplied at the end of the project to monitor changes.

### About using standardised evaluation methods

Standardised measures have been developed by psychologists using large sample to test their accuracy. As such they are more reliable than any measures you may develop. They are used to demonstrate if there has been any change following an intervention.

Sometimes these measures are called 'scales'; for example, the Strengths and Difficulties Questionnaire below, as they have a number of questions and the answers from the questions are added up to form a total score. This gives a rating at the start of the intervention to which we can compare at the end of the intervention.

The measures/scales should be completed by the client in privacy and if possible anonymously. This way they record the client's view without being influenced by others.

Most of these measures/scales are freely available on the Internet.

### **The Strengths and Difficulties Questionnaire (SDQ)**

The Strengths and Difficulties (SDQ) is a brief behavioural screening questionnaire for children aged 3 to 16. It exists in different versions to meet the needs of researchers, health and education professionals. All versions of the SDQ ask about 25 attributes, which are also divided between 5 scales: Emotional symptoms, conduct problems, hyperactivity/inattention, peer relationship problems, pro-social behaviour.

25 items are included in questionnaires for completion by the parents or teachers of 4-16 year olds.<sup>54</sup> There is a slightly modified version for the parents or nursery teachers of 3 (and 4) year olds. Questionnaires for self-completion by adolescents ask about the same 25 attributes, though the wording is slightly different for them.<sup>55</sup>

SDQ has been translated (and validated) into many languages. These translated versions are available for free on the website. This questionnaire has been used in national studies; for instance, in the UK to assess children at risk of mental health problems. The only restriction is that the wording must not be changed in any way.

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<sup>54</sup> Goodman, R. (1997): The strengths and difficulties questionnaire: A research note, *Journal of Child Psychology and Psychiatry*, Vol. 38:5, pp. 581–586. Available at: <http://onlinelibrary.wiley.com/doi/10.1111/j.1469-7610.1997.tb01545.x/abstract>

<sup>55</sup> Goodman, R.; Meltzer H.; and Bailey, V. (1998): The strengths and difficulties questionnaire: A pilot study on the validity of the self-report version, *European Child and Adolescent Psychiatry*, Vol. 7:3, pp. 125-130. Available at: <http://link.springer.com/article/10.1007%2Fs007870050057#page-1> See more at: [www.sdqinfo.com](http://www.sdqinfo.com).

In Ann Buchanan's experience, who has used this measure in many of her studies, the advantage of this tool is that it shows how a specific child, or groups of children sharing common characteristics, are responding to the particular challenges they face. For example, children whose parents are disputing in the courts over the child's care. A second advantage is that outcomes for children from small studies can be compared with outcomes for children from larger or national studies.

## Quality of life

### [A standardised measure to assess life quality: University of Sheffield's simple measure of quality of life](#)<sup>56</sup>

A very simple tool is this quality of life measure. Although very easy to administer, it is widely respected. A possible scenario when this survey may be used would be as follows: a group of residents; for example, in a facility for older people, where changes are to be made to improve their quality of life, can be asked to complete it before the changes are made. It is important each person completes this independently. Several months later, after the changes are made, the exercise can be repeated. This gives a simple before/after evaluation of the impact of the changes. Of course, an improvement may not be entirely related to the changes, as other factors may also have an impact, such as a change of staff, budgetary issues.

*Thinking about your own life and personal circumstances, how satisfied are you with your life as a whole?*

Completely											Completely
Dissatisfied											Satisfied
0	1	2	3	4	5	6	7	8	9	10	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### [Positive Psychology Centre, University of Pennsylvania](#)<sup>57</sup>

The measures from this Centre are similar to the 'quality of life' scale listed above. They are quick and easy to use and can be administered in a similar fashion. They have a variety of uses for most adult client groups, such as adults with disabilities, older people.

Useful measures retrieved from this site include:

<sup>56</sup> University of Sheffield: Wellbeing measures. Available at:

[https://www.shef.ac.uk/polopoly\\_fs/1.72794!/file/Resources\\_for\\_measuring\\_wellbeing.doc](https://www.shef.ac.uk/polopoly_fs/1.72794!/file/Resources_for_measuring_wellbeing.doc)

<sup>57</sup> University of Pennsylvania, Positive Psychology Center: Questionnaires for researchers. Available at:

<http://ppc.sas.upenn.edu/resources/questionnaires-researchers>

1. [Satisfaction with Life Scale](#) (SWLS)<sup>58</sup>
2. [Psychological Well-being Scales](#)<sup>59</sup>
3. [Subjective Happiness Scale](#) (SHS)<sup>60</sup>

The Satisfaction with Life Scale gives a longer term view, whereas the subjective Happiness Scale may reflect feelings of the moment; for example, happiness following a family visit. The Psychological well-being scales give more elaborate measurements.

### [Authentic Happiness website](#)<sup>61</sup>

The following scales are also similar to the above and available for self-completion. Most of these have been validated against large populations, so your sample can be compared to larger samples in other countries. Key references and copy-right information are given. Scales include those related with emotion, engagement, meaning and life satisfaction. Useful measures available at this site include:

- PANAS (Positive and Negative Affect Schedule)
- Fordyce Emotions Questionnaire
- Satisfaction with Life Scale
- Approaches to Happiness Scale

## Widely used standardised evaluation methods

### [Life satisfaction](#)<sup>62</sup>

The following three well-validated scales are available on the web and can be downloaded for free.

#### **Satisfaction with life scale**

A five-item scale designed to measure global cognitive judgments of one's life satisfaction (not a measure of either positive or negative affect). Participants indicate how much they agree or disagree with each of the five items using a seven point scale that ranges from 7 strongly agree to 1 strongly disagree.

#### **Subjective happiness scale** (also known as General Happiness Scale)

A four-item scale designed to measure subjective happiness. Each item is completed by choosing one of seven options that finish a given sentence fragment. The options are different for each of the four questions (see below for actual items).

#### **Bradburn scale of psychologic wellbeing** (*also known as the Affect Balance Scale*)<sup>63</sup>

The scale is made up of two components: the positive affect and the negative affect component. Each component has five items. The scale asks participants if, in the past few

<sup>58</sup> University of Pennsylvania, Positive Psychology Center: Satisfaction with life scale. Available at: <http://ppc.sas.upenn.edu/resources/questionnaires-researchers/satisfaction-life-scale>

<sup>59</sup> University of Pennsylvania, Positive Psychology Center: Psychological wellbeing scale. Available at: <http://ppc.sas.upenn.edu/resources/questionnaires-researchers/psychological-well-being-scales>

<sup>60</sup> University of Pennsylvania, Positive Psychology Center: Subjective happiness scale. Available at: <http://ppc.sas.upenn.edu/resources/questionnaires-researchers/subjective-happiness-scale/>

<sup>61</sup> University of Pennsylvania, Authentic Happiness Programme: Questionnaire center. Available at: <https://www.authentichappiness.sas.upenn.edu/testcenter>

<sup>62</sup> The Hong Kong Council of Social Service. Available at: [http://www.hkcss.org.hk/uploadfileMgnt/0\\_201443011362.pdf](http://www.hkcss.org.hk/uploadfileMgnt/0_201443011362.pdf)

<sup>63</sup> The Hong Kong Council of Social Service. Available at: [http://www.hkcss.org.hk/uploadfileMgnt/0\\_201443011362.pdf](http://www.hkcss.org.hk/uploadfileMgnt/0_201443011362.pdf)

weeks, they have felt certain emotions. The participant answers 'Yes' or 'No' to each question. The 'No' score is subtracted from the "Yes" score to create a positive/negative affect difference score.

## Mental health

### [GHQ-12](#)<sup>64</sup>

The GHQ-12 is intended to be a measure of 'coping'. Originally consisting of 60 questions about mild somatic and psychological symptoms, this questionnaire was later condensed to 30 and then to 12-item questionnaires. Though the 60 question variety is generally too long, the GHQ-12 is easy to understand and quick to administer. There are various ways to score the scale but based on experience, adding up the total score from each question gives a more precise account. As a matter of example, Ann Buchanan suggests that it would be good to assess all parents coming to social services with this non-intrusive scale as it indicates in a precise way the level of difficulties/need. The GHQ-12 has been used in a number of programmes, particularly with mothers at risk of abusing their children.<sup>65</sup>

### [Patient Health Questionnaire \(PHQ-9\)](#)<sup>66</sup>

This easy to use patient questionnaire is a self-administered one. It is not a screening tool for depression but it is used to monitor the severity of depression and response to treatment. However, it can be used to make a tentative diagnosis of depression in at-risk populations, such as those with coronary heart disease or after stroke.

### [Centre for Epidemiologic Studies Depression Scale \(CES-D\)](#)<sup>67</sup>

This is a 20-item scale questionnaire with four response options based on frequency of experiencing specified emotional states during the last week. Answers receive a score from 0 to 60.

## Needs based, flourishing and multi-dimensional measures of well-being

The following are more elaborate versions of the earlier life satisfaction/happiness/well-being scales. The WHO-QOL is interesting as it is aimed to be an international cross-cultural Quality of Life measure. It also explores various areas or domains of a person's life. The CASP19 is especially developed for use with older people. The particular value of the European Social Survey well-being measure is that there are scores from all over Europe, and scores from smaller samples can be compared with those from the survey.

### [Basic Psychological Needs Scale \(Deci and Ryan\)](#)<sup>68</sup>

This includes a family of scales developed by Deci and Ryan), one that addresses needs satisfaction in general in one's life, others address needs satisfaction in specific domains (e.g. work, inter-personal relationships). The original scale has 21 items concerning needs

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<sup>64</sup> CAMH Knowledge exchange: General health questionnaire (GHQ). Available at:

[http://knowledgex.camh.net/amhspecialists/Screening\\_Assessment/screening/screen\\_CD\\_youth/Pages/GHQ.aspx](http://knowledgex.camh.net/amhspecialists/Screening_Assessment/screening/screen_CD_youth/Pages/GHQ.aspx)

<sup>65</sup> The author has used the General Health Questionnaire (GHQ12) version in many studies and it has been very helpful in assessing change in well-being in adults. There is a Spanish version.

<sup>66</sup> Patient Plus: Patient health questionnaire (PHQ-9). Available at: <http://www.patient.co.uk/showdoc/40025272/>

<sup>67</sup> Center for Epidemiologic Studies: Depression scale Available at: <https://nts122.chcr.brown.edu/pcoc/cesdscale.pdf>

<sup>68</sup> University of Rochester: Self-determination theory. Available at: [http://www.psych.rochester.edu/SDT/measures/needs\\_scl.html](http://www.psych.rochester.edu/SDT/measures/needs_scl.html)

for three dimensions: competence, autonomy and connexion, but some studies work with only nine items (three for each dimension).

### **Approaches to Happiness (OTH) Scale**<sup>69</sup>

This includes three dimensions: meaning (6 questions), pleasure (6 questions), and engagement (6 questions). Each of these dimensions has the response scale: 1 "Very much unlike me" to 5 "Very much like me". Scoring for each dimension is the average of the 6 questions.

### **WHO-QOL**<sup>70</sup>

WHO-QOL aimed to be an international cross-culturally comparable quality of life assessment instrument. It comprises 26 items, which measure the following domains: physical health, psychological health, social relationships, and environment. The average of each domain is taken, giving a profile of four separate domain scores.

### **CASP-19**<sup>71</sup>

Quality of life index for older people, developed from a needs based perspective. It includes a 19 item Likert scaled index including questions on four domains: Control, Autonomy, Self-realisation and Pleasure.

### **European Social Survey**<sup>72</sup>

In the module on well-being, the questionnaire includes a wide range of questions on feelings and functioning.

### **Some standardised measures available for free on the Research in Practice (RIP) website**<sup>73</sup>

This website is well recommended by public, private and voluntary social services agencies in the UK who pay a subscription to access some of the material on their site and to attend training events. The following scales, however, can be downloaded free from their website<sup>74</sup>. Some of these scales were developed by the English or the Welsh Departments of Health for use by social workers.

### **Alcohol Use Disorders Identification Test (AUDIT)**<sup>75</sup>

The alcohol use disorders identification test (AUDIT) is a widely used measure developed by the World Health Organisation to help identify people who may be drinking in a manner that is potentially harmful to their health including hazardous or risk alcohol use, harmful alcohol

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<sup>69</sup> University of Pennsylvania, Positive Psychology Center: Authentic happiness programme. Available at: <http://www.authentic happiness.sas.upenn.edu>

<sup>70</sup> World Health Organization: WHO quality of life-BREF (WHOQOL-BREF). Available at: [http://www.who.int/substance\\_abuse/research\\_tools/whoqolbref/en/](http://www.who.int/substance_abuse/research_tools/whoqolbref/en/)

<sup>71</sup> Hyde, M.; Wiggins, R.; Higgs P.; Blane, D. (2003): A measure of quality of life in early old age: the theory, development and properties of a needs satisfaction model (CASP-19), *Ageing Ment Health*, Vol. 7:3, pp. 186-94. Available at: <http://www.ncbi.nlm.nih.gov/pubmed/12775399>

<sup>72</sup> University of Cambridge: Wellbeing institute. Available at: [http://www.cambridgewellbeing.org/Files/Well-being-Module\\_Jun06.pdf](http://www.cambridgewellbeing.org/Files/Well-being-Module_Jun06.pdf)

<sup>73</sup> Research in Practice: Standardised measures and guidance. Available at: <https://www.rip.org.uk/events-and-online-learning/change-projects/change-projects-resources/smg-change-project/>

<sup>74</sup> Research in Practice: Resources. Available at: <https://www.rip.org.uk/resources/>

<sup>75</sup> Research in Practice: Alcohol use disorders identification test. Available at: [https://www.rip.org.uk/download/254/SMG\\_change\\_projectAudit\\_C.pdf](https://www.rip.org.uk/download/254/SMG_change_projectAudit_C.pdf)

use, alcohol abuse and alcohol dependence. The AUDIT-C is a pencil and paper, self-report questionnaire that takes approximately five minutes to complete.

### **Depression, anxiety and stress scale (DASS)**<sup>76</sup>

The DASS presented here is a short version, the DASS21, which has seven items per scale and a total of 21 questions.

There are three scales:

1. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia, and inertia.
2. The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety, and subjective experience of anxious affect.
3. The stress scale is sensitive to levels of chronic non-specific arousal. It assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient.

The DASS is a pencil and paper, self-report questionnaire that takes approximately five minutes to complete. Participants are asked to use a four point severity/frequency scale to rate the extent to which they have experienced each state over the past week.

### **Emotional Regulation Questionnaire**<sup>77</sup>

This is a 10-item scale designed to measure respondents' tendency to regulate their emotions in two ways:

1. Cognitive Reappraisal
2. Expressive Suppression

The ERQ is a pencil and paper, self-report questionnaire. Respondents answer each item on a seven-point Likert-type scale ranging from 1 (strongly disagree) to 7 (strongly agree). The higher the scores the greater the use of the emotion regulation strategy.

### **Home conditions assessment**<sup>78</sup>

A tool to assess physical aspects of the home environment. This scale may appear judgmental, but workers necessarily make judgements about the safety, order and cleanliness of the place in which the child lives. The use of a list helps the objectivity of observation. The scale comprises a list of 11 items to be observed during home visits, and social presentation, the cleanliness of the children is included. The scale is best used as a mental checklist to provide a framework for observation.

The Home Conditions Assessment was made available as part of The Family Pack of Questionnaires and Scales from the Department of Health in the UK.

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<sup>76</sup> Psychology Foundation of Australia: Depression anxiety stress scales (DASS). Available at: <http://www2.psy.unsw.edu.au/dass/>

<sup>77</sup> University of Berkeley: Emotion regulation questionnaire (ERQ). Available at: <https://www.ocf.berkeley.edu/~johnlab/pdfs/ERQ.pdf>

<sup>78</sup> UK Department of Health: Home conditions assessment. Available at: <http://rsb.org.uk/uploads/home-conditions-assessment.pdf>



### **Maternal and paternal ante-natal attachment scales (MAAS and PAAS)**<sup>79</sup>

The MAAS and PAAS are used to assess maternal/paternal antenatal bonding to the unborn baby. The MAAS scale includes 19 items and the PAAS 16 items which focus on feelings, attitudes and behaviours towards the foetus with responses recorded on a five-point Likert Scale. Many of the questions require the respondent to select their answer based on their experience in the previous two weeks.

### **Multidimensional scale of perceived social support**<sup>80</sup>

The Multidimensional Scale of Perceived Social Support is a measure of how much support a parent feels they get from family, friends and significant others. Each of these forms a separate subscale. A total score can also be calculated.

### **Parenting daily hassles**<sup>81</sup>

This measure aims to assess the frequency and intensity/impact of 20 experiences that can be a 'hassle' to parents. It has been used in a wide variety of research concerned with children and families. The research suggests that parents/caregivers enjoy completing the scale, because it touches on aspects of being a parent that are very familiar and it is seen as helping them express what it feels like to be a parent.

The parent/caregiver is asked to score each of the 20 potential hassles in two different ways.

1. The frequency of each type of happening provides an 'objective' marker of how often it occurs.
2. The intensity or impact score indicates the caregiver's 'subjective' appraisal of how much those events affect or 'hassle' them.

The Parenting daily hassles tool was made available as part of The Family Pack of Questionnaires and Scales from the Department of Health.

## **Conclusion**

Most of the standardised measures listed in this document are very easy to use and can give practitioners a solid measure as a baseline at the start of a project. They can then be reapplied at the end of the project to monitor changes.

The main challenge in using these scales is that few of them are published or validated in other European languages than English. However, a simple but well-accepted method of using them in another language is first to translate them into the language required and then ask another translator to translate them back into English. The translated version is then tested with a pilot group of those with whom the tool is to be used.

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<sup>79</sup> Research in Practice: Maternal and paternal ante-natal attachment scales. Available at:  
[https://www.rip.org.uk/download/263/SMG\\_change\\_projectMaternal\\_antenatal\\_attachment\\_scale.pdf](https://www.rip.org.uk/download/263/SMG_change_projectMaternal_antenatal_attachment_scale.pdf)  
[https://www.rip.org.uk/download/264/SMG\\_change\\_projectPaternal\\_antenatal\\_attachment\\_scale.pdf](https://www.rip.org.uk/download/264/SMG_change_projectPaternal_antenatal_attachment_scale.pdf)

<sup>80</sup> University of York: Multidimensional scale of perceived social support. Available at:  
<http://www.yorku.ca/rokada/psycstest/socsupp.pdf>

<sup>81</sup> UK Department of Health: Parenting Daily Hassles SCALE. Available at:  
[https://www.cafcass.gov.uk/media/215160/parenting\\_daily\\_hassles\\_scale.pdf](https://www.cafcass.gov.uk/media/215160/parenting_daily_hassles_scale.pdf)

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## Useful links

Federal Institute for Construction, Urban and Area Research. Available at: <http://www.inkar.de>

Campbell Collaboration. Available at: <http://www.campbellcollaboration.org/>

CareLit. Available at: <http://www.carelit.de/cont/start/index.php>

Centre for Evidence Based Mental Health. Available at: <http://www.psych.ox.ac.uk/publications>

Centre for Quality in Care. Available at: <http://www.zqp.de/index.php?pn=project>

Danish Appeals Board. Available at: <https://ast.dk/tal-og-undersogelser>

Danish Centre for Social Research. Available at: [http://www.sfi.dk/view\\_all\\_projects-4843.aspx?Action=1&NewsId=4747&PID=10047#sthash.flqOPkt.dpuf](http://www.sfi.dk/view_all_projects-4843.aspx?Action=1&NewsId=4747&PID=10047#sthash.flqOPkt.dpuf)

Early Intervention Foundation. Available at: <http://www.eif.org.uk/>

EPPI centre. Available at: <http://eppi.ioe.ac.uk/cms/>

EUROSTAT. Available at: <http://ec.europa.eu/eurostat/web/main/home>.

European Social Surveys. Available at: [http://www.europeansocialsurvey.org/about/project\\_specification.html](http://www.europeansocialsurvey.org/about/project_specification.html)

German Centre for Gerology. Available at: <http://www.dza.de/en/fdz.html>.

German Federal Ministry of Health, future workshop on dementia. Available at: <http://www.bmg.bund.de/theme/n/pflege/demenz/zukunftswerktatt-demenz/uebersicht-projekte.html>

German Institute of Applied Nursing Research. Available at: <http://www.dip.de/datenbank-wise/informationen-zu-wise/ueber-wise/>

Gesis/SOWIPOINT. Available at: <http://www.gesis.org/en/institute/the-association/mission/>

Italian Social Assistants Association. Available at: [http://www.assistentsociali.org/servizio\\_sociale/buone\\_prassi\\_del\\_servizio\\_sociale.htm](http://www.assistentsociali.org/servizio_sociale/buone_prassi_del_servizio_sociale.htm)

Mathilda Wrede Institute. Available at: [http://www.fskompetenscentret.fi/mathilda\\_wrede\\_institutet/in\\_english](http://www.fskompetenscentret.fi/mathilda_wrede_institutet/in_english)

MOVISIE. Available at: <http://www.movisie.nl/>

National Institute on Drug Abuse. Available at: <http://www.drugabuse.gov/publications/preventing-drug-abuse-among-children-adolescents/chapter-1-risk-factors-protective-factors>

Project Oracle. Available at: <http://project-oracle.com/>

Samorzad Teritorialny Gwarancja Dobrych Usług. Available at: <http://www.dobrepraktyki.pl/index.php?p1=11>

Social Work Policy Institute. Available at: <http://www.socialworkpolicy.org/research/evidence-based-practice-2.html>

Substance Abuse and Mental Health Services Administration: National Registry of Evidence-Based Programs and Practices. Available at: <http://www.nrepp.samhsa.gov/Search.aspx> and <https://captus.samhsa.gov/prevention-practice/prevention-and-behavioral-health/key-features-risk-protective-factors/5>

The Incredible Years. Available at: <http://incredibleyears.com/>

Triple P International. Available at: <http://www.tripleparenting.uk.net/>

UK Parliament. Available at: <http://www.publications.parliament.uk/pa/cm200910/cmselect/cmchilsch/130/13006.htm>

University of Colorado Boulder, Center for the Study and Prevention of Violence. Available at: <http://www.blueprintsprograms.com/>

The content of this report and its toolkit consists of a guidance on what type of knowledge is required for planning and evaluating services accompanied by two questionnaires; the first aids practitioners when planning services, while the second questionnaire aids practitioners in their evaluation of local social services. The toolkit also includes a review of international evidence-based social work databases that may be useful for practitioners when planning services.

The European Social Network (ESN) has been working on aspects related to evidence-based policy and practice in public social services since 2012. This toolkit was tested with senior practitioners and applied researchers at a joint meeting on evidence-based practice in London in October 2015 and their feedback was integrated into this final report.

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