

# HRB drug and alcohol evidence reviews

**Integrative review on place-based and other geographically defined responses to drug-related threats in communities**





# Integrative review on place-based and other geographically defined responses to drug-related threats in communities

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## HRB drug and alcohol evidence review series

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## HRB drug and alcohol evidence reviews to date

Munton T, Wedlock E and Gomersall A (2014) *The role of social and human capital in recovery from drug and alcohol addiction*. HRB Drug and Alcohol Evidence Review 1. Dublin: Health Research Board

Munton T, Wedlock E and Gomersall A (2014) *The efficacy and effectiveness of drug and alcohol abuse prevention programmes delivered outside of school settings*. HRB Drug and Alcohol Evidence Review 2. Dublin: Health Research Board

Nic Gabhainn S, D’Eath M, Keane M and Sixsmith J A (2016) *Scoping review of case management in the treatment of drug and alcohol misuse, 2003–2013*. HRB Drug and Alcohol Evidence Review 3. Dublin: Health Research Board

Murphy L, Farragher L, Keane M, Galvin B and Long A (2017) *Drug-related intimidation – the Irish situation and international responses: an evidence review*. HRB Drug and Alcohol Evidence Review 4. Dublin: Health Research Board

Bates G, Jones L, Maden M, Cochrane M, Pendlebury M and Sumnall H (2017) *The effectiveness of interventions related to the use of illicit drugs: prevention, harm reduction, treatment and recovery. A ‘review of reviews’*. HRB Drug and Alcohol Evidence Review 5. Dublin: Health Research Board

Minyard K, Manteuffel B, Smith CM, Attell BK, Landers G, Schlanger M and Dore E (2019) *Treatment services for people with co-occurring substance use and mental health problems. A rapid realist synthesis*. HRB Drug and Alcohol Evidence Review 6. Dublin: Health Research Board

Miller J, Carver H, Masterson W, Parkes T, Jones L, Maden M and Sumnall H (2021) *Evidence review of drug treatment services for people who are homeless and use drugs*. HRB Drug and Alcohol Evidence Review 7. Dublin: Health Research Board

Pratschke J, Glanville J and Engling F (2022) *An integrative evidence review on service user participation in the design and delivery of drug treatment, recovery and harm reduction services*. HRB Drug and Alcohol Evidence Review 8. Dublin: Health Research Board



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# Abbreviations

BSaB	Barcelona Salut als Barris [Barcelona Health in the Neighbourhoods]
CCIM4C	Community Collective Impact Model for Change
CES	Cooperative Extension System
CTC	Communities That Care
CTH	Communities That HEAL
CYDS	Community Youth Development Study
EBP	evidence-based programme
EMCDDA	European Monitoring Centre for Drugs and Drug Addiction
ESPAD	European School Survey Project on Alcohol and Other Drugs
EU	European Union
GP	General Practitioner
HCS	HEALing Communities Study
HEAL	Helping to End Addiction Long-term Initiative
HIV	human immunodeficiency virus
HRB	Health Research Board
ICD	International Statistical Classification of Diseases and Related Health Problems
IPM	Icelandic Prevention Model
MOUD	medications for opioid use disorder
NIH	National Institutes of Health
OECD	Organisation for Economic Co-operation and Development
OEND	overdose education and naloxone distribution
ORCCA	Opioid-overdose Reduction Continuum of Care Approach
OUD	opioid use disorder
PRISMA	Preferred Reporting Items for Systematic Reviews and Meta-Analyses
PROSPER	PROmoting School-university-community Partnerships to Enhance Resilience
SAMHSA	Substance Abuse and Mental Health Services Administration
SCORE	Second Chance or Else
TMI	The Martinsburg Initiative
UK	United Kingdom
USA	United States of America
WHO	World Health Organization



# 1

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# Introduction

A key element in successive Irish drugs strategies has been the involvement of non-governmental organisations and public agencies at various levels, from the local to the national, with the participation of communities and local stakeholders being central to Action 4.1.39 of the current strategy (Department of Health 2017). The key role accorded to Local and Regional Drug and Alcohol Task Forces in responding to drug-related threats confirms the importance of working in partnership with communities, which is a central principle of the World Health Organization Ottawa Charter (WHO 1986) and the Action Framework of the European Monitoring Centre for Drugs and Drug Addiction (EMCDDA 2021). It is useful, in this context, to review the international literature on interventions that seek to tackle drug-related harms at the local level by involving communities, with a view to providing a more comprehensive evidence base that can contribute to policy debates in Ireland. The aim of this report is thus to provide a summary of the international evidence on place-based initiatives in the context of drug-related harms.

Programmes which seek to reduce drug-related harms at local level through integrated interventions that involve residents and stakeholders are variously referred to as place-based, community-driven, community-based, community-level, coalition-based, community-wide, whole-of-community, community partnership, comprehensive, collaborative, collective impact, targeted, ecological, environmental, or neighbourhood-based initiatives. In this report, we use the term “place-based initiatives”, which is often used in the United Kingdom (UK), while the alternative term “comprehensive community initiatives” is more often used in the United States of America (USA). A fundamental characteristic of these programmes is that they seek to harness local resources by promoting participation and involvement. They typically adopt a universal approach and target the entire population of the area concerned. Local involvement is promoted by a local steering committee (“coalition” in the USA) that includes a mixture of community leaders, local groups, stakeholders, private firms, service providers, and community members. Because they are community-driven and locally managed, the precise nature of these interventions varies in accordance with local needs, even where they form part of a broader programme.

The resources to fund and support place-based initiatives typically come from a public body like a municipality, county, region, or central/federal government. Place-based initiatives are often implemented in different locations, with training, resources, organisational support, and technical assistance provided by a central unit, perhaps in partnership with university-based researchers. They usually entail a multistranded intervention, involving a combination of prevention, reducing drug use, improving access to treatment, reducing drug-related harms, and promoting recovery. For this reason, they tend to be multisectoral, involving health and social services, schools, police, and other organisations. They are generally accompanied by the collection of standardised data, with the aim of implementing a scientific assessment of impacts, perhaps as part of a randomised controlled trial or a quasi-experimental study.

We dedicate considerable attention in this evidence review to the assessment of impacts in the context of place-based initiatives, as a fundamental question is whether they represent an effective way of addressing drug-related harms and threats. The EMCDDA's Action Framework for developing and implementing responses to drug problems underlines the importance of outcome assessment: when intervening to address drug-related harms, it is important to monitor progress and to evaluate initiatives. Several place-based initiatives to reduce drug-related harms have been studied using appropriate research designs, the largest of which have been discussed in journal articles and reports, providing a wealth of data on their effects and characteristics, which we summarise in this report.

Place-based initiatives emerged originally in the field of health, guided by new ideas relating to the social determinants of health (Marmot and Wilkinson 2006), the role of the socioecological context (Bronfenbrenner 1979), implementation science (Allotey *et al.* 2008), and the importance of community empowerment (Wallerstein and Bernstein 1994). Although there are considerable variations, it is possible to identify a coherent underlying model which focuses on providing universal, structural interventions that seek to improve health and well-being by modifying the social context in which health-related behaviour occurs. As Flanagan *et al.* (2018) observe in relation to these programmes, "population-level outcomes require systems-level intervention" (p. 38). Due to their universal approach, place-based initiatives place considerable emphasis on prevention, although there are also programmes which seek to reduce drug-related harms and to improve access to treatment.

The prospect of achieving significant improvements in population health, reducing social gradients, and preventing drug use by mobilising the resources present within communities has attracted the attention of many public bodies and international agencies. By documenting the efficacy of place-based initiatives using well-designed trials, successful initiatives have stimulated interest in this new paradigm. There have been several high-profile initiatives to tackle substance use among young people, including Communities That Care (CTC), PROMoting School-university-community Partnerships to Enhance Resilience (PROSPER), Communities That HEAL (CTH), and the Icelandic Prevention Model (IPM), which are described in detail in this report, along with other smaller programmes.

The Request for Tenders (RfT) identifies three objectives:

1. To describe how the association between place and drug-related threats to the population is understood in the literature and in policy documents.
2. To identify place-based and other geographically defined initiatives that show promise in responding to these threats.
3. To describe the theoretical frameworks that explain the mechanisms by which these initiatives are expected to impact on drug-related threats to populations.

These objectives are accompanied by a set of research questions:

1. How is the association between the characteristics of places and drug-related threats understood in the literature?
2. What criteria are used by policymakers and funders to select locations for place-based initiatives?

3. What place-based initiatives designed to tackle drug-related threats to communities show signs of promise?
4. What indicators have been developed to measure the impact of these interventions?
5. To what extent are these interventions applicable in the Irish context?

The RfT also indicates that the evidence review should cover different types of evidence:

*This is an integrative review and will take a mixed method approach to integrating findings from quantitative and qualitative studies and the theoretical literature on the topic. The search on which the review is based will include academic literature, official reports, unpublished research and advocacy documents. (p. 19)*

The research described in this report was carried out following these indications, employing state-of-the-art information search and retrieval techniques to maximise the probability of finding relevant academic articles, official reports, theses, unpublished research, and advocacy documents. Our extensive literature review meets the standards set by the Cochrane Collaboration, as it is based on a clear set of objectives, predefined criteria for determining eligibility, a clear, explicit, and reproducible methodology, a powerful search strategy, assessment of the quality of included studies, and a systematic synthesis of their design and findings.

The research work was divided into the following stages:

- » Refining the research questions
- » Developing and conducting the systematic literature search
- » Screening the retrieved records
- » Selecting and synthesising the findings
- » Completing a draft report
- » Presenting the findings
- » External peer review
- » Dissemination events
- » Submission of final report.

In Chapter 2 we provide an introduction to place-based initiatives and discuss how these have been defined and conceptualised, including variations on the basic model described above. In Chapter 3 we provide a detailed description of our extensive literature search, including screening, assessing, and synthesising the eligible publications. In Chapter 4 we describe the place-based initiatives mentioned in these publications and in Chapter 5 we seek to answer the research questions listed above.

## 2

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# Place-based initiatives: key concepts

Place-based initiatives represent a relatively recent innovation in terms of policies to tackle inequalities in health and well-being (Taylor and Buckley 2017). Throughout most of the postwar period, health-related interventions in OECD countries were designed and implemented by professionals, with little or no consultation or involvement of service users, communities, or stakeholders (O'Mara-Eves *et al.* 2015). Programmes typically involved providing a single prevention intervention or treatment practice in a single setting (Chandler *et al.* 2020). Based on the disappointing results of these initiatives – particularly in deprived areas – researchers and practitioners highlighted the difficulties generated by the interaction between different forms of disadvantage at local level, high levels of distrust and disaffection in relation to state institutions, and the weakness of the social fabric in poor neighbourhoods.

The idea that universal, comprehensive programmes can be used to tackle social problems at local level dates back to the 19th century (Bremner 1956), although the place-based approach assumed its current form in the 1970s in programmes that aimed to improve general health (Stern *et al.* 1976). Place-based initiatives were extended during the 1980s and 1990s to include interventions that focused on a range of outcomes, including cardiovascular disease, obesity, breastfeeding, smoking, and HIV (COMMIT Research Group 1995; Dennis *et al.* 2015; Hudson *et al.* 2015; Luepker *et al.* 1994; McGowan *et al.* 2021; Spoth and Greenberg 2005), and were employed to tackle substance use among adolescents in the 1990s (Hawkins 2008). The concepts of spatial targeting and community involvement had already been adopted in the fields of community development, urban regeneration, industrial innovation, housing improvement, and crime prevention (Bailey *et al.* 2023; Braga *et al.* 2019; Dillman *et al.* 2017; Lawless 2004; Moore and Fry 2011). This was initially confined to the USA, although place-based initiatives have also been adopted in the UK, Australia, and other countries, where the influence of this new paradigm is expanding as a result of emulation and parallel innovations.

## Place-based initiatives focused on substance use

In the USA, programmes such as the Community Coalitions and Community Partnership Programs, the Drug-Free Communities Program, the Fighting Back Initiative, and the Substance Abuse and Mental Health Services Administration (SAMHSA) State Incentive Grant encouraged the formation of “community coalitions” during the 1990s, preparing the way for place-based responses to drug-related harms. According to Minnick *et al.* (2022), the Drug-Free Communities Program was supporting roughly 700 community coalitions by 2020. Private foundations, such as the Annie E. Casey Foundation, Ford Foundation, Hewlett Foundation, and the John S. and James L. Knight Foundation have also provided funding for place-based initiatives in the USA (Flanagan *et al.* 2018):

*In the 1990s, the Community Partnership Program and later the Community Coalitions Programs supported by the Substance Abuse and Mental Health Services Administration (SAMHSA) shifted the federal approach to addressing substance misuse from focusing on individual behavioral change to using community-based interventions to prevent, address, and treat substance use disorders .... Communities formed coalitions of diverse stakeholders to plan and implement community-based approaches, consistent with an evidence-based approach previously used to address other public health issues. (Chen et al., 2023, p. 2)*

The high-profile, well-funded programmes that have driven research on place-based initiatives emerged in this context, with the aim of assessing the effectiveness of this new approach. These initiatives go beyond prevention to address treatment and harm reduction among adult populations, although impact assessments for the most recent programmes have yet to be carried out. Feinberg *et al.* (2022, p. 1264) note that “for the past half-century, the leading front of prevention strategy development, testing, and dissemination has been in the area of substance use”.

Interest in community-based programmes was also stimulated by a growing awareness of the complex relationships that exist between different factors at local level. Research on neighbourhoods flourished during the 1980s and 1990s in fields such as urban studies, child development, health research, crime, and education (Duncan and Aber 1997; Sampson *et al.* 1997). Studies showed that ‘space matters’, and documented the existence of neighbourhood effects, spatial segregation, diffusion processes, and other forms of geographical heterogeneity. During the 1990s, researchers began to incorporate a more sophisticated understanding of these socio-spatial patterns into studies of inequalities in health, education, and the labour market. Scholars drew links between recalcitrant social inequalities in these different areas and social conditions at neighbourhood level. National policies to tackle these inequalities would not be successful, they argued, unless systemic changes were made at local level to empower and enable individuals and families to change their own situation. Researchers also argued that services targeted at individuals would not be sufficient to reduce substance use among young people; in addition to providing services where they are needed, a system-level approach is needed that targets the broad social determinants of health and well-being (Halsall *et al.* 2022).

Simplifying somewhat, the earliest place-based initiatives to tackle drug-related harms used community coalitions to develop and implement interventions, including campaigns to change community norms, to implement policies to prevent drug abuse, and preventive interventions involving young people and their families (Snell-Johns *et al.* 2003). Rather than focusing on individual behaviour, they sought to change social conditions in order to reduce drug-related harms. This encouraged policymakers to shift their attention on evidence-based, targeted initiatives. Place-based initiatives fit well with the concept of health promotion, and Nagorcka-Smith *et al.* (2022) observe that “there is agreement that health promotion is done most effectively when interventions are place-based”.

## Defining place-based initiatives

One of the defining features of place-based initiatives is community involvement, which implies that decisions about how to intervene are taken by committees that include community leaders, local stakeholders, and representatives of the local community. This ensures local ownership of the initiative and empowers local actors to play a leading role in shaping, promoting, and implementing programmes. Research interest in the role of community coalitions in designing and implementing health-related initiatives has accelerated since 2000 (Nagorcka-Smith *et al.* 2022), and the composition, functioning, and leadership of coalitions are widely considered to be crucial to the success of place-based initiatives (Butterfoss and Kegler 2002; Foster-Fishman *et al.* 2001).

Community coalitions comprise a group of individuals representing different organisations, sectors, and constituencies, who work together in order to achieve a common goal (Butterfoss and Kegler 2002). Christens *et al.* (2021) provide the following description:

*Coalitions are formalized collaborative structures consisting of representatives from multiple organizations and sectors (e.g., healthcare, law enforcement, media, religious and educational institutions, voluntary associations) within a community. Over the last few decades, they have increasingly been adopted as a strategy for government agencies and philanthropic foundations attempting to drive changes in social and environmental factors at local scales that influence health, education, and positive human development ... coalitions represent a community development approach to health promotion and local systems change. (Christens et al. 2021, p. 366)*

This accords an important role to social innovation at the local level: local people and local stakeholders must be empowered to identify new arrangements, relationships, and practices which meet their needs more effectively. Community members and their representatives must have an opportunity to define local needs and to participate actively in the required transformations (Halsall *et al.* 2022). This process is viewed as unlocking assets that are already present within the community, enhancing the capacity of the initiative to generate positive change (Kristjansson *et al.* 2020a). There is a growing awareness of the complexity of communities in terms of the distribution of power and wealth, and of the need to integrate minorities, members of disadvantaged groups, and people with lived experience of drug use within community coalitions. The role of central administrators, coordinators, and experts is to provide advice on effective programmes, technical support in relation to collecting and analysing data, and information on wider employment opportunities, funding, and resources.

A second defining feature of place-based initiatives is the adoption of a holistic approach, which includes all relevant spheres of community life. Consequently, interventions may take place at the level of the individual (such as prevention programmes for children), the family (meeting the needs of local households), the school (training programmes for teachers), and the community (recreational opportunities, better local infrastructure or new policies, for example). Local service providers are often expected to reach out to the population or to provide wraparound services that support vulnerable groups in all areas of their lives. As inequalities in health, education, and the labour market are reproduced through the effects of a series of interlocking factors, it is argued that effective interventions must also exploit cross-sectoral synergies and seek to influence a number of risk and protective factors simultaneously (Shapiro *et al.* 2013).

This brief overview shows how place-based initiatives have absorbed a number of innovative recent themes regarding effective ways of delivering services and responding to local needs. Because of their nature, it is often argued that place-based initiatives should be evaluated at the population level, rather than through the effects they have on specific groups of people. In the context of drug-related harms, there is a difference between policies that are centred on the provision of treatment and those that emphasise prevention, and place-based initiatives in this area increasingly seek to integrate treatment, harm reduction, and recovery within a single framework.

The third defining feature of place-based initiatives, alongside community involvement and holistic approaches to service delivery, is their focus on neighbourhoods. By improving social conditions in specific communities, place-based initiatives aim to address entrenched inequalities and aspire towards larger impacts. The areas concerned are typically neighbourhoods, quarters, districts, or towns with recognisable boundaries, and are sometimes as small as a single school district. This raises the risk of defining communities exclusively in geographical terms, suggesting that disadvantaged neighbourhoods are by definition socially isolated. Flanagan *et al.* (2018) provide a useful overview of some of these interventions:

*Comprehensive community initiatives (CCIs) – locally organized, multi-sector collaborations – have become an increasingly popular avenue for building the capacity of a particular place to coordinate public resources, mobilize previously untapped family, cultural, and community-based resources, and, ultimately, to design social interventions that lead to better population-level outcomes. Models for such systemic interventions use several terms to describe themselves, such as cradle-to-career initiatives, collective impact, and comprehensive community initiatives. Despite the variation in terminology, all employ the philosophy that improved population-level outcomes for children and families can best be achieved by engaging multiple community systems, structures, and constituencies that coalesce around a common goal and work in concert to achieve that goal. (p. 1)*

## Theoretical frameworks

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A number of theoretical models have been proposed for the development and assessment of place-based initiatives. We discuss these in Chapter 4, as they vary across initiatives. One common feature, however, is an ecological approach to behaviour which emphasises the role of contextual factors such as community norms, peer influence, deprivation, discrimination, stereotyping, and exclusion from opportunities (e.g. Brown *et al.* 2014). Many theoretical frameworks also adopt a developmental perspective to the life course, which highlights the importance of intervening at critical stages to reduce risks and to prevent problems (e.g. Fagan and Hawkins 2013). Another key issue that is often highlighted involves the adverse consequences of exposure to violence and trauma (including adverse childhood experiences), the effects of which pose challenges for institutions and service providers in disadvantaged areas (Wisdom *et al.* 2022). In order to reduce drug-related problems, place-based initiatives must find ways of managing and treating a series of social issues which are, at least to some extent, a legacy of enduring, concentrated disadvantage (Winhusen *et al.* 2020). Place-based initiatives seek to use aspects of the local context in order to achieve collective impact. The latter is a key concept which highlights the conceptual distance that separates these interventions from models that seek to bring about change by acting at the individual level.

## Methodological and conceptual challenges

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The aim of this report is to provide a summary of the available evidence on place-based initiatives. The identification of documents and reports describing these is a challenging task for a number of reasons. Firstly, as they are relatively new, the language used to describe these initiatives varies greatly. As mentioned in the introduction, a range of different terms have been used, with only a modest degree of convergence. The search strategy must also take into account the possibility of finding place-based initiatives to tackle drug-related threats in a range of different fields, from children's services to policing and health screening. This means that we must use a large number of synonyms when searching databases, which increases the amount of screening required.

Secondly, the features of these programmes are not unique to place-based initiatives and may be found in other contexts. For example, under the influence of the WHO Ottawa Charter and due to pressure from community groups, community coalitions have been established in many localities, particularly in the USA, in order to provide representation and to improve coordination between local actors (Nagorcka-Smith *et al.* 2022; O'Mara-Eves *et al.* 2015; Orwin *et al.* 2014; Yin *et al.* 1997). Although most place-based initiatives are guided by a community coalition, the latter are also used in other contexts, and service providers may use community coalitions simply to coordinate interventions cross-sectorally. Röding *et al.* (2021) describe "local intersectoral networks for health promotion" as the most common approach to prevention of substance use in Germany. However, many researchers have noted that the establishment of community coalitions is not sufficient on its own to improve outcomes for young people (Steketee *et al.* 2013). Place-based initiatives go far beyond community coalitions to identify structured ways of intervening at local level in a concerted manner, guided by the available evidence on what works.



The third difficulty is that treatment programmes provided on an outpatient basis are sometimes referred to as community-based services, and a number of policies have been introduced to encourage service user involvement within these services. This contributes to the amount of screening that is needed in order to identify place-based initiatives. Another problem is that the term 'community' is often used to describe groups that are defined by a socio-demographic characteristic (Native Americans, LGBTQ+, etc.) rather than geographical location. Fourthly, interventions may appear to be place-based simply because they are located in a specific area (e.g. a satellite treatment centre in a deprived neighbourhood). Top-down prevention programmes are widely employed in schools, and cluster randomised controlled trials are sometimes used to evaluate them, giving rise to studies which have superficial similarities with place-based initiatives. Finally, many interventions by statutory or voluntary bodies that aim to reduce drug-related threats are geographically targeted, including community drug projects and harm reduction services. Although these services are often described in ways that are reminiscent of place-based initiatives, there are important differences. This increases the difficulty of carrying out literature searches, makes it challenging to define database queries, reducing our ability to correctly classify records based on their abstract.

It is important to stress that programmes to reduce drug-related harms and threats do not automatically qualify as place-based initiatives just because they have a degree of geographical targeting or some form of community involvement (such as relying on a local survey, for example). This is an important point, as practically all health-related services now employ some form of geographical targeting in the construction of catchment areas, treatment centres, and the organisation of workloads at local level. The main difference is that community coalitions in place-based initiatives have a mandate to introduce innovative cross-sectoral solutions, addressing all kinds of risk and protective factors as they manifest themselves within specific localities. They are not driven predominantly by the organisational interests of service providers or experts, but by local people and community stakeholders with their lived experience of drug-related harms and threats.

## **Challenges achieving impacts through place-based interventions**

As well as giving local stakeholders and community members greater power, it is evident that the governance of place-based initiatives poses complex challenges. If local coalitions break down as a result of interpersonal or interorganisational rivalries, or if they are unable to make decisions due to a lack of information or skills, then the entire programme can be placed at risk. Similarly, if coalitions are not sufficiently representative or influential within the community, residents may become suspicious and withdraw their support. As coalitions are generally formed on the basis of invitations made by programme administrators, they tend to comprise influential local stakeholders (like the head of police, religious leaders, local businesspeople, professionals), who may not be universally appreciated by community members. Similarly, professionals and administrators working in existing roles in treatment provision or harm reduction may feel threatened by these initiatives or fear that they will lose influence or power. Innovating and "thinking outside the box" can lead to conflict and failure just as they have the potential to generate positive change.

As we noted above, a defining feature of place-based initiatives is community involvement in decision-making. This means that interventions are likely to vary from one community to another, which in turn is likely to contribute to cross-site heterogeneity in outcomes. Where initiatives are part of a randomised controlled trial, research methods need to be able to model this heterogeneity using appropriate statistical tools. This issue has received greater attention since 2010 and a number of studies have been published using new methods to provide a more precise evaluation of older initiatives.

Place-based initiatives face formidable challenges, and they are likely to be costly programmes. Although they incorporate mechanisms that facilitate incremental change and continuous monitoring, there are no guarantees that they will be successful. In order to be successful, they must correctly identify a range of causal factors and the relationships between them in complex, multilevel systems. As we show in Chapter 4, the results of empirical studies suggest that this is a difficult task. At least some of the causal factors are likely to originate outside the community, including economic factors, national policies, and cultural representations, to name just a few. Faced with problems that derive from wider structures and processes, community coalitions can often find themselves merely managing the effects of these and seeking to minimise harms.

It is also important to recognise the challenges posed by community involvement itself, as the people who are expected to participate in initiatives may not have the time, energy, motivation, skills or resources needed to do so. Participation is much easier for professionals, administrators, organisers, and other institutional figures who have a salary and appropriate training. A similar consideration applies to interventions: many programmes to prevent drug-related harms require local people to participate in courses, activities, and discussions, which again requires time and resources. A low level of participation can undermine the universal character of area-based initiatives and reduce their ability to bring about structural change and collective impacts. Merzel and D’Afflitti (2003) highlight the difficulty of engaging large enough proportions of a population in activities that are sufficiently intensive to generate change in a given area.

Each new wave of place-based initiatives tends to be accompanied by ambitious goals, which generally fail to materialise. One of the key findings of research on place-based initiatives is that it is much more difficult, much more costly, and it takes much more time to counteract entrenched social inequalities than researchers and administrators typically realise. At the same time, these initiatives represent a promising innovation, with the potential to have a significant impact in a field where mainstream interventions are coming under increasing criticism from service users and local communities. In this political context, initiatives that emphasise the active role of communities, that represent a break with established practices, that shift power towards local actors and stakeholders, and that address entrenched social issues may have the potential to promote positive change. It is particularly important, therefore, to evaluate effectiveness and to avoid demoralising local people by encouraging them to have inflated expectations of rather modest interventions.

A final consideration that is relevant when discussing place-based initiatives relates to their role within broader strategies for tackling the effects of disadvantage and social inequality. Place-based initiatives tend to emphasise the importance of a wide range of risk and protective factors, while focusing on a single outcome (whether this is obesity, HIV or illicit drug use). Researchers have highlighted the possibility that programmes which focus on one area (adolescent drug use) could have positive effects in others (delinquency or mental health, for example). Similarly, what is considered an outcome from one perspective (substance abuse) may be considered a risk factor from another (population health). Given these complex interdependencies, initiatives that tackle substance abuse would be expected, all else being equal, to have positive effects on health:

*Because many mental, emotional, and behavioral problems share common predictors ... coalition-based community planning can address risk and protective factors without contributing to service redundancies or overlooking gaps. (Shapiro et al. 2013, p. 155)*

This raises the issue of how to exploit these synergies and avoid redundancies in disadvantaged areas which are targeted simultaneously by several interventions. Similar questions have been formulated in relation to local development and social inclusion, where it is challenging to find ways of integrating initiatives at community level. Rather than creating parallel initiatives, it may be more appropriate to develop integrated initiatives which target multiple outcomes (health, substance use, crime, education). There are likely to be considerable economies of scale, and considerable synergies in terms of governance, administration, technical assistance, and monitoring. The difficult task of collaborating across disciplinary and organisational boundaries may also become more tractable within this kind of institutional context. When designing and evaluating place-based initiatives, there is also scope for cross-sectoral and interdisciplinary learning and synergies. Feinberg *et al.* (2022) provide the following assessment:

*Given the limited funding available for prevention implementation, most communities are unable to implement multiple prevention programs that target specific adolescent problems (e.g., depression, anxiety, sexual risk, violence, suicide, school dropout, academic achievement). Consequently, programs that yield collateral benefits or cross-over benefits (i.e., beneficial, but non-targeted intervention outcomes) are important to consider. (Feinberg et al. 2022, pp. 1264–1265)*

This raises a number of challenging issues, ranging from appropriate governance structures to integrated interventions and combined forms of data collection. Given the multiplicity of interrelated disadvantages that characterise deprived communities, it may be possible in the future to develop a theoretical framework which takes these kinds of interventions as a starting point for place-based initiatives, rather than proceeding in a compartmentalised manner.

# 3

## Literature searches

The research questions guiding this study were addressed by carrying out an extensive search of the literature, including academic publications, unpublished research, official reports, and advocacy documents. In order to summarise the criteria used to select locations for place-based initiatives that respond to drug-related threats in communities, we need to identify the programmes. To assess their effectiveness, we need to summarise the results of robust evaluation studies. To explore the link between the characteristics of local communities and drug-related threats, we need to read programme descriptions and reports, and impacts are reported in academic articles.

In order to prepare the ground for our main search, we carried out a review of reviews. The aim was to identify existing literature reviews that touch on the theme of place-based initiatives that respond to drug-related threats in communities. The searches were conducted using databases likely to yield appropriate publications, restricting the results to documents published over the last 10 years, in the academic as well as grey literature. Potentially relevant reviews were also identified from documents supplied by the Health Research Board (HRB) and during the screening process. The searches were conducted on 3–9 January 2023 and integrated as required over the following 3 months.

### 3.1 Review of reviews

The main purposes of this review were: (1) to identify relevant terminology for the main literature search, (2) to identify studies that might be included in the main search, (3) to identify named initiatives that might enrich the search strategy, (4) to provide some context for the broader literature search, and (5) to ensure that we do not duplicate existing research. The key concepts for the search were as follows.

**Place-based terms** in the title/author keywords/subject indexing

AND

**Drug/drug use terms** in the title/author keywords/subject indexing

AND

**Review terms**

This literature search was carried out using databases that were likely to yield review studies such as systematic reviews or meta-analyses, namely: (1) MEDLINE/PubMed; (2) Cochrane Library; (3) Campbell Library; and (4) Epistemonikos. The search terms for the MEDLINE/PubMed search are shown in Table 3.1; these were largely informed by the HRB evidence brief entitled *Place-based initiatives to improve health and well-being outcomes in deprived communities* (Keane *et al.* 2022). Equivalent searches were carried out using other databases (see Appendix A), and led to the identification of 712 records. Following deduplication and screening by one reviewer (JG) to remove obviously irrelevant records, 119 reviews were screened for relevance by a second reviewer on title and abstract (JP) using Rayyan software (Ouzzani *et al.* 2016).

**Table 3.1: Results of the searches for reviews dealing with place-based interventions**

Database	URL	Date of search	Number of records retrieved	Number of records loaded to EndNote	Duplicates/ineligible reviews removed	Number of records assessed for relevance
PubMed	<a href="https://www.ncbi.nlm.nih.gov/">https://www.ncbi.nlm.nih.gov/</a>	3/1/2023	549	549	483	66
Cochrane Library	<a href="https://www.cochranelibrary.com/">https://www.cochranelibrary.com/</a>	9/1/2023	64	1	1	0
Campbell Library	<a href="https://onlinelibrary.wiley.com/journal/18911803">https://onlinelibrary.wiley.com/journal/18911803</a>	9/1/2023	70	16	8	8
Epistemonikos	<a href="https://www.epistemonikos.org/">https://www.epistemonikos.org/</a>	9/1/2023	120	120	101	19
Records identified from HRB documents	–	10/1/2023	17	17	0	17
Records identified from other documents	–	Spring 2023	9	9	0	9
<b>Total</b>			<b>829</b>	<b>712</b>	<b>593</b>	<b>119</b>

After screening on title and abstract, we identified 11 studies as potentially relevant (see Appendix B; after each record we indicate the outcome of the full-text screening process: (1) eligible; (2) does not deal with drug-related threats and harms; (3) does not relate to place-based initiatives; (4) not a systematic review or meta-analysis).

We defined the eligibility criteria for full-text screening as follows:

- » **Population:** small areas, recognisable communities, neighbourhoods, localities, places, local areas or residential districts, even where these do not have precisely defined boundaries.
- » **Intervention:** at least one of the following kinds of intervention in the context of drug-related problems: prevention, education, treatment, harm reduction, family support, policing, crime reduction, recovery (excluding interventions to address alcohol or tobacco-related harms, which were not part of the terms of reference).
- » **Themes:** any theme relating to place-based initiatives such as scope, potential, targeting, enabling factors, obstacles, impacts, effectiveness, community involvement, funding, governance, etc.
- » **Study design:** systematic review or meta-analysis.

The following four publications were deemed to meet the eligibility criteria:

1. Flanagan SK, Varga SM, Zaff JF, Margolius M, Lin ES (2018). *Comprehensive Community Initiatives: The Impact on Population-Level Children, Youth, and Family Outcomes*. New York: Weiss Institute.
2. Hutchison M, Russell BS (2021). Community coalition efforts to prevent adolescent substance use: a systematic review. *Journal of Drug Education*, 50(1–2): 3–30. <https://doi.org/10.1177/00472379211016384>
3. Nagorcka-Smith P, Bolton KA, Dam J, Nichols M, Alston L, Johnstone M, Allender S (2022). The impact of coalition characteristics on outcomes in community-based initiatives targeting the social determinants of health: a systematic review. *BMC Public Health*, 22(1): 1358. <https://bmcpublichealth.biomedcentral.com/articles/10.1186/s12889-022-13678-9>
4. Stockings E, Bartlem K, Hall A, Hodder R, Gilligan C, Wiggers J, Sherker S, Wolfenden L (2018). Whole-of-community interventions to reduce population-level harms arising from alcohol and other drug use: a systematic review and meta-analysis. *Addiction*, 113(11): 1984–2018. <https://doi.org/10.1111/add.14277>

**Flanagan et al. (2018)** searched ERIC, PAIS International, PsycARTICLES, PsycBOOKS, PsycINFO, PsycTESTS, Social Services Abstracts, Sociological Abstracts, Dissertation Abstracts, and PubMed, as well as manually searching relevant websites. They confined their attention to publications relating to programmes that targeted young people and their families in the USA over the period 1990–2017, and used terms like “community collaboration”, “community coalition”, and “collective impact”. Although they were not primarily interested in substance use, most of the documents they included relate to this area. Included studies had either an experimental (randomised control trial) or quasi-experimental design with a matched comparison group. They identify 25 publications (out of 1,900 records) relating to five initiatives: CTC; PROSPER; Kentucky Incentives for Prevention; New Directions; and the SAMHSA–Center for Substance Abuse Prevention (CSAP) Community Partnership Program. There are some overlaps with our main search relating to studies of CTC and PROSPER from the period 2013–2017 (namely Hawkins et al. 2014; Oesterle et al. 2014; Oesterle et al., 2015; Van Horn et al. 2014). This is the systematic review that proved to be closest to the terms of reference of the present project. By including studies published after 2017, considering countries other than the USA, and by including a range of research designs, we can provide a richer and more complete overview of place-based initiatives at the international level.

**Hutchison and Russell (2021)** searched MEDLINE/PubMed, PsycINFO, and Scopus to identify studies published between 1997 and 2020, using the keywords “community”, “coalition”, “substance (mis)use”, “alcohol (mis)use”, “prevention”, and “intervention”. Eligible records are related to community coalitions and are in English. This yielded 1,435 articles, of which 1,027 were excluded because they were duplicates or due to a lack of focus on prevention in the context of substance use. After screening on abstract, another 388 articles were excluded because they did not relate to adolescents. After screening on full text, four articles were excluded, yielding a final sample of 16 eligible records, including nine experimental trials, seven of which draw data from the multisite Community Youth Development Study (CYDS) as a part of the CTC programme. The authors define community coalitions as a tool for implementing community-based prevention interventions, which bring together stakeholders such as families, business owners, educators, law enforcement, and policymakers using some kind of local infrastructure. Two of the included studies also satisfied our eligibility criteria (namely Shapiro *et al.* 2013; Shapiro *et al.* 2015). After Flanagan *et al.* (2018), this was the second most relevant review that we identified.

**Nagorcka-Smith *et al.* (2022)** searched six electronic databases (MEDLINE, Embase, Global Health, Informit Health Collection, SocINDEX, and Cochrane Library) to identify peer-reviewed studies that analysed the relationship between coalition characteristics and outcomes in community-based initiatives to tackle the social determinants of health published between 1980 and 2021. Eligible studies relate to whole-of-community interventions which seek to prevent or reduce population-level harms arising from alcohol or illicit drugs, involving more than one community-based setting (e.g. schools, sports clubs, healthcare, services, hospitals, police and criminal justice system, local businesses, media, and workplaces) within a specific geographical area, employing any parallel comparison group. The searches yielded 5,970 unique records, 63 of which were found to be eligible. Most of these involved cluster randomised controlled trials targeting substance use among adolescents (mainly alcohol). Four studies collected data on 12-month prevalence of illicit drug use, two of which were pooled using meta-analysis. None of the studies met our eligibility criteria, mainly because the review does not focus specifically on drug-related harms.

**Stockings *et al.* (2018)** searched CENTRAL, Embase, MEDLINE, MEDLINE In-Process, and PsycINFO for trials with parallel comparison groups, relating to interventions in two or more community settings targeting alcohol or other drug use as well as related harms. The aim of the review is to estimate the effectiveness of whole-of-community interventions in reducing population-level harms arising from alcohol or other drug use. The search retrieved 10,112 articles, and 63 studies met the inclusion criteria. Data were pooled using random-effects inverse-variance meta-analysis. None of the included studies meet our eligibility criteria, either because they were published before 2013, focused on alcohol or were carried out in a developing country.

Recapitulating, Flanagan *et al.* (2018) confine their attention to the USA and their observation window terminates in 2017. Hutchison and Russell (2021) focus on all kinds of community coalitions, although their review looks mainly at CTC (Shapiro *et al.* 2013). Nagorcka-Smith *et al.* (2022) review studies of community coalitions, looking at their impact on the social determinants of health. Although their remit includes illicit drug use, they do not focus specifically on the role of place or neighbourhood. Finally, Stockings *et al.* (2018) link community coalitions and substance-related harms in a review that is more similar in focus to our own study. However, many of the publications they include focus on alcohol and some relate to countries not included in our review. They nevertheless cite some studies relating to PROSPER and the CTC programme which are outside our window of observation.

As a whole, the reviews underline the difficulties involved in surveying the literature and applying appropriate definitions and criteria. We now summarise their key findings, as they relate to place-based initiatives. We first present the evidence on evaluating impacts, before synthesising their findings in relation to local actors and communities.

## Evaluating impacts

Flanagan *et al.* (2018) summarise the evidence on programme impacts. They conclude that place-based initiatives have demonstrably delayed initiation and reduced frequency of use across an array of drugs, particularly in the case of the CTC and PROSPER initiatives. They present a useful thematic review which leads them to identify the following key processes: collaborative governance (to facilitate a diverse range of perspectives and improve decision-making), comprehensive planning (collecting data, identifying needs and strengths, and developing a theory of change), resources and sustainability (availability of external funding and additional human resources), evidence-based prevention programming, monitoring, and constantly seeking to improve initiatives and interventions.

Hutchison and Russell (2021) note that community coalitions have demonstrated some positive effects in reducing substance use (four of the studies reported significant impacts on adolescent drug use).

Nagorcka-Smith *et al.* (2022) report significant associations between a wide range of coalition characteristics and outcomes, the main factors being resources, formalisation of coalition structure, member engagement, quality of leadership, use of strategic plans, and internal cohesion. These factors echo some of the factors cited by Flanagan *et al.* (2018). However, the authors underline a number of methodological weaknesses and lack of assessments in relation to key outcomes.

Stockings *et al.* (2018) observe that the interventions in their review appear to have little impact on the prevalence of substance use. Like Nagorcka-Smith *et al.* (2022), they highlight difficulties in relation to research design and data, underlining the need for well-designed studies which use longitudinal data to study substantively important population-level impacts. As we will see, some recent publications not covered by these reviews help to clarify these issues.

## Role of local actors

Flanagan *et al.* (2018) describe the role of local actors in place-based initiatives. For example, CTC seeks to involve community leaders who control resources – mayors, police chiefs, school superintendents, faith and business leaders – to create a cross-sector community coalition. In PROSPER, community strategic teams were rooted in the educational infrastructure, including a university-affiliated convener, school personnel, district-level educational personnel, and local service providers.



Hutchison and Russell (2021) argue that successful substance use prevention coalitions focus on community-level risk factors while working to increase access to effective treatment. Effective programmes use evidence-based interventions, with the provision of technical assistance leading to better performance.

Nagorcka-Smith *et al.* (2022) note that greater diversity in the composition of community coalitions tends to lead to more frequent conflicts, which bring with them a series of risks. However, diversity is important for innovation and local representation, suggesting that the structure of coalitions is likely to involve a delicate balance between these different goals. As far as community member involvement is concerned, they note that this raises difficulties, pointing to negative correlations between involvement and positive change on outcome variables in some studies.

To conclude, these four reviews highlight the need for further research on coalition formation, governance, and dynamics, which appear to be important independent variables in the context of place-based initiatives. As far as our first research question is concerned – associations between the characteristics of places and drug-related threats – the four reviews adopt a similar position, which is rooted in the risk and protective factors approach. Flanagan *et al.* (2018) refer to risk factors such as favourable attitudes towards drug use (in the family, community, and among peers), low commitment to school, antisocial behaviour, parental skills, and community disorganisation. The negative influence of these characteristics is counteracted by protective factors, such as social skills, commitment to school, attachment skills, opportunities for prosocial engagement at school and with peers, and rewards for prosocial behaviour at school.

Hutchison and Russell (2021) observe that successful community coalitions focus on reducing drug use at the individual level, but also tackle community-level risk factors. Nagorcka-Smith *et al.* (2022) and Stockings *et al.* (2018) do not discuss drug-related risk factors in relation to communities. All four reviews provide little information on our second research question, which relates to the criteria used to select locations for place-based initiatives. As we will show in Chapter 4, this issue has not received sufficient attention in the literature.

After a careful reading of these four reviews, we identified the following key terms for our main search: community coalition, community partnership, community plan, community action, community-based approach, community engagement, whole-of-community approach, coalition-based intervention, and comprehensive community initiative. We also identified a number of named programmes that are potentially relevant: Strategic Prevention Framework, CTC, PROSPER, Project Lazarus, Kentucky Incentives for Prevention, New Directions, and the Community Partnership Program. Through manual web searching, we identified some other initiatives: Drug-Free Communities, Sure Start Local Programme, HEALing Communities Study (HCS), Communities First, and the Icelandic Prevention Model (IPM). These terms were integrated into our database searches to improve our ability to identify relevant documents.

## 3.2 Extensive literature search

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We now describe the search strategy used for our main review, starting with the eligibility criteria. As the research questions do not follow a standard PICO (Population, Intervention, Comparison, Outcome) structure, we set out the eligibility criteria using our own PITS headings (Population, Intervention, Themes, Study design).

### A. Population

The research questions refer to populations which are defined by identifiable geographical boundaries, which we refer to as communities or neighbourhoods. It is not necessary for the boundaries to be precisely identified as long as the spatial focus of the intervention is clear. Studies which do not adopt an area-based approach – including those which use the term ‘community’ to refer to a subgroup of the general population (e.g. African Americans) – are excluded.

### B. Intervention

Eligible interventions include some combination of prevention, treatment, harm reduction, and recovery programmes, as long as these are implemented with a view to tackling drug-related threats in a specific place. Interventions which relate to any form of problem drug use or drug-related harm are potentially eligible, while initiatives that only tackle alcohol-related or tobacco-related harms, or those associated with legitimate use of prescribed drugs, are excluded by the terms of reference.

### C. Themes

Following the terms of reference, studies that explore any of the following themes can potentially be included:

- » The design of place-based initiatives to address drug-related threats
- » The scope and potential of place-based initiatives
- » The identification of areas for interventions
- » Strengths and weaknesses of place-based programmes
- » Key elements and enabling factors
- » Involving local communities and stakeholders in design and delivery
- » The evaluation of place-based programmes and projects
- » Effectiveness of place-based interventions in terms of reducing threats and harms.

## D. Study design

Qualitative, quantitative, and mixed methods research designs are all eligible for inclusion. Studies can use quantitative designs such as randomised controlled trials or quasi-experimental methods, as well as qualitative designs that rely on narrative research, ethnographic methods, or interviews. Case reports restricted to a single person, non-systematic reviews, and commentaries are excluded, in line with standard practice. All relevant systematic reviews and meta-analyses are discussed in our review of reviews (see Section 3.1).

## E. Year of publication

Studies published in the period between 2013 and 2023 are considered eligible for inclusion, ensuring that the evidence presented is up-to-date.

## F. Countries and languages

Only documents published in English are considered, and the research is confined to studies carried out in the European Union (EU), USA, Canada, and Australia. This is to limit the heterogeneity of settings and to ensure that the results are as relevant as possible to the Irish context.

## 3.3 Search strategy

There are three main components to the search, which can be summarised as follows:

*Drug-related threats AND Communities AND Interventions*

There is no standard vocabulary for expressing these concepts in the scientific literature and each concept yields a large volume of information. Most of the terms associated with these concepts can be used in multiple contexts. For example, “community-based” is often used to refer to outpatient services; the term “local” sometimes refers to a whole city or county; “substance use” is employed in studies of tobacco or alcohol use. For these reasons, we adopted a multistrand search using different combinations of concepts.

Based on a series of scoping searches, we developed the following search for the large bibliographical databases (MEDLINE and Embase):

- » **Strand 1:** relevant “named” programmes
- » **Strand 2:** location (**Concept A**) AND intervention (**Concept B**) AND drug use (**Concept C**)
- » **Strand 3:** community involvement AND **Strand 2, Concept C**
- » **Strand 4:** family resource, crime, harm reduction AND (**Strand 2, Concept A** OR community phrase)

Then:

- » Combine the results of the strands.
- » Limit the results to publications in English.
- » Remove letters, editorials, posters, commentaries, etc.

The literature search was undertaken using the following databases between 25 January 2023 and 2 February 2023 (see Appendix C for details):<sup>1</sup>

Embase

Cochrane Library: Cochrane Database of Systematic Reviews

Cochrane Library: CENTRAL database

Social Care Online Database

Social Sciences Citation Index

Social Services Abstracts – searched within Sociological Abstracts

Sociological Abstracts

Scopus Database

Criminal Justice Abstracts

HRB National Drugs Library

LitSense

Semantic Scholar

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1. We initially planned to search the Social Policy and Practice Database and Policy Commons; however, they were not available/functional on the days we conducted the search.

We also searched a number of websites, identified using expert knowledge and the results of previous studies (see Table 3.2 in Section 3.4). These searches relied on a preselected set of terms, as follows (for websites with no search options we screened each page, or all relevant pages):

Place-based

Placebased

Area-based

Areabased

Mersey model

Icelandic model

Healing communities

Drug task force

Hotspots

Grassroots

Drugs task force

Drug project

Recovery community

Recovery communities

Recovery capital

Community assets

Local initiative

Local intervention

### **3.4 Results of database searches**

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Including all databases and sources, our main literature search yielded 40,929 records (see Table 3.2). Some records were screened online, with the result that a total of 39,052 were downloaded. As we observed previously, the complexities inherent in this topic compelled us to carry out a large amount of screening in order to achieve satisfactory coverage of the literature.

**Table 3.2: Results from extensive literature search**

Resource	URL
Embase	<a href="https://www.embase.com">https://www.embase.com</a>
Cochrane Library: Cochrane Database of Systematic Reviews	<a href="https://www.cochranelibrary.com/">https://www.cochranelibrary.com/</a>
Cochrane Library: CENTRAL database	<a href="https://www.cochranelibrary.com/">https://www.cochranelibrary.com/</a>
Social Care Online Database	<a href="https://www.scie-socialcareonline.org.uk/">https://www.scie-socialcareonline.org.uk/</a>
Social Policy and Practice Database	Database not available
Social Sciences Citation Index	<a href="https://www.webofscience.com/wos/woscc/basic-search">https://www.webofscience.com/wos/woscc/basic-search</a>
Social Services Abstracts – searched within Sociological Abstracts	<a href="https://www.proquest.com/">https://www.proquest.com/</a>
Sociological Abstracts	<a href="https://www.proquest.com/">https://www.proquest.com/</a>
Scopus Database	<a href="https://www.scopus.com">https://www.scopus.com</a>
Criminal Justice Abstracts	<a href="https://www.ebsco.com/">https://www.ebsco.com/</a>
Policy Commons	<a href="https://policycommons.net/">https://policycommons.net/</a>
HRB National Drugs Library	<a href="https://www.drugsandalcohol.ie/">https://www.drugsandalcohol.ie/</a>
LitSense	<a href="https://www.ncbi.nlm.nih.gov/research/litsense/">https://www.ncbi.nlm.nih.gov/research/litsense/</a>
Semantic Scholar	<a href="https://www.semanticscholar.org">https://www.semanticscholar.org</a>
US National Institute of Drug Abuse (NIDA)	<a href="https://www.drugabuse.gov/">https://www.drugabuse.gov/</a>
US SAMHSA	<a href="https://www.samhsa.gov/">https://www.samhsa.gov/</a>
Addictions Centre at King's College London	<a href="https://www.kcl.ac.uk/ioppn/depts/addictions/index">https://www.kcl.ac.uk/ioppn/depts/addictions/index</a>
Action on Addiction	<a href="https://www.actiononaddiction.org.uk/">https://www.actiononaddiction.org.uk/</a>
Scottish Drugs Forum	<a href="http://www.sdf.org.uk/">http://www.sdf.org.uk/</a>
Wales Council for Voluntary Action (WCVA, formerly Participation Cymru)	<a href="https://wcva.cymru/influencing/engagement/">https://wcva.cymru/influencing/engagement/</a>
Pompidou Group	<a href="https://www.coe.int/en/web/pompidou">https://www.coe.int/en/web/pompidou</a>
Addiction Policy Forum	<a href="https://www.addictionpolicy.org/">https://www.addictionpolicy.org/</a>
Civil Society Involvement in Drug Policy	<a href="https://csidp.eu/">https://csidp.eu/</a>
Correlation – European Harm Reduction Network	<a href="https://www.correlation-net.org/">https://www.correlation-net.org/</a>
INPUD (International Network of People who Use Drugs)	<a href="https://www.inpud.net/">https://www.inpud.net/</a>
UISCE (Union for Improved Services, Communication and Education)	<a href="https://myuisce.org/">https://myuisce.org/</a>
Drugs.ie – Health Service Executive drug and alcohol information	<a href="https://www.drugs.ie/">https://www.drugs.ie/</a>
Merchants Quay Ireland	<a href="https://mqi.ie/">https://mqi.ie/</a>
CityWide Drugs Crisis Campaign	<a href="https://www.citywide.ie/">https://www.citywide.ie/</a>
Dublin North, North East Recovery College	<a href="https://recoverycollege.ie/">https://recoverycollege.ie/</a>
Ballymun Local Drugs Task Force	<a href="http://ballymunlocaldrugstaskforce.ie/index">http://ballymunlocaldrugstaskforce.ie/index</a>

	Date searched	Number of records identified	Number of records downloaded	Number of records after deduplication	Number of duplicates
	25/1/23	8,608	8,608	8,413	195
	25/1/23	15	15	1	14
	25/1/23	941	941	487	454
	25/1/23	1,468	1,468	1,172	296
	30/1/23	16,137 (in 17 files)	16,137	13,235	2,902
	1/2/23	N/A	N/A	N/A	N/A
	1/2/23	2,931	2,931	1,185	1,746
	31/1/23	7,086	7,086	2,002	5,084
	2/2/23	1,152	1,152	119	1,033
Export function not working					
	31/1/23	642	642	397	245
	29-30/4/23	700	21	7	14
	26-27/7/23	737	9	0	0
	1/2/23	75	5	5	0
	1-2/2/23	162	9	9	0
	2/2/23	20	0	0	0
	2/2/23	0	0	0	0
	19/4/23	2	2	2	0
	17/4/23	211	1	1	0
	17/3/23	0	0	0	0
	17/3/23	10	10	10	0
	17/3/23	0	0	0	0
	17/3/23	8	8	8	0
	17/3/23	0	0	0	0
	17/3/23	12	0	0	0
	18/4/23	6	1	1	0
	18/4/23	1	1	1	0
	18/4/23	2	2	2	0
	19/4/23	0	0	0	0
	7/2/23	0	0	0	0

Resource	URL
Ballyfermot Local Drug and Alcohol Task Force	<a href="https://ballyfermotldatf.ie/">https://ballyfermotldatf.ie/</a>
Blanchardstown Local Drug and Alcohol Task Force	<a href="https://www.blanchardstowndrugtaskforce.ie/">https://www.blanchardstowndrugtaskforce.ie/</a>
Bray Local Drug and Alcohol Task Force	<a href="https://countywicklowppn.ie/represent/committees/bray-local-drug-alcohol-task-force/">https://countywicklowppn.ie/represent/committees/bray-local-drug-alcohol-task-force/</a>
Canal Communities Local Drug and Alcohol Task Force	<a href="https://ccras.ie/aims/">https://ccras.ie/aims/</a>
Clondalkin Drug and Alcohol Task Force	<a href="https://www.clondalkindrugtaskforce.ie/">https://www.clondalkindrugtaskforce.ie/</a>
Cork Local Drug and Alcohol Task Force	<a href="https://www.corkdrugandalcohol.ie/">https://www.corkdrugandalcohol.ie/</a>
Dublin 12 Local Drugs and Alcohol Task Force	<a href="https://www.dublin12ldatf.ie/">https://www.dublin12ldatf.ie/</a>
Dublin North East Drugs and Alcohol Task Force	<a href="https://dnetaskforce.ie/">https://dnetaskforce.ie/</a>
Dun Laoghaire Rathdown Drug and Alcohol Task Force	<a href="https://dlrdatf.ie/">https://dlrdatf.ie/</a>
East Coast Regional Drugs and Alcohol Task Force	<a href="https://ecrdatf.ie/">https://ecrdatf.ie/</a>
Finglas Cabra Local Drug and Alcohol Task Force	<a href="https://finglascabraldtf.ie/">https://finglascabraldtf.ie/</a>
Mid-West Regional Drugs and Alcohol Task Forum	<a href="https://www.mwrdatf.ie/">https://www.mwrdatf.ie/</a>
Midland Regional Drug and Alcohol Task Force	<a href="https://www.mrdatf.ie/">https://www.mrdatf.ie/</a>
North Dublin Regional Drug and Alcohol Task Force	<a href="https://ndublinrdtf.ie/">https://ndublinrdtf.ie/</a>
North Eastern Regional Drug and Alcohol Task Force	<a href="https://nedrugtaskforce.ie/">https://nedrugtaskforce.ie/</a>
North Inner City Drugs and Alcohol Task Force	<a href="http://www.nicdatf.ie/">http://www.nicdatf.ie/</a>
Northwest Regional Drug and Alcohol Task Force	<a href="https://nwdrugtaskforce.ie/">https://nwdrugtaskforce.ie/</a>
South East Regional Drug and Alcohol Task Force	<a href="http://www.serdatf.ie">http://www.serdatf.ie</a>
South Inner City Drugs and Alcohol Task Force	<a href="https://www.facebook.com/SICLDATF/">https://www.facebook.com/SICLDATF/</a>
South Western Regional Drugs and Alcohol Task Force	<a href="http://swrdatf.ie/">http://swrdatf.ie/</a>
Southern Regional Drug and Alcohol Task Force	<a href="https://www.srdatf.ie/">https://www.srdatf.ie/</a>
Tallaght Drug and Alcohol Task Force	<a href="https://tallaghtdatf.ie/">https://tallaghtdatf.ie/</a>
Western Region Drug and Alcohol Task Force	<a href="https://www.wrdatf.ie/">https://www.wrdatf.ie/</a>
<b>Total</b>	



	<b>Date searched</b>	<b>Number of records identified</b>	<b>Number of records downloaded</b>	<b>Number of records after deduplication</b>	<b>Number of duplicates</b>
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	1	1	1	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	2	2	2	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
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	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
	7/2/23	0	0	0	0
		<b>40,929</b>	<b>39,052</b>	<b>27,060</b>	<b>11,983</b>

## 3.5 Screening

The records identified during the searches were loaded into EndNote<sup>2</sup> and deduplicated against each other and against the results of the review searches described in Section 3.1, leaving 27,060 documents. Obviously irrelevant records (because of their subject area or another characteristic) were removed by one reviewer (JG) in EndNote, leaving 3,406 records.

### Double independent screening of titles and abstracts

Following deduplication and rapid screening, the records were uploaded to Rayyan<sup>3</sup> and two reviewers (JP and PK) independently screened each record using information from the title and abstract. A high level of agreement between the two reviewers was obtained through training and trials. The training process involved one induction session with the information retrieval specialist (JG), two trials using test datasets containing 70 records each, followed by discussion. By the end of this process, the reviewers had achieved an agreement rate of 95%; this percentage was exceeded during the subsequent screening process. Where there were differences in relation to specific records, the reviewers discussed these and agreed on a list of documents to be included in the next stage of screening. These differences arose, for example, due to differences of interpretation when applying the eligibility criteria. Out of the 3,406 records that were screened on title and abstract, 102 were retained as potentially relevant.

### Full-text screening of publications

The full electronic text of each potentially eligible document was acquired and assessed for eligibility by one reviewer (JP). After a decision had been taken, a reason for rejection was recorded for all excluded documents (see Appendix D). Following full-text screening, 32 documents were deemed eligible for inclusion.

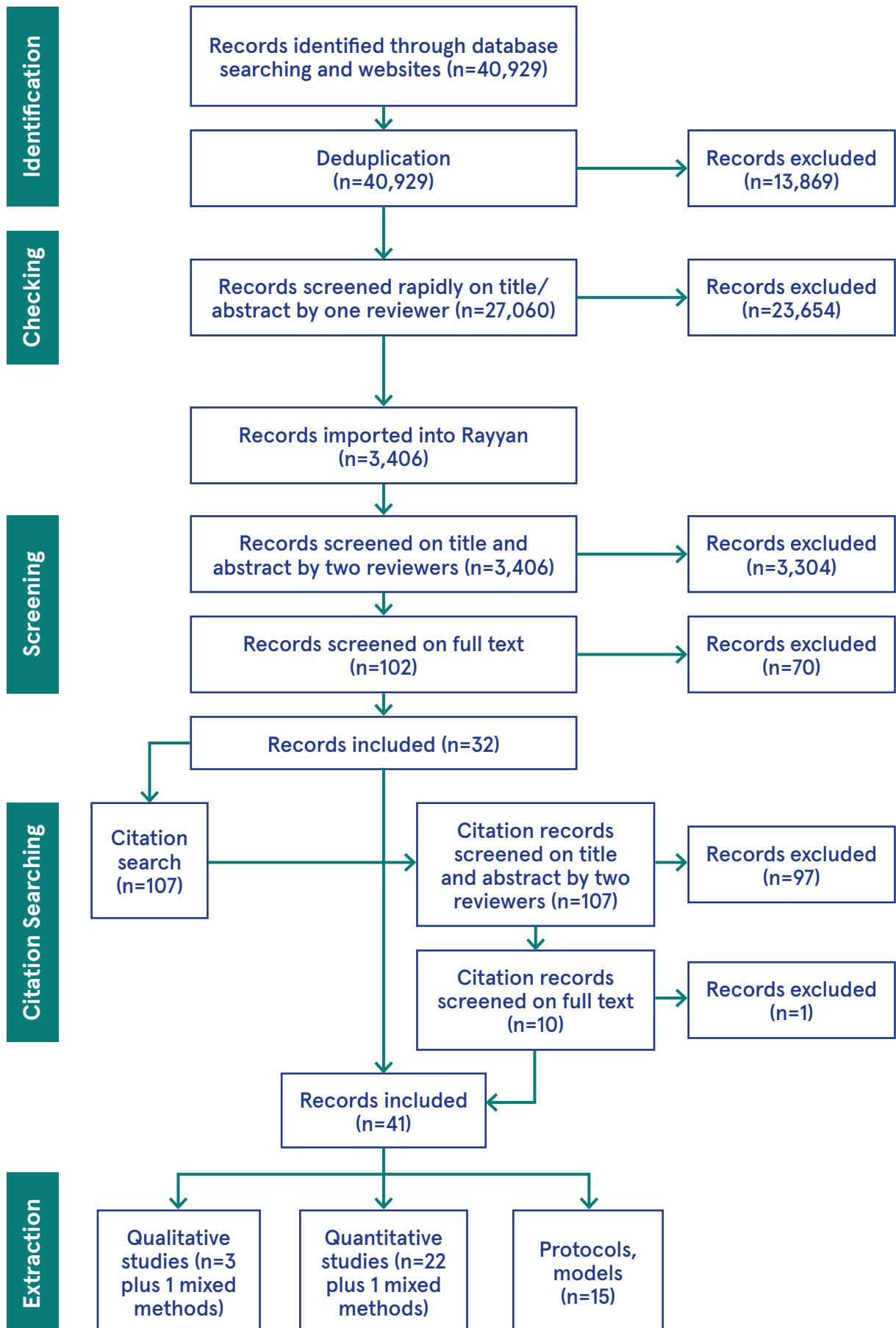
### Citation searches

Next, we carried out citation searches for the aforementioned list of eligible documents, after excluding those without digital object identifiers (DOIs). We used citationchaser (<https://estech.shinyapps.io/citationchaser/>) on 18 July 2023 to identify publications which had cited these articles or reports. This is an effective way of identifying recent publications and saturating coverage of this specific strand of research. This led to the identification of 107 publications not already in our database. These were screened as before on title and abstract, leading to the identification of 10 additional documents (see Appendix E). After full-text screening, only one was excluded, bringing the total number of eligible documents to 41. A PRISMA diagram depicting all aspects of the extensive search and screening process is shown in Figure 3.1.

2. EndNote (The EndNote Team 2013) is a stand-alone software programme for managing and analysing bibliographical references.

3. Rayyan is a collaborative, web-based tool for the management of literature review projects; see <https://www.rayyan.ai/> (Ouzzani *et al.* 2016).

Figure 3.1: PRISMA diagram of extensive search and screening process



## Risk of bias assessment

All eligible publications were assessed for risk of bias. This involved evaluating the quality and reliability of each study using a standardised tool with a view to identifying studies with a high risk of bias due to their design or implementation. We used three tools to carry out this assessment: CASP (for qualitative studies),<sup>4</sup> ROBINS-I (for quantitative observational studies),<sup>5</sup> and RoB 2 (for randomised controlled trials).<sup>6</sup> All publications contained enough information for this evaluation to be carried out, even where no results were presented (e.g. research protocols).

Following this assessment, each study was classified as having a low, moderate, or high risk of bias, in line with common practice in systematic reviews (e.g. O'Mara-Eves *et al.* 2015). As most studies of place-based initiatives are based on large well-funded trials, the research designs we reviewed were generally of high quality and had low risk of bias. Risk of bias is indicated in the discussion whenever citing results from potentially unreliable studies.

**Table 3.3: Synthesis of studies**

No.	Author/year/country/type	Intervention	Type of study	Study design
1	Crowley <i>et al.</i> (2014), USA, academic	PROSPER	Quantitative	Cluster randomised study of 28 school districts. Two 6th grade cohorts in 14 rural and small town school districts in Iowa and Pennsylvania were assigned to receive the intervention, with 14 control districts
2	Feinberg <i>et al.</i> (2022), USA, academic	PROSPER	Quantitative	Cluster randomised study of 28 school districts. This study assessed whether assignment to PROSPER in 6th grade promoted long-term resilience, using a sample of 223 parents from PROSPER, roughly one-half of whom were in the intervention sample
3	Osgood <i>et al.</i> (2013), USA, academic	PROSPER	Quantitative	Cluster randomised study of 28 school districts. A family-based intervention was offered in 6th grade and a school-based intervention was provided in 7th grade. Over 11,000 respondents provided five waves of data on friendship networks, attitudes, and behaviour in 6th–9th grades

4. The Critical Appraisal Skills Programme (CASP) (2018) is a 10-item checklist for assessing whether there is any risk of bias when summarising the results of qualitative research.

5. ROBINS-I (Risk Of Bias In Non-randomised Studies – Interventions) is a tool for evaluating risk of bias in quantitative research that does not rely on randomisation to allocate units to comparison groups (Sterne *et al.* 2016).

6. RoB 2 is the revised version of the Cochrane risk of bias tool for randomised trials, which was published in 2019 (Sterne *et al.* 2019).

We then constructed an evidence matrix by extracting information from the studies themselves, including location, intervention, type of publication, research design, analysis, and results (see Table 3.3 in Section 3.6). The documents in the table are grouped by initiative, as this is how they are analysed in the narrative and thematic syntheses presented in Chapters 4 and 5.

### Selecting and synthesising the research findings

Once we had identified the eligible studies, we carried out a narrative synthesis of the findings using the research questions listed in the Introduction to identify relevant material. The research questions were used to define a set of themes, and extracts dealing with these themes were identified through careful textual analysis. The narrative synthesis was based on a comparative analysis of these extracts, set against the backdrop of some broader issues that cut across many or all of the studies, which are discussed separately.

## 3.6 Eligible documents

Analysis	Results	Risk of bias
The authors estimated propensity and marginal structural models to take account of the likelihood of receiving a specific kind of intervention	Participation in a programme was associated with a reduction of 5.8–10.5% in the probability of having used prescription opioids for non-medical purposes by 12th grade. The incremental cost-effectiveness ratio ranged from USD 613 to USD 4,932	Low
Using multilevel models, PROSPER participants and their caregiving partners were modelled simultaneously but separately across multiple timepoints	There was no statistically significant group difference in marijuana use (the only substance considered)	Low
Network-specific bivariate regressions were used to estimate difference in centrality in relation to antisocial behaviour. Repeated measures were nested within schools, nested in districts, and nested in assignment pairs	PROSPER significantly reduced antisocial influence potential in adolescents' friendship networks. Antisocial youth tended to be less central in intervention communities than in control communities. Effect sizes for the significant effects were small	Low

No.	Author/year/country/type	Intervention	Type of study	Study design
4	Spoth <i>et al.</i> (2013), USA, academic	PROSPER	Quantitative	Cluster randomised study of 28 school districts
5	Spoth <i>et al.</i> (2017), USA, academic	PROSPER	Quantitative	Cluster randomised study of 28 school districts
6	Spoth <i>et al.</i> (2022), USA, academic	PROSPER	Quantitative	Cluster randomised study of 28 school districts
7	Bašić (2015), Croatia, academic	CTC	Mixed methods	Assessment of community readiness in intervention areas using a survey of 151 stakeholders and focus groups with 20 professionals
8	Brown <i>et al.</i> (2015), USA, academic	CTC	Quantitative	Longitudinal cross-lagged panel models were used to study 74 CTC coalitions in Pennsylvania
9	Chilenski <i>et al.</i> (2019), USA, academic	CTC	Quantitative	Quasi-experimental assessment of impacts in school districts in Pennsylvania in 2001–2011, during the natural dissemination of CTC
10	Gloppen <i>et al.</i> (2016), USA, academic	CTC	Quantitative	Baseline assessment took place among a cohort of youth during the autumn semester of 10th grade (ages 15–17 years) before intervention initiation. Surveys were conducted every 6 months until 6 months after high school graduation
11	Hawkins <i>et al.</i> (2014), USA, academic	CTC	Quantitative	Cluster randomised study of 24 communities

Analysis	Results	Risk of bias
Longitudinal multilevel models from post-test to 12th grade (6.5 years after baseline) were applied to analyse substance misuse outcomes and growth trajectories	Intervention main effects were significant for past-year marijuana use and past-year methamphetamine use. Relative reduction rates for most current use outcomes showed significant effects of 12% to 16% (higher for methamphetamine and inhalants). Stronger effects were observed for higher-risk students, and there was significantly slower growth in use among young people in PROSPER districts	Low
Examined intervention effects at age 19 using multilevel ANCOVAs with design factors for school district size and location, experimental condition, cohort, and state	Significant intervention effects were found for lifetime use of most illicit drugs: marijuana, cocaine, ecstasy, methamphetamine, LSD, and non-prescription narcotics. Relative reduction rates for significant binary outcomes favoured the intervention group in all instances, ranging from 9.4% (lifetime marijuana use) to 41.0% (lifetime meth. use)	Low
Multilevel models were used to assess effects of intervention at ages 23 and 25, including growth patterns, risk-related modification, longitudinal growth, and growth moderation effects across 10 waves, controlling for confounding variables	Lower levels of lifetime substance misuse were observed in the intervention group for methamphetamines, non-prescribed narcotics, and the Illicit Substance Use Index. However, there were mostly null findings for current substance use and frequency of substance use	Low
Using survey data and focus groups, the communities were assessed in terms of readiness for prevention	Implementation of CTC in Istria may have enhanced community readiness; established CTC communities are at a higher level of readiness compared with those just starting to prepare	High
The main parameter of interest relates to the standardised path estimate from earlier years of coalition functioning to later years of implementation support	All aspects of coalition functioning – self-reported coalition efficiency, leadership style, mobiliser skill, and sustainability planning – are significantly related to implementation support, but the reverse is not true	Low to medium
Repeated cross-sectional design with propensity score weighting at the school district level. Three-level models were used to estimate adjusted odds ratios (ORs)	CTC school districts had significantly lower levels of adolescent substance use. The effects were stronger when focusing on districts with evidence-based programmes (EBPs) (OR of 0.76 for past 30-day and 0.77 for lifetime marijuana use), compared with 0.85 if no EBPs were used. The OR for any lifetime drug use was 0.92	Low to medium
Participants in the Community Key Informant Survey	In 2011, CTC community leaders reported a significantly higher level of adoption of science-based prevention than those in control areas (OR=4.00, 95% confidence interval [CI] [2.51–5.49])	Low
A longitudinal panel of 4,407 students who completed the survey in waves 1 and 2	By spring of 12th grade, students in CTC communities were more likely than students in control communities to have abstained from any drug use (adjusted risk ratio [ARR] = 1.32; 95% CI, 1.06–1.63)	Low

No.	Author/year/country/type	Intervention	Type of study	Study design
12	Kuklinski <i>et al.</i> (2021), USA, academic	CTC	Quantitative	Cluster randomised study of 24 communities
13	Oesterle <i>et al.</i> (2015), USA, academic	CTC	Quantitative	Cluster randomised study of 24 communities
14	Oesterle <i>et al.</i> (2018), USA, academic	CTC	Quantitative	Cluster randomised study of 24 communities
15	Röding <i>et al.</i> (2021), Germany, academic	CTC	Research protocol	A quasi-experimental study in four states (42 communities) using a cluster non-randomised controlled trial based on a repeated cross-sectional and cohort design
16	Shapiro <i>et al.</i> (2013), USA, academic	CTC	Quantitative	Cluster randomised study of 24 communities
17	Steketee <i>et al.</i> (2013), the Netherlands, academic	CTC	Quantitative	Non-randomised study of CTC in 10 areas
18	Van Horn <i>et al.</i> (2014), USA, academic	CTC	Quantitative	Cluster randomised study of 24 communities
19	Asgeirsdottir <i>et al.</i> (2021), Lithuania, academic	IPM	Quantitative	Longitudinal observational study in three cities using repeated cross-sectional survey data (4 or 6 waves, depending on city)
20	Halsall <i>et al.</i> (2020), Canada, academic	IPM	Research protocol	A single case study based on mixed methods (social network analysis, practice profile, interviews, surveys)
21	Halsall <i>et al.</i> (2022), Canada, academic	IPM	Qualitative	Case study looking at the impact of IPM in a rural community (Lanark County)
22	Kristjansson <i>et al.</i> (2020a), Iceland, academic	IPM	Theoretical model	No formal analysis
23	Kristjansson <i>et al.</i> (2020b), Iceland, academic	IPM	Theoretical model	No formal analysis



Analysis	Results	Risk of bias
Analysed data collected 12 years after baseline (age 23) with generalised linear mixed models, including individual- and community-level covariates	In CTC communities, 41.7% of subjects abstained from illicit drugs, compared with 35.6% in control communities (p=0.01). CTC had a net present value of between USD 7,152 per participant (primary impacts) and USD 17,919 (primary and secondary impacts)	Low
Examined the effects of CTC 9 years after baseline using generalised linear mixed models, adjusting for adolescent and community characteristics and pre-intervention baseline measures of outcomes	CTC did not have a significant effect on frequency of current drug use	Low
Assessed the effects of CTC at 21 years of age using generalised linear mixed models with random intercepts, adjusting for individual, community, and baseline characteristics	For marijuana, the adjusted rate of sustained abstinence from marijuana was 36.4% in CTC communities and 28.8% in control communities (t=2.23), not significant	Low
-	-	Low
Used data collected from key community informants 1.5 years after implementation began to measure adoption of prevention science concepts. The weighted mean effect size across communities captures the overall difference	An overall effect size of 0.78 (Cohen's d, SE=0.21, p<0.001) suggests that CTC communities have significantly higher levels of adoption of a science-based approach to prevention	Low
Some 79 community leaders were surveyed, and degree of adoption of a science-based approach was estimated using a multilevel regression model	No evidence of a science-based approach to prevention being adopted to a greater extent in the CTC communities in the Netherlands, compared with control communities	Moderate
Examined profiles of adolescent substance use and delinquency in 8th and 10th grades, surveyed in 2004 and 2010 using a repeated cross-sectional survey design	No difference in the probability of belonging to drug-user latent class in CTC communities, compared with control communities for 8th and 10th grade students	Low
Cochran-Armitage test for linear trend in seven substance use variables; logistic regression models to relate prevention to substance use	Significant downward linear trends for amphetamine use in all cities and for cannabis use in Vilnius and Klaipėda	High
-	-	Moderate
Semi-structured interviews were carried out with nine members of the local steering committee, followed by thematic analysis	Upstream prevention approaches like IPM should build on existing initiatives and should be combined with a comprehensive strategy so that nobody is "left to drown"	Low
-	-	-
-	-	-

No.	Author/year/country/type	Intervention	Type of study	Study design
24	Meyers <i>et al.</i> (2023), Spain, academic	IPM	Quantitative	The authors use survey data for 15–16-year-olds in Tarragona in 2015 and 2019 to evaluate the assumptions of the IPM in the context of Catalonia
25	Western Region Drug and Alcohol Task Force (2020), Ireland, grey literature	IPM	Broad overview	No formal analysis
26	Aldridge <i>et al.</i> (2020), USA, academic	HCS	Research protocol	A multisite, parallel arm, cluster randomised, wait list-controlled trial in 67 communities in four states
27	Chandler <i>et al.</i> (2020), USA, academic	HCS	Research protocol	A multisite, parallel arm, cluster randomised, wait list-controlled trial in 67 communities in four states
28	Chandler <i>et al.</i> (2023), USA, academic	HCS	Quantitative	Describes a selection of interventions by community coalitions as a function of site, setting, and baseline opioid overdose death rate
29	Chen <i>et al.</i> (2023), USA, academic	HCS	Qualitative	Qualitative interviews with community coalition members from 56 communities with preexisting substance use coalitions (321 interviews). Purposive sampling prioritised relevant sectors Salut als Barris
30	Drainoni <i>et al.</i> (2022), USA, academic	HCS	Qualitative	The implementation science team in each state conducted a study involving 382 local stakeholders
31	Slavova <i>et al.</i> (2020), USA, academic	HCS	Research protocol	A multisite, parallel arm, cluster randomised, wait list-controlled trial in 67 communities in four states
32	Sprague Martinez <i>et al.</i> (2020), USA, academic	HCS	Research protocol	A multisite, parallel arm, cluster randomised, wait list-controlled trial in 67 communities in four states
33	Walsh <i>et al.</i> (2020), USA, academic	HCS	Research protocol	A multisite, parallel arm, cluster randomised, wait list-controlled trial in 67 communities in four states
34	Winhusen <i>et al.</i> (2020), USA, academic	HCS	Research protocol	A multisite, parallel arm, cluster randomised, wait list-controlled trial in 67 communities in four states
35	Corsaro and Brunson (2013), USA, academic	Pulling Levers	Quantitative	Non-randomised study of a single area

Analysis	Results	Risk of bias
Logistic regression models of main effects with and without time interactions; chi-square tests and Wilcoxon–Mann–Whitney U tests of association	The results suggest that the IPM assumptions regarding risk and protective factors and substance use outcomes are valid in Tarragona and are relatively stable over time, with the exception of organised recreational activities and sport	Low
–	–	–
–	–	Low
–	–	Low
Descriptive analysis using frequencies and percentages	All communities exceeded requirements, with 618 strategies, 453 more than the minimum. Active strategies to provide people with naloxone were preferred over passive strategies	Low
Interview transcripts were coded in NVivo to identify themes associated with the internal context of coalitions, using inductive thematic analysis	When coalitions originally formed, there was a misconception that the opioid problem affected primarily individuals who identified as White non-Hispanic. Most coalitions are now aware that that is not the case	Low
This paper draws on qualitative interviews with key local informants on substance use issues and existing community coalitions to provide information on HCS communities	Participants identified primary care, behavioural health, Suboxone, access to short-term and long-term treatment, aftercare services, and recovery housing as priorities for reducing opioid-related harms	Low
–	–	Low
–	–	Low
–	–	Low
–	–	Low
Change in neighbourhood crime was assessed using autoregressive integrated moving average (ARIMA) interrupted time series analysis, with monthly data from January 2006 to December 2010	No significant effects were found for disaggregated crime types (violent, property, drug, and disorder offences) or total calls for service between the pre- and post-intervention periods	High

No.	Author/year/country/type	Intervention	Type of study	Study design
36	Domínguez and Montolio (2021), Spain, academic	Salut als Barris [Health in the Neighbourhoods]	Quantitative	Non-randomised study of an intervention in 13 of 72 neighbourhoods in Barcelona
37	Palència <i>et al.</i> (2018), Spain, academic	Salut als Barris and other community programmes	Quantitative	Non-randomised study of interventions in neighbourhoods across Barcelona
38	Cantu <i>et al.</i> (2023), USA, academic	CCIM4C	Broad overview	No formal analysis
39	Dorton and Semien (2016), USA, academic	SCORE	Broad overview	No formal analysis
40	Komro <i>et al.</i> (2022), USA, academic	Cherokee Nation	Research protocol	A cluster randomised trial with one baseline and six follow-up surveys in 20 school districts; 3-year integrated multilevel intervention in schools and associated local communities
41	Wisdom <i>et al.</i> (2022), USA, academic	TMI	Broad overview	Descriptive analysis of changes associated with participating in certain programmes – more time is needed to evaluate outcomes

Analysis	Results	Risk of bias
The deployment sequence provides conditionally exogenous variation in timing of intervention (quasi-random roll-out), analysed using a difference-in-differences approach where the observational units are neighbourhood-year-month pairs, controlling for socioeconomic variables	The intervention was found to have no effect on drug-related crime in intervention neighbourhoods	Low
Poisson regression analysis using repeated cross-sectional geocoded survey data	Drug use remained stable in neighbourhoods without any interventions but decreased in neighbourhoods with strong community action for health (14.3% in 2001, 5.9% in 2011, multivariate PR: 0.48, 95% CI: 0.25–0.92)	Moderate to high
–	–	–
–	–	–
–	–	Low
Pre-post analysis of short-term effects on participants using two-tailed significance tests	Participants in training courses reported or demonstrated increased knowledge of trauma and its relationship with drug use, or acquired greater empathy. The 20 children receiving home visits had significantly lower strengths and difficulties questionnaire (SDQ) scores after 12 months	Moderate

# 4

## Description of place-based initiatives

In this chapter, we describe the initiatives that are discussed in the included studies. The most important of these are: (1) the PROMoting School-university-community Partnerships to Enhance Resilience (PROSPER) study, (2) the Communities That Care (CTC) study, (3) the Icelandic Prevention Model (IPM), and (4) the HEALing Communities Study (HCS). We identified six documents relating to PROSPER, 12 relating to CTC, seven relating to IPM, and nine relating to HCS. The other studies are much smaller, and we found just one publication, for example, relating to Pulling Levers, two relating to Salut als Barris, and one each for the Community Collective Impact Model for Change (CCIM4C), the Second Chance or Else (SCORE) programme, the Cherokee Nation trial, and The Martinsburg Initiative (TMI). Where information is available, we describe the theoretical frameworks that inform each of these initiatives in the following paragraphs.

### PROSPER

The PROSPER study began in 2002, with 28 communities located in small towns and rural areas of Iowa and Pennsylvania (USA). A total of 14 communities were initially identified in each state and assigned to the intervention, while the other 14 served as a comparison group. The study employed a cohort sequential design that included two successive cohorts of 6th graders (who would typically be 11–12 years old). Communities coincided with school districts, which were blocked on size and location, and then randomised to the intervention or control group (one district from each blocked pair was randomly assigned to receive the intervention and the other to serve as a control).

This place-based initiative relied on university staff, school district officials, and other stakeholders to implement a programme of family-focused and school-based prevention services. It was made possible by the Cooperative Extension System (CES), which is a feature of the “land-grant universities” in the USA. The theoretical assumptions guiding PROSPER are not described in any of the included publications.

In the PROSPER intervention communities, local teams led by CES educators were responsible for selecting, implementing, and evaluating evidence-based prevention programmes designed to reduce substance misuse and other problems among young adolescents. The reason for targeting this age group is as follows: “the early onset of substance use predicts the presence and severity of substance use disorders and problems in early adulthood – which itself represents the highest risk period for drinking and drug use over the life course” (Feinberg *et al.* 2022, p. 1265). Spoth *et al.* (2022) observe that young adults who exhibit substance misuse “may not transition into positive adult roles and are at risk for interpersonal difficulties, school dropout, early parenthood, and employment difficulties”.

The PROSPER community teams were led by CES educators and involved a representative of the local public school system as well as other stakeholders (e.g. community representatives and practitioners). They were expected to select two programmes from a list. In all cases, they chose the Strengthening Families Program (10–14 years), which is a seven-session programme for parents and children provided by paid facilitators. Families could choose whether to attend this evening programme or not. For the school-based programme, the teams chose one of three programmes, which were delivered by the class teacher. Average annual funding per team (across the 4 years of the programme) ranged from USD 3,485 to USD 34,357 in Pennsylvania, and from USD 2,421 to USD 19,612 in Iowa (Welsh *et al.* 2016). As Welsh *et al.* observe, the communities that participated were generally small, ethnically homogeneous, rural towns characterised by low levels of substance-related risk.

Chilenski *et al.* (2016a) describe the development of PROSPER teams, starting with the “organizational” phase, which typically lasted for 6–8 months. During this period, members were recruited to the team and basic operating procedures were put in place. During the “implementation” phase, team members focused on specific objectives. In the third phase, referred to as “sustainability”, implementation became more efficient and institutionalised. Prevention coordinators linked the community-level teams to the state/university level. Each community team was expected to have a scheduled meeting with a coordinator every second week, although the coordinator had more frequent, informal contacts with the team leader.

Kim *et al.* (2015a) identify four different levels of governance within PROSPER: (1) the community team; (2) the prevention coordinator team, which provided guidance to the community team; (3) the state management team (comprising university researchers and CES administrators); and (4) the network team, which provided technical assistance and evaluation services at state level. According to Brown *et al.* (2021), technical assistance for each local team did not exceed 25% of a full-time equivalent position.

PROSPER involves the provision of a universal intervention using a community-based partnership model, working primarily through local education and health-related systems. Although local providers of educational, health, and social services are an obvious choice for inclusion in local teams or coalitions, Spoth *et al.* (2013) point out that they do not automatically possess the necessary skills for implementing place-based interventions.

## Communities That Care

CTC was developed in the 1980s in the USA by J. David Hawkins and Richard F. Catalano to promote the use of tested, effective programmes for preventing problem behaviours among young people. This initiative is based on the assumption that the behavioural health of adolescents is influenced by their environment (including their family, school, and peer group). In order to reduce the risks associated with drug use among young people, it is necessary to secure the participation of all stakeholders who influence children's lives. CTC has its roots in prevention science, including both the risk and protective factor paradigm and the social development model:

*Communities That Care (CTC) is a prevention system that activates a coalition of stakeholders to develop and implement a science-based approach to prevention in the community to achieve collective impact on youth development community wide. The CTC prevention system seeks to achieve this goal by increasing the use of tested, effective preventive interventions that address risk factors for adolescent problem behaviors prioritized by the community. This is expected to produce community-wide reductions in targeted risk factors and, in turn, decreased adolescent substance use, delinquency, and violence. (Hawkins et al. 2014, p. 123)*

According to Fagan and Hawkins (2013), risk factors are characteristics of individuals, peer groups, families, schools, or communities "that increase the likelihood of becoming involved in delinquency, promotive factors directly reduce the likelihood of such behavior, and protective factors moderate the impact of risk factors on antisocial behaviors" (p. 278). Influential risk factors include low incomes, low education, favourable attitudes towards drug use, low self-control, negative peer behaviour, parental behaviour, rule-setting and monitoring of children, and community disorganisation. In addition to the USA, CTC has been implemented in Germany (Röding et al. 2021), the Netherlands (Steketee et al. 2013), and Croatia (Bašić 2015). The associations between specific risk/protective factors and drug use among young people have been found to be broadly comparable across countries (Haggerty and Shapiro 2013). Compared with PROSPER, CTC adopts a broader perspective on the community, considers a wider selection of interventions, and provides community coalitions with a stronger role.

The social development model sustains that young people need to participate in positive family, school, community, and peer environments in order to achieve positive outcomes. In particular, they need to be exposed to clear, shared and healthy behavioural standards. Young people are also described as needing strong bonds with caring adults. Haggerty et al. (2007) provide the following overview: "If we are to dramatically improve high school and college graduation rates for the nation's most disadvantaged youth, then we must create comprehensive strategies to effectively strengthen families and neighborhoods, and to promote healthy, prosocial bonds among youth, families, schools, and communities" (2017, p. 138). As many behavioural health problems are determined by shared risk and protective factors, interventions that tackle their social determinants can have positive effects across a range of outcomes.



Twenty-four communities located in seven US states (Colorado, Illinois, Kansas, Maine, Oregon, Utah, and Washington) participated in the CYDS, which tested the CTC intervention. These were small- and medium-sized towns with an average population of 14,646 people (Brown *et al.* 2014). Matched pairs of communities were formed within each state based on community-level demographic indicators, and one community from each pair was assigned randomly to receive the intervention or remain as a “prevention-as-usual” control. Community coalitions in each area implemented between one and five programmes each year, including universal school, family, and community programmes (Hawkins *et al.* 2014). By contrast with PROSPER teams, CTC coalitions do not always have the same structure and leadership.

Communities implementing CTC complete a five-phase training process that lasts several months. At the beginning, coalition members learn how to assess implementation fidelity and how to use data to make adjustments to local plans as needed. Although CTC targets all children and young people (aged 0–18 years), as well as their families, CYDS communities focused their plans on children aged 10–14 years so that any effects on drug use and delinquency would be observed within the 5-year study period. In the context of CTC, community-wide effects on risk and protection are expected to be observed within 2–4 years, and effects on youth outcomes within 4–10 years (Kuklinski *et al.* 2013, p. 371).

During the CYDS, data on adolescent drug use (and other behaviours) were gathered from 4,181 5th-grade public school students in the 24 participating areas using the Youth Development Survey (a self-administered, paper-and-pencil questionnaire designed to be completed in a 50-minute classroom session). CTC implementation began in the intervention communities in summer 2003 and funding ended 5 years later (spring 2008). Another difference between CTC and PROSPER is the use of epidemiological data at local level in CTC – collected and interpreted by the community coalition – to identify risk and protective factors requiring intervention.

The CTC intervention is characterised by local ownership, focused goals, a choice of evidence-based prevention programmes, an emphasis on high-quality implementation, evaluation of impacts, and technical support so that local communities can achieve their desired outcomes. Broad-based coalitions learn to identify risk and protective factors by participating in six workshops, where they are taught how to carry out a needs assessment to identify local levels of risk and protective factors (Gloppen *et al.* 2016):

*After key community leaders are oriented to the CTC model, they appoint a CTC prevention coalition composed of diverse stakeholder groups (e.g. human services, law enforcement, juvenile justice, education, business, youth recreation, media, and religious). The coalition receives training and technical assistance to identify elevated risk factors and depressed protective factors experienced by the community's youth population, select and implement prevention programs and policies that have been tested and found to be effective in a rigorous evaluation study that targets specific elevated risks, and monitor the implementation quality and the outcomes of their efforts. Implementation of evidence-based prevention programs and policies, through the work of the coalition, is hypothesized to lead to reductions in targeted community risks, improvements in community protection, and, ultimately, reductions in adolescent problem behaviors. (Brown *et al.* 2014, p. 626)*

CTC is based on: (1) a science-based approach to prevention (comprising a combination of public health and community mobilisation models), (2) collaborative prevention initiatives, (3) community support, (4) positive community norms regarding adolescent drug use, and (5) provision of opportunities for prosocial engagement. Each community involved must pass through five phases: (1) mobilisation of community leaders, (2) creation of a prevention board (and training of members), (3) identification of risk and protective factors at local level using epidemiological data, (4) selection of evidence-based prevention programmes; and (5) evaluation of effectiveness. Kuklinski *et al.* (2015) provide a useful summary of the challenges facing CTC communities:

*Community-based models typically rely on local coalitions to coordinate the implementation of multiple prevention strategies across agencies, and it can be very difficult to engage and ensure collaboration among diverse stakeholders who may have different skills, needs, resources, and ideas about what is needed ... In addition, ensuring the adoption and high-quality implementation of a single prevention strategy is difficult, and problems are likely to be multiplied when implementing several programs across a variety of settings ... Furthermore, enacting multiple programs and delivering them at a scale large enough and long enough to produce community-wide changes is likely to require significant human and financial resources, as well as longterm investments ... securing funds can be challenging, particularly if benefits may not be seen for many years. (p. 166)*

As mentioned above, CTC has also been implemented outside the context of the CYDS evaluation. Starting in 1995, public funding was made available to communities in Pennsylvania to implement CTC. Over the following 7 years, 127 neighbourhoods were given 3-year start-up funding to prepare a series of interventions. Applicants were free to define their own communities and no attempt was made to target resources at poorer neighbourhoods.

In 2009, CTC was transferred to Germany and has since been implemented in 33 communities. A database of German-language evidence-based prevention programmes has been developed for use with this initiative, and a feasibility study in Lower Saxony revealed a high level of acceptance and identification with the CTC approach in the selected communities (Röding *et al.* 2021). CTC has been implemented in more than 25 communities in the Netherlands (Steketee *et al.* 2013). One of the difficulties faced in the Netherlands is that there are only five evidence-based programmes (EBPs) which focus on treatment rather than prevention of antisocial behaviour among young people.

### **Icelandic Prevention Model**

The IPM uses a multicomponent, community-based participatory approach to identify and modify contextual risk and protective factors to reduce or prevent substance use among young people (Halsall *et al.* 2020). It was inspired by classical theories of social deviance in sociology and criminology and promotes the constructive use of time by young people to reduce unstructured time spent with peers in the absence of adult supervision. It seeks to strengthen the connections linking distinct microsystems (e.g. different families, families and schools, parents and peers) (Kristjansson *et al.* 2020a). It has attracted interest because of claims that it was responsible for a dramatic decline in substance use among Icelandic youth after the mid-1990s, when it was implemented throughout the country and due to the distinctive way in which it incorporates the social environment, community action, empowerment, bottom-up teamwork, and local resources.

Environmental interventions like the IPM aim to modify the contexts in which behaviour occurs, while developmental programmes aim to develop skills by working with individuals. We highlighted this important distinction in Chapter 2, as many place-based initiatives start by emphasising ecological, population-level determinants but end up focusing their attention on much narrower interventions that seek to modify individual behaviour, in line with established forms of prevention. By contrast, the IPM is firmly rooted in the bioecological approach and focuses explicitly on collective impacts:

*Although there is increasing recognition that programmatic interventions that focus on one issue will not be as effective as approaches that take a multi-level approach, there continues to be few models that actualize an ecological strategy. One exception is the IPM that has been developed and implemented on a national scale in Iceland. The IPM applies a community-based health promotion approach that places an ecological focus on developmental contexts to tailor system-level strategies to prevent substance use in youth. (Halsall et al. 2022, p. 2)*

The IPM emphasises the importance of monitoring young people, imposing rules (including curfews and strict rules on alcohol advertising and display, for example), intervening in relation to policing, street lighting, provision of leisure activities, and other issues of a collective nature. The primary unit of intervention is the neighbourhood, which is operationalised as a school district or catchment area (Kristjansson et al. 2020a). In terms of theoretical frameworks, the IPM is guided by the following five principles: (1) primary prevention, (2) community engagement, (3) use of high-quality, timely local data, (4) collaboration between researchers, policymakers, practitioners, and community members, and (5) aligning the scope of the solution with the nature of the problem (Kristjansson et al. 2020a).

A school survey provides data on risk and protective factors in relation to individual, family, peer, school, and community characteristics, as well as information on substance use, mental health, and well-being. Using these data, a local committee develops a strategic plan. A communication strategy is used to increase community awareness, while participation is encouraged by providing food, childcare, and transportation assistance for community meetings.

Implementation involves the following steps: (1) develop local coalition capacity, (2) identify local sources of funding, (3) community engagement and planning, (4) collection of population-level data on risk and protective factors, (5) enhance community engagement, (6) disseminate survey findings, (7) community-driven goal-setting, (8) align policy and practice with community goals, (9) exposure to healthier developmental contexts, and (10) repeat (Kristjansson et al. 2020b). These principles and steps were only formalised in 2020, although the IPM was initially implemented in Iceland from the mid-1990s. They thus represent an attempt to formalise and “manualise” the IPM as a place-based initiative, as local actors in other countries have expressed an interest in adapting it to their local context.

Like CTC, the IPM has been implemented in a number of countries, in collaboration with the Icelandic Centre for Social Research and Analysis (ICSRA) under the auspices of the Planet Youth platform. The Western Region Drug and Alcohol Task Force (WRDATF) introduced the Planet Youth model to Ireland in 2018 and the programme is being implemented in Galway, Mayo, and Roscommon (2018–2023). The IPM typically has high implementation costs associated with data collection, training courses, local facilitators (generally quantified as one full-time employee per area), community activities, provision of transportation, vouchers for structured leisure activities, and so on. Koning et al. (2021) note that the IPM vouchers alone cost more than most of the preventive programmes that have been developed in the USA.

Halsall *et al.* (2020) describe Planet Youth Lanark County (PYLC), a project which aims to export the IPM to a rural area of Canada. In its original context, the IPM did not involve young people themselves in the development and implementation of interventions. In Lanark County, this was viewed as a weakness; as a result, community nurses were asked to recruit students to a Youth Advisory Group, which was involved in all aspects of the intervention design and implementation. This led to a questioning of the more restrictive aspects of the programme (such as curfews), with young people arguing that it should focus on empowerment and individual decision-making, rather than imposing rules and restrictions. Halsall *et al.* (2023) note that while unstructured leisure time with peers is a well-known risk factor, “risky play” and “independent mobility” are potentially beneficial to children, promoting self-esteem, independence, and social skills. This implies that a careful balance must be struck when implementing place-based initiatives such as the IPM.

Another feature of the IPM in Lanark County, Canada, is that Steering Committee meetings are open to any community member who wishes to attend. This was considered important, as the promoters initially had to build acceptance for place-based models by explaining the benefits of ecological interventions. By doing so, they sought to capitalise on previous policies and programmes that included aspects of the IPM approach:

*...a key concern for PYLC was the communication of the importance of integrating prevention within an overall framework that includes harm reduction and intervention. Recognizing that partners commonly deal with significant needs and crises, it was often very difficult to shift conversations away from individual-focused interventions and to support population health initiatives that would complement the ongoing work in harm-reduction and substance use treatment. (Halsall et al. 2022, p. 7)*

This is an important issue, particularly in European countries which have well-developed local welfare systems with a mandate to address drug-related harms and threats (social workers, health centres, general practitioners (GPs), community nurses, community drug projects, etc.) (Steketee *et al.* 2013). These professionals are well-placed to contribute to place-based initiatives, but their training, organisational culture, and professional orientation may push them in the opposite direction. Rather than considering ecological/environmental determinants, these groups are accustomed to treating individual outcomes and may view place-based initiatives as a threat or distraction.

Meyers *et al.* (2023) draw on research in Spain to argue that the theoretical assumptions regarding the role of risk and protective factors in determining substance use initially developed in Iceland appear to be valid also in the case of Spain, and are relatively stable over time. Interestingly, however, they found that participation in organised recreational activities may not function as a protective factor in and of itself, in contrast with findings that have been reported for Iceland. A similar result was also reported by Asgeirsdottir *et al.* (2021) for Lithuania, in another study that describes implementation of the IPM outside Iceland.

## HEALing Communities Study

The HCS study is set against the backdrop of the opioid epidemic in the USA, which was declared a public health emergency in 2017. Opioid overdoses resulted in more than 750,000 deaths in the USA between 1999 and 2018 (Knudsen *et al.* 2020). This epidemic was initially characterised by deaths due to prescription opioids, which were quickly overtaken by heroin-related deaths and fentanyl overdoses (Chandler *et al.* 2020; Ciccarone 2019). Between February 2021 and February 2022, over 100,000 people in the USA died as a result of overdose. In recent years, the burden of opioid overdose deaths has expanded from rural areas to cities, involving a larger number of Black and Latino/a people (Chandler *et al.* 2020; Chen *et al.* 2023; Walsh *et al.* 2020). Minority populations in the USA have suffered disproportionately from drug-related harms for decades:

*...since the 1960's, a less well publicized and often neglected opioid crisis has been underway in the U.S., driven largely by heroin use in primarily urban areas and disproportionately impacting minority populations. (Walsh et al. 2020)*

In 2019, the National Institutes of Health (NIH) announced that they would invest more than USD 350 million to support HCS as part of the HEAL (Helping to End Addiction Long-term) Initiative, a trans-agency effort. HCS is jointly supported by the NIH and SAMHSA. It is an ambitious programme, involving the coordinated implementation of interventions across several organisations in target communities. It promotes the use of evidence-based practices such as medical treatment for opioid use disorder (OUD) and easier access to naloxone to reduce opioid overdose mortality (Drainoni *et al.* 2022). In the US, as in many other countries, addiction treatment has often been isolated from medical and mental health care services, and is poorly integrated within the criminal justice system (Winhusen *et al.* 2020). Most Opioid Treatment Programs are located in urban communities, provide methadone only, and are not integrated into traditional healthcare settings (Walsh *et al.* 2020).

Community involvement is an important element of Communities That HEAL (CTH), as the programme aims to reach high-risk and underserved populations. Community engagement involves “working collaboratively with and through groups of people affiliated by geographic proximity, special interest, or similar situations to address issues affecting the well-being of those people”, and leads to the selection of more relevant interventions, drawing on the lived experience of community members (Sprague Martinez *et al.* 2020). A typical CTH coalition includes representatives from the health service, social care, criminal justice, and harm reduction sectors, together with representatives of private firms and patient groups (Sabounchi *et al.* 2022). At state level, Community Advisory Boards with representation from state agencies and HCS communities enhance the scope of the project and give these groups greater voice.

HCS did not initially have an explicit commitment to promoting racial equity. In fact, majority-White research teams, Community Advisory Boards, and coalitions were formed in several localities during the early stages of the project (Chatterjee *et al.* 2022). Efforts were subsequently made to tackle bias using Racial Equity and Social Justice (RESJ) Committees, particularly as the Black Lives Matter movement gained momentum. Chen *et al.* (2023) highlight similar issues in relation to HCS, drawing on 321 semi-structured interviews with community leaders. They observe that coalition leadership is predominantly White and drawn from groups which hold power within communities. The inclusion of stakeholders from different backgrounds, in terms of lived experience of OUD and racial diversity, poses considerable challenges. In some communities, the police played a leading role within coalitions, although the legacy of institutional racism within law enforcement made it difficult to recruit people from minority groups. They conclude that “lack of recognition of the role that systemic racism plays in the opioid epidemic and its affected populations increases the likelihood that coalitions implement ineffective and unsustainable initiatives” (Chen *et al.* 2023, p. 8).

The aim of HCS is to ascertain whether a 4-year, integrated, multi-pronged, evidence-based and place-based initiative represents an effective and cost-efficient response to the opioid epidemic. It involves an unblinded, multisite, parallel arm, cluster randomised, waiting list-controlled trial in 67 communities (towns, cities or counties) across four states (Kentucky, Massachusetts, New York, and Ohio) (Aldridge *et al.* 2020). A total of 34 of these communities will implement the CTH intervention for roughly 2 years (January 2020 to June 2022), with the 33 control communities not receiving any intervention during that period. The main analysis will compare opioid overdose deaths in the two sets of communities during year 2. Starting in year 3, the control communities will implement the intervention for at least 12 months (between July 2022 and December 2023). Secondary goals of HCS include increasing naloxone distribution, expanding access to (and use of) medications for opioid use disorder (MOUD), and reducing high-risk opioid prescribing.

CTH was inspired, at least in part, by CTC (Aldridge *et al.* 2020; Oesterle *et al.* 2018), and is the largest addiction research study ever conducted in the USA. Informed by implementation science and participatory research, the initiative will be evaluated and studied in detail using mixed methods, including qualitative and quantitative research as well as cost-benefit analysis. It aims to reduce opioid-related deaths by roughly 15% per annum in targeted communities. Following the CTC model, CTH relies on menus of EBPs from which community coalitions must choose:

*Similar to the CTC model, community coalitions play a major role in identifying community needs and setting priorities by selecting EBPs and strategies from the ORCCA. However, the CTH intervention is more complex in that the EBPs to be implemented span a continuum of overdose prevention and OUD treatment, in contrast to CTC's focus on youth drug use prevention. Furthermore, the EBPs are to be implemented in a wider range of settings, which adds complexity. Moreover, the inclusion of communication campaigns represents an additional innovation of CTH relative to CTC. (Knudsen *et al.* 2020)*

Another precursor of CTH was Project Lazarus, which was piloted between 2007 and 2010 and then implemented across North Carolina in early 2013 (Alexandridis *et al.* 2019). A number of distinct strategies were implemented using community-based coalitions, including public information campaigns, diversion control, support programmes for patients, professional education for practitioners, prescription policy revision, an expansion of addiction treatment services, and more liberal distribution of naloxone to opioid users (and their close contacts) as well as first responders. While Project Lazarus focused on prescription opioid analgesics, CTH has a wider remit and a much larger budget.

CTH has two main components: the Opioid-overdose Reduction Continuum of Care Approach (ORCCA) and a communication campaign to reduce stigma and raise awareness of different ways of reducing opioid-related harms. The conceptual model for communication campaigns relies on a community-engaged approach that involves coalition members in activities such as selecting targets, conducting research, working with creative teams to develop and pretest materials, and participating in evaluation activities (Lefebvre *et al.* 2020).

ORCCA comprises overdose education and naloxone distribution (OEND), effective delivery of MOUD, and safer opioid prescribing and dispensing practices. The MOUD programme must include interventions that expand availability, link people in need to MOUD, and improve retention rates. Although the intervention is relatively structured, it relies on community engagement to facilitate data-driven selection and implementation of programmes. In this way, local coalitions can influence the intervention with advice, training, and support from a university research centre. Preliminary data on CTH implementation show that the participating communities have greatly exceeded the programme requirements by selecting no less than 618 different strategies, 453 more than required, with a particular focus on active OEND strategies to improve naloxone access in groups considered to be at risk (Chandler *et al.* 2023).

CTH has a substantial budget for mixed methods research, with the aim of shedding light on key barriers and facilitators of effective interventions:

*To examine the contextual factors critical to understanding implementation, before the CTH intervention began in January 2020, the implementation science team (IS Team) in each state conducted a mixed-methods assessment using surveys and qualitative interviews with community coalition members and key stakeholders in each community. The goal of these surveys and interviews was to obtain an in-depth understanding of community members' perspectives about their communities, current substance use-related services, and other important contextual issues that could impact the CTH process and implementation of EBPs in communities. (Drainoni et al. 2022)*

In the aforementioned study by Drainoni *et al.* (2022), a total of 382 semi-structured interviews were carried out, guided by a well-structured comparative research design. Interviewees identified primary care, behavioural health, access to Suboxone, longer-term treatment options, aftercare services beyond MOUD, and recovery housing as the areas of greatest need in their communities, as well as more affordable and insurance-covered services. The authors conclude that innovative community responses are needed to create new service delivery models that are both grassroots and peer-driven, particularly as existing institutions have failed to reach vulnerable groups and individuals.

The CTH intervention includes the following phases: (0) preparation, (1) getting started, (2) getting organised, (3) community profiles and data dashboards, (4) community action planning, (5) implementation and monitoring, and (6) sustainability planning (Sprague Martinez *et al.* 2020). A community engagement facilitator supports the implementation of CTH in each community, and community champions are also identified. Research staff interact with community coalitions to achieve a shared understanding of local needs, resources, and policies. This leads to the development of a community profile (used to identify gaps in local resources and services) and a data dashboard (to visualise data related to community goals and HCS outcomes).

Chen *et al.* (2023) observe that many community coalitions have prioritised prevention programming among young people and efforts to reduce stigmatisation, but have failed to focus attention on the policies, systemic factors, and structural changes that are required to tackle drug-related harms. This echoes the comments by Kristjansson *et al.* (2020a) that we reported above, which highlight the critical importance of collective action and impact. The HCS is collecting data on preexisting assets and infrastructure in HCS communities, on decisions about interventions, and funding sources (Aldridge *et al.* 2020) to facilitate the evaluation.

## Pulling Levers

Mainstream policies addressing drug-related harms and threats have been called into question over the past two decades, and this has created a space for alternative approaches to expand their influence. For example, research has shown that patterns of drug use are highly resilient to supply-side interventions based on traditional forms of policing. The application of evidence-based policies in this area has encouraged police departments in the USA to experiment with new approaches:

*Pulling levers policing is described as a focused deterrence strategy comprised of the following components: (a) identification of high-risk offenders through extensive data analysis; (b) call-in sessions where high-risk offenders are notified of the leverage mechanisms available to police (e.g., intensive surveillance, probation, parole, or the use of federal prosecution) in an effort to facilitate compliance (i.e., lower offending rates); and, (c) the integration of varied community groups, faith-based organizations, and social service providers. (Corsaro and Brunson 2013, p. 116)*

This involves a differentiated strategy of suppression for high-risk offenders (major dealers), social services for low-risk offenders (small-scale dealers), and community involvement in poor neighbourhoods in an effort to build popular support and identify ways of reintegrating offenders into the community through targeted education and training programmes. This place-based initiative is based on the assumption that family members and community figures can bring informal social control to bear on minor offenders, reducing drug-related crime. By encouraging people to engage with the police, this strategy aims to enhance informal deterrence of crime by reinforcing social norms that discourage drug use and drug-related crime. The case study analysed by Corsaro and Brunson (2013) relates to Peoria (Illinois), which has a population of roughly 115,000 people.



## Salut als Barris

In 2005, the Barcelona Public Health Agency and the Barcelona Healthcare Consortium in Spain began to work with stakeholders from across the city to develop a place-based initiative, denominated Barcelona Salut als Barris (BSaB). In 2008, it was deployed in some of the most disadvantaged neighbourhoods in Barcelona in an effort to reduce health disparities, and subsequently remained in operation. It is managed by local health centres together with social workers and community members (Domínguez and Montolio 2021). The interventions that have been adopted aim to strengthen the social fabric in participating neighbourhoods and to increase the number of associations that are active within them. It is anticipated that this will lead to a reduction in crime:

*innovative strategies to prevent crime assign a crucial role to new societal agents. ... The soft policies set of strategies is of particular importance in deprived areas, where social interventions are most needed and a strong police presence may have a disruptive effect. (Domínguez and Montolio 2021, p. 917)*

This approach draws inspiration from the decline in crime rates that has been observed following natural disasters, which has been attributed to higher rates of cooperation among neighbours and stronger social capital at the community level. Domínguez and Montolio also refer to the contact hypothesis, arguing that local initiatives which promote social interaction between different social and ethnic groups can be effective in reducing stereotyping, prejudice, and discrimination. While none of the American initiatives described above actually target disadvantaged areas, this was an explicit aim of this Spanish programme, which also adopts a multisectoral and multi-outcome approach.

The BSaB initiative involves the following stages: (1) establishment of political alliances and a steering group, (2) collection of qualitative and quantitative data to identify problems, (3) selection of interventions by local community and authorities, (4) definition of an intervention plan by steering group, (5) evaluation, and (6) maintenance of an active working group on health. The interventions that were implemented as part of the initiative aimed to facilitate non-competitive physical activity, social relationships, healthy recreation, health literacy, and sexual health. They included substance addiction care and prevention, training and job placement, sexual and reproductive health advice, parenting skills training, mental health care, and healthy leisure workshops. Different combinations of these activities were undertaken in each neighbourhood, based on the assessments of local steering groups.

Palència *et al.* (2018) provide the following overview of the initiative:

*This strategy aims to introduce programs to address priority health needs using a community-based approach. It includes alliances with partners and stakeholders, assessment and planning of health needs and assets and implementation and evaluation of programs and interventions ... These interventions include programs for preventing addiction in young people, especially smoking; for reducing risky sexual behaviour; improving parenting skills; and reducing social isolation in the elderly. (p. 1385)*

## Community Collective Impact Model for Change

The 12 Ohio counties involved in the CCIM4C initiative in the USA sought to identify the causes of the opioid crisis and to expand the number of partners involved in tackling this epidemic. This initiative was launched in 2017 by the Ohio Department of Mental Health and Addiction Services. This led it to embrace broader efforts to support communities and to focus attention on the social determinants of health. Each county sought to involve a diverse range of actors, such as local employers, community colleges, healthcare organisations, faith leaders, youth organisations, first responders, librarians, school board members, public health officials, parks and recreation staff, and people with lived experience of problem drug use. By bringing together these community coalitions, they hoped to develop new ways of preventing unhealthy substance use by addressing the social and economic conditions that put people at risk (Cantu *et al.* 2023). Cantu *et al.* provide the following summary of the main factors identified:

*When we look upstream at the causes of the opioid crisis, we see rural and postindustrial communities hit hard by social and economic instability and decline, loss of living-wage jobs, underfunded schools, criminalization of substance use, limited access to health care providers and behavioral health services, structural racism, intergenerational poverty, social isolation, and underfunded social services that struggle to meet the community's needs ... Conditions like these create or exacerbate trauma in communities and put residents at risk of developing diseases of despair, such as substance use disorders, depression, and suicide. (p. 17)*

Community members – especially people with lived experience of substance-related harm and addiction – were involved at all stages in identifying challenges and developing solutions, although the article by Cantu *et al.* does not provide much information on this process. The CCIM4C initiative is rather different to CTC, IPM, PROSPER, and other programmes due to its focus on counties, which are rather large areas. Perhaps due to resource constraints, the interventions undertaken in these counties were not very ambitious (e.g. “Ashtabula County librarians hosted an event for over 600 community members”; “Community engagement efforts include inviting residents to photograph their neighborhoods to illustrate how their community supports or undermines health”).

## Second Chance or Else Programme

The SCORE programme involved a collaboration between the Drug Market Intervention Program of the US Attorney’s Office, on the one hand, and the police department, the Board of Health, and community leaders in Mobile, Alabama. The focus of the strategy was on improving one of Mobile’s most disadvantaged and drug-ravaged neighbourhoods by implementing a place-based initiative.

The programme began with the gathering of intelligence on crime and drug activity, with law enforcement agencies sharing their intelligence with influential community leaders before initiating activity in the community. The programme involved a combination of behavioural correction, offender reintegration, and neighbourhood reconciliation for non-violent offenders. The latter could avoid all charges if they adhered to a specific programme for offenders based on behavioural change.

Dorton and Semien (2016) provide the following summary:

*The program was piloted in an economically blighted neighborhood known as the Campground. The Campground's residents are almost exclusively African-American, and these residents have faced a neighborhood in steady economic decline for well over a decade. The social decline of the neighborhood, defined by poverty, abandoned residences, and an open-air drug market centered on a dilapidated house, mirrored its economic decline. (p. 102)*

The drug offenders facing felony charges were given an opportunity to participate in a programme of addiction treatment, training in fatherhood skills, remedial education, and occupational training. The authors observe that a key challenge for this kind of programme that is “soft on crime” is to demonstrate that it represents an effective use of resources. As police officers are mainly White and local residents in these poor neighbourhoods of Mobile are nearly all Black, another key challenge is addressing the legacy of institutional racism and overcoming mistrust between citizens and the police department.

There are similarities between SCORE and the “Weed and Seed” initiative, a community-based programme that was funded by the Department of Justice in the USA during the 1990s, which aimed to prevent, control, and reduce violent crime, drug abuse, and gang activity in high-crime neighbourhoods. It followed a two-pronged approach: local law enforcement agencies and prosecutors worked together to “weed” out the hardened criminals, while social services agencies sought to bring prevention, intervention, treatment, and revitalisation initiatives to the neighbourhoods. There are also obvious similarities with the Pulling Levers initiative described above. By contrast with CTC, PROSPER, and HTC – which target White, rural, lower middle-class towns – initiatives like SCORE, Pulling Levers, and Weed and Seed focus on urban, lower working-class areas, where White people constitute a small minority. While CTC and PROSPER focus on prevention, education, reducing stigmatisation, supporting families, and engaging communities, SCORE, Pulling Levers, and similar programmes focus primarily on repression, stigmatisation, redirection to treatment, and remedial programmes. The challenge of implementing and testing non-repressive place-based initiatives in deprived urban areas has not yet been adequately addressed in the USA. Although some of the HCS communities have a more urban character, this programme adopts only a weak form of targeting of disadvantage at the local level.

### **Cherokee Nation trial**

This is a trial that involves a universal primary prevention initiative for adolescents living in small rural towns within the boundaries of the Cherokee Nation reservation in Northeast Oklahoma in the USA. This reservation spans 14 counties and includes citizens of other indigenous tribes as well as a substantial White population. Like CTC, PROSPER, and other American programmes, it focuses on rural areas. The interventions will be implemented universally within the selected communities by Cherokee Nation Behavioral Health, in collaboration with Cherokee Nation Health Services. The initiative builds on a previous NIH-funded trial in the Cherokee Nation, which found that a school- and community-based preventive intervention reduced alcohol use among adolescents and had beneficial effects on other drug use (Komro *et al.* 2022).

In common with HCS, this trial was funded by the NIH HEAL Initiative. The starting point for the programme is similar to that of other place-based initiatives:

*Interventions to prevent initiation and progression of alcohol, marijuana, and opioid misuse among rural adolescents need to address barriers to accessing health and social services, facilitators of access to harmful drugs, family and community cohesion, and educational and economic opportunities. (Komro et al. 2022)*

The study design involves a cluster randomised trial with one baseline and six follow-up surveys. The initial cohort will participate in baseline data collection in the autumn of their 10th grade (when aged between 15 and 17 years). Follow-up surveys will be carried out every 6 months until 6 months after the participants have graduated from high school. The intervention thus involves 3 years of integrated, multilevel, cross-sectoral interventions in schools, families, and communities. The control communities will be offered project intervention materials, resources, and training at the end of the study period.

The programme involves the delivery of evidence-based prevention programmes at the individual, social network, and community levels. Two EBPs were selected by researchers at the beginning: Communities Mobilizing for Change and Action (CMCA) and Connect. This marks a difference with CTC and HCS, where local coalitions could choose the actions that they considered most appropriate.

Demand reduction strategies include strengthening social connections and support, building self-efficacy among young people, and supporting social norms that discourage substance use. Supply reduction strategies include strengthening norms, policies, and law enforcement to reduce young people's access to alcohol and other drugs. One to two community organisers will be hired to work with local people on reducing the supply of drugs. Komro *et al.* (2022) do not discuss local structures in their article, so it is unclear whether a local committee or coalition will be established, and what role local people will play in shaping the initiative.

The programme has six stages, with adult volunteers involved in each: (1) assessment of community conditions, norms, and practices, (2) building local involvement, (3) enhancing knowledge and skills, (4) developing interventions, (5) implementing actions, and (6) assessing results, celebrating accomplishments, and refining interventions.

## The Martinsburg Initiative

The TMI place-based initiative was finalised in 2017, with funding from various US federal agencies, and activities began in 2019 (Wisdom *et al.* 2022). Martinsburg is a city in Berkeley County, West Virginia, with a very high overdose-related death rate and a population of just under 20,000 people (approximately 80% White). TMI focuses on: (1) promoting social norms that protect young people against violence, (2) teaching prosocial skills, (3) connecting youth to caring adults and activities, and (4) intervening to lessen the immediate- and long-term harms produced by adverse childhood experiences. The latter are treated as an important “upstream risk factor” for substance use, which means that policies and programmes to reduce their impact need to be put in place, while also offering treatment to adults who use drugs. Although the initiative covers the whole of Martinsburg, it is being implemented through schools, which gives it a local dimension.

Practitioners in contact with children (including police officers, teachers, school staff, health service personnel) were offered training in trauma-informed approaches to service provision. The aim is to improve their understanding of the physical and psychological impacts of adverse childhood experiences. For example, the Handle with Care programme was designed to support children who have been exposed to trauma or violence. If a child is identified by law enforcement officers as falling into this category, the school principal is notified to “handle the child with care” and social workers are asked to prepare early interventions involving in-home visits, screening, brief interventions, and “wraparound” services (which form an individualised, integrated, and coordinated system incorporating family members, teachers, GPs, etc. designed to support the child in all areas of life).

TMI also teaches socio-emotional skills in the classroom (through Too Good for Drugs, an evidence-based programme) and targets parents who have been in trouble with the law by using the Nurturing Parenting programme. This is a trauma-informed intervention that fosters supportive family-centred parenting skills and aims to reduce the risk of maltreatment and neglect. There are after-school programmes (e.g. music, yoga, homework support) for young people, which bring them into contact with caring adults and safe activities in stable and predictable environments. Using a mentoring programme, children are also paired with trained, background-screened, caring adults with whom they can interact at regular intervals, increasing the number of supportive adults in their lives (Wisdom *et al.* 2022).

Although TMI targets urban neighbourhoods with high levels of drug-related harms, it does so in a relatively small city with a majority White population. Nevertheless, the initiative targets mechanisms which are believed to reproduce deprivation and substance use across generations, particularly exposure to trauma. It combines universal actions and interventions targeted at young people who are at risk. The article by Wisdom *et al.* (2022) does not provide information on local engagement and representation, which plays an important role in other place-based initiatives.

# 5

## Research questions

In this chapter, we provide a narrative synthesis of the main issues and challenges that must be faced when developing and implementing place-based initiatives. We discuss some important aspects of these programmes, including targeting appropriate sites, identifying risk factors, measuring impacts, constructing indicators, and exporting programmes to new locations. We focus on the research questions listed in the Introduction, using a thematic analysis of eligible publications from the main literature search. For each research question, we identified relevant material in the documents and produced a synthesis using qualitative research methods, mainly by coding relevant extracts using themes derived from the research questions.

It is worth pointing out that research on place-based initiatives is still at a relatively early stage, and many of the documents we identified relate to programmes which have been implemented in recent years and have yet to be evaluated. As we show in Chapter 4, there is still a high degree of experimentation with different kinds of initiatives, adopting a variety of strategies in relation to spatial targeting, community engagement, type of intervention, and overall framework. It is therefore difficult to identify promising initiatives, particularly from an Irish perspective. At the end of the chapter, we nevertheless provide some observations on this issue.

### Research question 1

#### **How is the association between the characteristics of places and drug-related threats understood in the literature?**

The relationship between neighbourhood characteristics and drug-related threats is typically theorised in the literature using the risk and protective factor framework. This is particularly true for CTC, IPM, and CTH, but this framework has become very influential and all programmes are shaped by it. Rather than identifying specific characteristics as inherently indicative of risk, it is interesting that many place-based initiatives attribute this task to community coalitions. Drawing on local data and direct knowledge of the local context, these groups are expected to identify elevated risk and depressed protective factors. This information can then be used to guide the choice of intervention and to set targets for community actions. For example, community coalitions in CTC are expected to select “effective preventive interventions to change locally identified elevated risk and suppressed protective factors” (Oesterle *et al.* 2015). Another example relating to CTC is provided in the following extract:

*Following this training, the coalition reviews their youth survey and other needs assessment data to prioritize elevated risk and depressed protective factors, and negative outcomes for intervention. After identifying priorities and programming gaps, the coalition matches existing EBPs to their identified priorities and demographics. (Chilenski et al. 2019, p. 948)*

Steketee *et al.* provide the following overview:

*The premise of CTC is that a reduction in the prevalence of adolescent problem behaviours in a community, such as violence, delinquency and drug abuse, can be achieved by identifying elevated risk factors and depressed protective factors experienced by the community's youth population, and then selecting and implementing preventive interventions that have been shown in experimental or quasi-experimental studies to affect those specific risk and protective factors and, in turn, adolescent problem behaviours. (2013, p. 99)*

This approach is motivated by the conviction that risk and protective factors are likely to vary at local level, implying that no assumptions should be made about these at the programme level. It is even possible that a specific feature or phenomenon could constitute a risk in one community but not in another.

As we noted earlier, many researchers conceptualise risk and protective factors in terms of individual-level characteristics, rather than referring to aggregate-level characteristics or processes. This methodological individualism is present in the literature on place-based initiatives, and is particularly evident in the use of school surveys to identify elevated risk and depressed protective factors by comparing mean scores with a set of reference values derived from representative surveys. This can reduce the visibility of factors like stigmatisation, systemic racism, social isolation, community disorganisation, local problems, economic hardship, and organised crime. The use of standardised local surveys also reduces the likelihood that community coalitions will identify other risk factors.

Another tendency is to link malleable risk and protective factors generically with relational and socio-emotional skills (Spoth *et al.* 2022), presumably because these are typically the focus of preventive interventions. For example, Oesterle *et al.* (2015) refer to the following variables as potential secondary outcomes: suicidal behaviour, depression, high school graduation, college attendance, teen pregnancy, and sexual risk behaviours. Spoth *et al.* (2017) identify the following variables as potential protective factors: family relationship quality, monitoring, parent-child warmth and affection, positive peer relationships, school engagement, and school task completion.

TMI describes adverse childhood experiences and health disparities between ethnic groups as "upstream risk factors" for substance use and overdose, but Wisdom *et al.* (2022) do not link these with the socio-structural characteristics of specific places or communities. Perhaps the best overview of neighbourhood characteristics and drug-related threats is provided by Cantu *et al.* (2023) in a passage we cited earlier. Meyers *et al.* (2023) summarise the link between neighbourhood characteristics and drug-related problems in the context of the IPM:

*...the model assumes that adolescents who grow up in supportive environments from their parents or caregivers and family, have non-substance-using friends, attend a supportive and nurturing school, and have access to positive, character-building, and pro-social leisure activities are less likely to engage in substance use at an early age compared to those who lack such support. (p. 3)*

The IPM focuses attention on the need to alter the social environment within which young people make decisions. However, it uses an individual-level survey to measure things like parental monitoring and involvement, youth participation in organised leisure activities, unsupervised parties, and late outside hours. It also refers specifically to community norms, policies, links between families and schools, and characteristics such as transportation, peer networks, and accessibility of leisure activities, which broadens the scope of the initiative and raises the possibility of analysing risks using individual data but responding to them in an imaginative way using collective interventions.

Other neighbourhood characteristics have been identified. For example, Crowley *et al.* (2014) refer to community norms regarding substance use. Drainoni *et al.* (2022) point out that local governance, access to funding, healthcare provision, the social determinants of health, and stigmatisation all play a role in shaping disparities in access to treatment services for drug addiction. Based on a large number of interviews with local stakeholders in HCS communities, they identify the following neighbourhood characteristics as particularly relevant: (1) community perceptions of opioid-related risks, (2) stigmatisation of people with a history of substance use, (3) the health services environment and availability of treatment, and (4) funding for services that tackle drug-related harms or facilitate recovery (including access to Suboxone, longer-term treatments, aftercare services, and recovery housing).

Other characteristics that researchers typically refer to include population size/density, demographic composition, ethnic composition, economic indicators (including eligibility for free school lunches or poverty rates), and crime rates. These variables are frequently used when matching communities prior to randomisation, suggesting that they are fundamental determinants of drug-related harms.

To recapitulate, the American literature rarely emphasises the role of neighbourhood deprivation and ethnic composition in relation to drug-related threats (see Brown *et al.* 2015). Indeed, structural factors are rarely theorised at all in the American literature, despite occasional references to the social determinants of health. Discussions of the IPM are rather similar to the American literature, as they also avoid talking about the socioeconomic characteristics of neighbourhoods. This would raise contentious issues, as well as highlighting some of the fundamental causes of health-related behaviours that cannot be altered at local level (Link and Phelan 1995). It would seem, therefore, that debates regarding the social determinants of health have remained relatively detached from this literature on place-based initiatives, and this has perhaps contributed to the risk of inflated expectations.

## Research question 2

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### What criteria are used by policymakers and funders to select locations for place-based initiatives?

In the case of PROSPER, eligibility requirements included having 1,300–5,200 students enrolled at local schools and having stakeholder agreement to random assignment, as well as a willingness and capacity to support implementation if assigned to the intervention condition. Most students were White (85%), 51% were female, 64% lived with both biological parents, and 31% received free or reduced-cost school lunches (Spoth *et al.* 2017).



In the case of CTC, communities in the CYDS trial were small- to moderate-sized incorporated towns with their own governmental, educational, and law enforcement structures, ranging from 1,500 to 50,000 residents (Oesterle *et al.* 2015). They were located in seven states (Colorado, Illinois, Kansas, Maine, Oregon, Utah, and Washington) and were matched with regard to population size, poverty, ethnic and racial diversity, and crime indices (Gloppen *et al.* 2016). Randomisation was by coin toss (Hawkins *et al.* 2014). The sample was 20% Hispanic/Latino, 64% non-Hispanic White, 3% non-Hispanic African American, 5% non-Hispanic Native American, 1% non-Hispanic Asian American, and 6% other.

To be included in the CTC trial in Germany, communities had to have at least one secondary school and a willingness to sign a cooperative agreement for study participation with the principal investigator. This resulted in a final sample of 21 CTC communities (16 small towns and five city districts) by July 2021 (Röding *et al.* 2021).

The Dutch quasi-experimental study tested the effectiveness of CTC in 10 neighbourhoods (five intervention and five control neighbourhoods) located in five cities in the provinces of Zuid-Holland and Zeeland. These cities have an average population of about 65,500 people (ranging between 45,000 and 75,000). Study sites were matched in pairs on population size, racial and ethnic diversity, economic indicators, and rates of crime and other problem behaviour (Steketee *et al.* 2013).

In the context of HCS, the targeted communities include counties, towns, and city districts located in states burdened with above-average rates of opioid overdose morbidity and mortality. At least 15 communities within each participating state had to be identified, implying a degree of coordination between levels:

*Research sites were required to demonstrate they had viable state, local, and community partners; administrative data sources and data sharing plans; existing infrastructure and resources to support EBP deployment, including SAMHSA State Opioid Response funding and technical assistance services, such as the SAMHSA Technology Transfer Centers and the Opioid Response Network; the involvement of a key governmental official (KGO) with the ability to influence funding, policy, and service provision for addressing OUD and opioid overdose deaths; and an individual from each community representing the site's Community Advisory Board (CAB). The KGO and CAB members needed to be familiar with the community perspective, represent the diversity of the state's population, and show commitment to guide the study development and deployment. (Chandler *et al.* 2020)*

Communities across four states (Kentucky, Massachusetts, New York, and Ohio) were selected to participate in HCS, based on the following eligibility criteria, which were established by the National Institute on Drug Abuse: (1) expressed willingness to address the implementation of MOUD and OEND; (2) expressed willingness to develop partnerships across healthcare, behavioural health, and justice settings for EBPs to address opioid misuse, OUD, and overdoses; (3) within each state,  $\geq 30\%$  of selected communities had to be rural; and (4) across the HCS communities in each state, there had to be  $\geq 150$  opioid-related overdose fatalities (at least 15% occurring in rural communities) and a rate of  $\geq 25$  opioid-related overdose fatalities per 100,000 people, based on 2016 data (Walsh *et al.* 2020).

In summary, the three largest trials that have been implemented so far to evaluate place-based initiatives have used weak forms of spatial targeting, while IPM is not associated with spatial targeting. In the Cherokee Nation trial described by Komro *et al.* (2022), the school districts to be included had to meet the following criteria: (1) they must be in counties that fall within the Cherokee Nation reservation, (2) they must be part of towns with a population of no more than 3,000 people, (3) the relevant student cohort had to be between 30 and 100 students, and (4) there had to be no established community drug prevention coalitions. These conditions recall those used in the case of PROSPER and CTC, where the aim was to identify relatively self-contained, White, rural communities.

The reasons for these preferences are not discussed in the literature, but the designers were probably aiming to create conditions that were favourable for identifying a positive programme effect. It is easier to avoid contamination between intervention and control sites if these are independent towns rather than forming part of the same city (Steketee *et al.* 2013). And presumably it is also easier to mobilise support for place-based initiatives in small towns that are relatively homogeneous in ethnic and social terms. TMI covered a small city, Martinsburg, so this programme involved no spatial targeting.

Two of the remaining initiatives (both situated in the USA) are confined to single locations: Pulling Levers (Peoria, Illinois) and SCORE (Mobile, Alabama). Single neighbourhoods were selected and both were areas characterised by high crime rates and large-scale drug dealing. These were clearly very deprived, ethnically mixed neighbourhoods, and the initiatives had a strong focus on police repression, as we have already noted.

The last initiative, denominated Salut als Barris, is confined to Barcelona, but is the only one that targets deprived neighbourhoods (defined as districts where per capita income is below 90% of the city median). This is not a particularly exacting requirement, as 49 out of 73 districts qualified, and 12 decided to participate in the programme. The areas targeted as part of this initiative were actually districts (urban quarters) with a mean population of well over 20,000 people.

## Research question 3

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### What place-based initiatives designed to tackle drug-related threats to communities show signs of promise?

The first step when seeking to identify promising initiatives is to determine which programmes have been shown to be effective using high-quality trials or impact assessments. From this perspective, PROSPER and CTC are the only place-based initiatives that have been shown to have a significant impact on drug-related harms, following well-designed controlled trials (Van Horn *et al.* 2014). For this reason, these are often termed Tier 1 trials (Flanagan *et al.* 2018) and these initiatives have attracted considerable attention.

There is robust empirical evidence that both programmes were effective in reducing drug use among adolescents in small rural towns. Furthermore, in an evaluation of the roll-out of CTC in Pennsylvania, Chilenski *et al.* (2019) report significant effects in relation to past 30-day and lifetime marijuana use as well as lifetime use of any drug, with odds ratios of between 0.85 and 0.95, using observational data and inverse probability weighting to test the intervention effect. The effects were stronger for CTC districts which implemented evidence-based programmes (odds ratio of 0.76 for past 30-day and 0.77 for lifetime marijuana use). On the other hand, Van Horn *et al.* (2014) do not find evidence of a reduction in rates of serious drug use for students in CTC versus control communities when they were in 8th–10th grades.

In the Netherlands, Steketee *et al.* (2013) found no evidence that CTC neighbourhoods were implementing more or better prevention programmes compared with control areas. However, they found evidence of contamination, due to the integrated nature of policymaking in the Netherlands and the actions of practitioners working in the areas concerned:

*Because control and CTC neighbourhoods were situated in the same city in the Netherlands, a number of human service and youth workers who participated in CTC coalitions also worked in the control neighborhood. Realizing that the same problems and risk factors were present in the control area, some coalition members working in both neighborhoods implemented the programs also in this control area. In 3 of the 5 experimental cities, there is evidence that both experimental and control neighborhoods were provided the same or nearly the same preventive interventions. (Steketee et al. 2013)*

When assessing PROSPER and CTC, we can also include the results of studies using data collected several years after the original intervention. One of the strengths of both of these trials is that they have continued to collect data on participants even as they complete high school, attend college, and enter the labour market. For example, one study shows that CTC did not lead to reductions in the risk or prevalence of current drug use in 12th grade, which coincides with the final year of high school (Hawkins *et al.* 2014).

Turning now to PROSPER, Spoth *et al.* (2013) examine its effects in 11th and 12th grades (5.5 and 6.5 years after baseline). Longitudinal multilevel models were used to analyse point-in-time outcomes and growth trajectories for various substances (methamphetamine, ecstasy, marijuana, medications like Vicodin, Percocet, or OxyContin). Lifetime use of any of these substances was 18.8% lower in the intervention group than in the control group in 11th grade, and 15.0% lower in 12th grade. Effects for past-year methamphetamine use were larger, with relative reduction rates of approximately 31%, and for past-year inhalant use at 12th grade (28.3%). Relative reduction rates were 15.1% and 14.4% for frequency of marijuana use at the 11th and 12th grades, and stronger effects were observed among higher-risk students.

Osgood *et al.* (2013) study the impact of PROSPER on the structure of friendship networks and show that one effect of the intervention was to reduce the influence of antisocial students within class networks. They estimate network-specific bivariate regression coefficients that express the mean difference in centrality corresponding to a unit increase in antisocial attitudes or behaviour computed across the students in that network. The effect was small but statistically significant, suggesting that one mechanism which may have contributed to its effectiveness was the way it favoured a reconfiguration of friendships which penalised substance-using students.

In follow-up assessments, US researchers have largely failed to find evidence of impacts on past-month or past-year drug use after participants have left high school. This applies to CTC participants at 19, 21, and 23 years of age (Oesterle *et al.* 2015; Oesterle *et al.* 2018) and PROSPER participants at 19, 23 and 25 years of age (Feinberg *et al.* 2022; Spoth *et al.* 2017; Spoth *et al.*, 2022). Although no significant differences have been identified in relation to recent use, significant effects remain in relation to lifetime use, suggesting that the programmes may have been effective in deterring people from trying drugs during adolescence. For example, Spoth *et al.* (2017) report a relative reduction rate of 41.0% for lifetime methamphetamine use and 25.8% for non-prescribed narcotics in the context of PROSPER. Spoth *et al.* (2022) observe relative reduction rates between 24.9% and 36.8% for lifetime methamphetamine use, even in the presence of null findings for current substance use and frequency of substance use. Kuklinski *et al.* (2021) analyse the long-term effects of CTC at age 23 years and report significant differences in sustained abstinence from marijuana and illicit drugs, but no data on current use or frequency of use are reported.

Asgeirsdottir *et al.* (2021) use data from repeated, comparative, cross-sectional surveys of 30,572 10th graders in the cities of Kaunas, Klaipėda, and Vilnius in Lithuania, where the IPM was implemented between 2006 and 2019. Primary prevention variables were associated with substance use, and moved in the expected direction, based on the theoretical model, with the exception of participation in sports, which was not associated with a reduced likelihood of alcohol, cannabis, or amphetamine use. The results indicate a significant downward trend over time for cannabis and amphetamine use in all three cities between 2008 and 2018, which coincides roughly with the period in which the programme was implemented. There were simultaneous improvements in parental monitoring and involvement and a decline in the prevalence of what the authors term “party lifestyle”, which is coherent with the theoretical model underlying the IPM. However, this study has a weak design and a high risk of bias.

Kristjansson *et al.* (2020b) discuss the impact of the IPM in the Icelandic context:

*Since the original development of the model, Iceland has led the decline in substance use in all of Europe. In 2015, the rate of ever smoking tobacco was 46% among 10th-grade adolescents in Europe but had plunged to 16% in Iceland; average rates of current alcohol use were 48% in Europe but 9% in Iceland; and average rates of lifetime use of cannabis substances remained at 16% in Europe, similar to 1999, but declined to 5% in Iceland .... In all instances, the 2015 rates in Iceland represented either the lowest or the second lowest of all 35 countries that participated in the ESPAD [European School Survey Project on Alcohol and Other Drugs] study that year ... Corresponding to these changes in substance use, Iceland had also witnessed large reductions in risk factors and strengthening of protective factors. (p. 64)*

Unfortunately, the IPM has not been subjected to rigorous assessment and there are no Tier 1 trials. An earlier publication by Kristjansson *et al.* (2010) (outside our observation window) reports significant impacts on smoking and alcohol consumption, but this quasi-experimental study has been criticised in the literature and probably contains flaws (Koning *et al.* 2021). Corsaro and Brunson (2013) assess the impact of the Pulling Levers intervention, but find no clear evidence of impacts in either direction for disaggregated crime or total calls for service within the target neighbourhood, between the pre- and post-intervention periods. The study design was relatively weak, as there were no controls, so the risk of bias is high.

Domínguez and Montolio (2021) apply an innovative difference-in-differences methodology combined with control variables and time and space fixed effects to evaluate the impact of the BSaB programme. Because the progressive implementation of the programme in 12 out of 73 districts between 2008 and 2014 did not follow any pattern, they were able to use this variation to identify causal impacts on crime (with a geocoded administrative dataset of all 1.5 million crimes recorded in Barcelona between 2007 and 2014). The BSaB initiative reduced crimes against the person and other types of crime by 12% and 18%, respectively, but no significant impacts were detected for crimes against property or drug-related crimes. Palència *et al.* (2018) analyse community action in Barcelona using survey data (2001 and 2011 health surveys). They report that drug use decreased in neighbourhoods with strong forms of community action (from 14.3% in 2001 to 5.9% in 2011, multivariate PR: 0.48, 95% CI: 0.25–0.92), while remaining constant in other neighbourhoods. However, the study design is weak and this conclusion is associated with a high risk of bias.

In conclusion, only PROSPER and CTC have been rigorously assessed and have a robust and demonstrable impact on drug-related harms. Both programmes targeted young adolescents and focused primarily on smoking and drinking alcohol, but they nevertheless had an impact on drug use that persisted over time and was detectable for most of the high school years. The trial which is being implemented in the Cherokee Nation reservation will provide further evidence on this kind of initiative in another rural context.

The evidence that has been published regarding the effectiveness of the IPM is largely observational, but has convinced many policymakers and practitioners of its value. This is partly because data from Iceland on substance use among young people compare favourably with data from other countries, although it is not clear what role the IPM played in this and what influence factors such as national policies and other specificities (low population density, relative affluence) may have had.

Of course, initiatives may be promising even if they have not yet demonstrated their effectiveness. A good example is HCS, which is expected to produce significant improvements in drug-related harms in the target communities. As this programme is situated at the frontier of research and practice-related innovations in place-based initiatives, it is arguably the most promising study of all. The large amount of resources allocated to studying HCS will ensure that dozens of publications will appear over the next few years analysing all aspects of this programme. HCS thus offers an excellent opportunity to assess the potential of place-based initiatives to reduce drug-related harms.

Some of the other initiatives described above are promising for other reasons. For example, Salut als Barris is an innovative programme that exploits the existing infrastructure of health and social services, which in Barcelona appear to have welcomed the initiative. Some of the interventions that were implemented as part of this programme have the hallmarks of innovative grassroots actions that were developed by engaging with local communities. The emphasis on childhood trauma in TMI – training police officers, teachers, emergency services, and professionals to deal with its effects – is very innovative, and this is an interesting programme. The least promising initiatives are Pulling Levers and SCORE, and their failure to produce positive effects is arguably related to their inability to engage with local communities. There is evidence now from several projects that repressive place-based initiatives headed by law enforcement agencies are unlikely to yield positive impacts.

## Research question 4

### What indicators have been developed to measure the impact of these interventions?

As we have seen, some place-based initiatives have been tested in rigorous impact studies, using a range of indicators. As the results of these studies are typically published in the form of academic articles, there is a sizeable literature on this topic. In CTC and PROSPER, impacts were measured in different ways: (1) by assessing the nature of the interventions they promoted (e.g. number of evidence-based programmes adopted), (2) fidelity of implementation, and (3) by quantifying substance use over the past month or year (or over the respondent's lifetime). In the Cherokee Nation trial, a similar approach is adopted, with the primary outcome measures coming from a count of the number of days of (1) alcohol use, (2) heavy alcohol use, (3) marijuana use, and (4) prescription opioid misuse, over the past 30 days (Komro *et al.* 2022).

The primary aim of HCS is to reduce opioid overdose deaths, while the secondary outcomes of interest include reducing overdose events, opioid misuse and injection drug use, MOUD and behavioural treatment, treatment retention, people receiving recovery support, access to naloxone, and targeting other health conditions, including hepatitis C, HIV, and endocarditis (Chandler *et al.* 2020). Slavova *et al.* (2020) list four key hypotheses for HCS, each of which is linked with an indicator: (H1) reduce opioid overdose deaths, (H2) increase naloxone distribution, (H3) expand use of medical treatments for OUD, and (H4) reduce high-risk opioid prescribing. During the early stages of HCS, problems were encountered with these indicators due to differences in postmortem examinations, delays in publishing data, and problems with classifications. For example, ICD-10 codes may identify individuals with a physiological dependence on prescribed opioid analgesics, but not OUD. Efforts have been made to overcome these issues in the areas participating in the study.

Brown *et al.* (2015) use longitudinal cross-lagged panel models to explore the relationship between community coalitions and programme outcomes. They highlight the following qualities as relevant to the success of place-based initiatives: collaborative processes (how coalition members interact as a team); coalition capacities (including the attitudes, knowledge, and skills of the coalition members and paid coordinator); and coalition activities (how coalitions direct their energy). All these features of coalitions predicted their capacity to implement preventive programmes.

Bašić (2015) analyses the process of CTC implementation in 12 communities (four cities and eight villages) in Croatia. Interviews were carried out with community leaders, leading people in local government, social and health services, and schools. The conclusion is that building community readiness is an essential step before implementing place-based initiatives, and this concept is measured using a local version of the survey questionnaire originally used in the USA.

This suggests that it is important to distinguish between primary and secondary aims when developing place-based initiatives and to formulate precise definitions of the indicators that will be used to assess progress in relation to each of these. This process is a complex one, particularly if community coalitions are involved in selecting programmes, identifying aims, and collecting data on outcomes. The secondary aims of these initiatives will often be closely related to the mechanisms that they seek to mobilise in order to achieve their primary aim. By collecting data on these mechanisms, programme evaluations can not only assess whether a given initiative is effective, but also whether it functions as anticipated.

## Research question 5

### Could these place-based initiatives and indicators be used in Ireland?

Unfortunately, no research has been carried out that might shed light on this issue and the studies discussed in this report only enable us to make some broad observations. When considering transferring initiatives from one country to another, it is important to be aware of differences in national context, social structure, and neighbourhood characteristics. There may be specific features of the national or regional context which are essential to the success of an initiative in its original form. For example, national policies in Iceland may have played a role in reducing access to alcohol, tobacco, and other substances, alongside the IPM. The healthcare policies adopted in the USA may have contributed to the opioid epidemic, as levels of opioid use and opioid-related overdoses are higher in this country than in Europe, for example.

Secondly, a programme may not work as expected if a country has different social or cultural features, compared with the original context. For example, cultural practices surrounding sports events may be different and have a different relationship with substance use; families may have a different role or composition; the relationship between neighbourhoods and schools may also vary; socialisation processes may accord a different role to families, schools, and peer groups, making certain interventions harder to implement.

Finally, it may not be possible to implement a certain kind of initiative in a different context due to differences at the neighbourhood level. Some neighbourhoods may host ethnically homogeneous migrant communities, or have such a weak social fabric that it is difficult to engage with local people. In countries with centralised welfare systems, it may be difficult to convince educators, healthcare, and social service providers to implement a new initiative or to adopt a differentiated approach at neighbourhood level. Alongside these disparities, there are language differences, cultural specificities, and organisational features, which mean that interventions, accompanying materials, and questionnaires need to be adapted to each context.

Even in countries that are superficially quite similar (EU member states; Anglo-Saxon countries), it cannot be assumed that interventions will work in exactly the same way as in their original context. An evidence-based programme or a place-based initiative that has been found effective in one country may not be equally effective in another. New trials are likely to be required, perhaps after reviewing the logic and assumptions of the programme. Koning *et al.* (2021) make the following observation about attempts to export the IPM to other countries:

*Iceland is comparable to some European countries, yet not all and certainly not in terms of geography and social context ... The findings of the IPM should be considered in the context of Iceland as a country different in many aspects from other countries. That is, we know that the context shapes the conceptualization of the intervention by the impact on outcomes as well as how the intervention can be implemented, translated and scaled up. (p. 372)*

At the same time, there are clearly similarities between countries and it cannot be assumed that an approach which is effective in one country will not be useful in another. It would be foolish to reinvent the wheel if careful extensions and emulations of good practices and promising models can have beneficial effects. This is probably the main factor that has encouraged countries to adopt the CTC and IPM models, for example. Koning *et al.* (2021) note that the IPM is currently being implemented in 32 countries worldwide (including Ireland), while CTC has been implemented in the USA, Australia, Canada, Croatia, Germany, the Netherlands, and the UK. There is a CTC-EU-Network that is funded by the EU to support adoption in European countries. These programmes have been evaluated in some of these countries, often without using robust and reliable research designs.

This brings us back to the countries that decide to implement place-based initiatives. In many cases, they will not have the time and resources to develop a completely new framework and to test it, along with locally specific interventions. It might make sense, in this case, to use an existing model, even if this decision brings with it certain risks. However, it also makes sense to set aside a budget to evaluate the initiative in its new context, using appropriate research methods. The basic principle espoused by the EMCDDA, which we mentioned in the Introduction, regarding the importance of research, monitoring, and assessment, is particularly pertinent here. Investing resources in research adds value to an initiative and ensures accountability. Implementation of complex, costly interventions without adopting robust forms of evaluation inevitably involves a waste of resources, as it will never be possible to determine effectiveness. The provision of earmarked funding and coordination at national level is a good way of ensuring that place-based initiatives are implemented correctly and assessed appropriately.

## Future directions for research

Because place-based initiatives are a relatively recent innovation in the context of strategies to tackle drug-related harms, it would be a mistake to confine our attention to the best-known examples. As we showed in Chapter 4, other models are possible. The starting point for a debate about the usefulness and applicability of place-based initiatives in Ireland should arguably be the Irish context itself: what kinds of drug-related harms are observed at local level and how could new approaches contribute to improving conditions? What resources and knowledge are already present and how can these be mobilised in order to tackle risk factors and to strengthen protective factors?

Rather than treating place-based initiatives as a single package, to be implemented without reflection, it may be helpful to distinguish between frameworks and interventions. All place-based initiatives share certain features at the framework level, including: (1) external funding, political support, and technical assistance, (2) spatial targeting, (3) structures for community engagement, (4) an emphasis on social innovation, (5) use of local data to guide decisions, and (6) cross-sectoral collaboration at local level. This lends a recognisable structure to the initiative and creates pressure for local involvement to break down sectoral and organisational boundaries and to target resources at communities in need. This framework is likely to have broad cross-national validity, which makes its adoption more straightforward. The framework is a meta-structure with responsibility for choosing, developing, and implementing interventions.



On the other hand, the framework can only produce impacts through interventions, and interventions vary in their effects. In order to be effective, interventions must be well-suited to the local context and capable of producing the desired impacts. There is thus a role for researchers to work with community coalitions in order to evaluate existing interventions, identify obstacles, and explore alternative approaches. Because innovation is central to place-based initiatives, community coalitions may come up with new ideas about how to intervene to tackle drug-related harms, and innovations should be expected and welcomed at the intervention level.

From this perspective, it is the community coalition which must decide whether an existing intervention or survey questionnaire meets its needs, or whether a new tool or programme should be developed. If a robust monitoring framework is in place, the coalition can assume responsibility for this choice, in the knowledge that all impacts will be assessed in an impartial way. Evidence on the effectiveness of interventions will be considered when deciding how to intervene, without necessarily becoming an obstacle to innovation. This kind of compromise could be appropriate as long as monitoring and assessment are accorded an important role in studying the impact of an intervention.

One of the main difficulties that CTC initiatives have faced in Europe relates precisely to the interventions they involve, as CTC insists on the implementation of evidence-based programmes. Although there are dozens of such programmes in the USA, only a few have been tested in European countries. This can lead to a short circuit, as local coalitions are forced to choose from a restricted range of programmes if they want to be faithful to the principles of CTC. In this way, however, they are no longer free to explore innovative solutions, and one could argue that they are not even needed.

If we consider place-based initiatives as the combination of a framework and a set of interventions, a number of questions can be addressed more effectively. The first is whether the framework should be implemented in all neighbourhoods (like the IPM) or whether there should be targeting (e.g. deprived areas or neighbourhoods with high crime rates or problem drug use). Another question relates to governance and oversight: what rules should be followed when establishing community coalitions, and what constraints should be placed on their decision-making powers in relation to spending, for example? What kind of influence should coalitions have over statutory services, and how should conflicts be managed?

Another important aspect of this research question is the existence in Ireland of the Local and Regional Drug and Alcohol Task Forces. These bodies have a number of similarities with place-based initiatives, leading us to ask whether they play the same role. This is a complex issue, which goes beyond the scope of the present review, but we can make some observations in relation to this question. The task forces were introduced in the context of the Drugs Initiative in Ireland, following the establishment of a Ministerial Task Force on Measures to Reduce the Demand for Drugs in 1996. One aim of this initiative was to respond to the concerns of local communities about drug-related harms. The task forces were expected to bring together organisations and individuals from the statutory, community, and voluntary sectors to develop an integrated locally based response to problem drug use. Between October 1996 and May 1997, Local Drugs Task Forces were established in 13 areas, 12 of which were in Dublin (Ballyfermot, Ballymun, Blanchardstown, Canal Communities, Clondalkin, Dublin 12, Dublin North-East, Dun Laoghaire/Rathdown, Finglas/Cabra, North Inner City, South Inner City, and Tallaght) and one in Cork. Later, in 2000, a 14th Local Drugs Task Force was established in Bray. Ten Regional Drug and Alcohol Task Forces were introduced between 2001 and 2006 under the auspices of the first national drugs strategy, *Building on Experience* (2001–2008).

The role of the task forces includes: (1) carrying out research, (2) gathering information, (3) providing education and training, (4) undertaking preventive interventions, (5) working towards the reduction of supply, (6) improving access to treatment, and (7) providing recovery services. They address these challenges by identifying local needs and promoting the development of projects which can satisfy these. They work cross-sectorally and inter-institutionally with the aim of ensuring that local responses are coherent, integrated, and effective. To meet these objectives, they design action plans that are guided by the national drugs strategy and informed by an analysis of the local drug situation. This entails identifying needs and gaps in provision and developing strategies to address these.

The task forces operate as a committee and aim to involve representatives from statutory agencies, the voluntary sector, representatives of the local community, and local public representatives. Given its complexity and due to the difficulties involved in defining responsibilities within this kind of institutional architecture, it is perhaps unsurprising that there have been several attempts to improve accountability by strengthening the vertical links between projects, task forces, funding agencies, oversight committees, and relevant Government Departments.

This summary highlights the similarities that exist between task forces and community coalitions in the case of place-based initiatives. Both involve local stakeholders, community groups, voluntary organisations, elected representatives, and community members. Both aim to identify innovative solutions that build on local knowledge and work across organisational and sectoral boundaries. They are both concerned with developing interventions that are effective in tackling drug-related harms by providing services in relation to prevention, treatment, harm reduction, and recovery.

In order to provide a full assessment of the task forces from this perspective, it would be necessary to go beyond this formal description to ascertain whether there is effective local ownership of the task forces, whether local people and community groups are adequately represented, whether they can use the task forces to tackle local drug-related problems, and convince statutory bodies and Government agencies to change their practices and policies. Without effective community engagement, place-based initiatives lose their potential for innovation and may end up being administered in line with the priorities of national or State-funded bodies. If local plans, policies, and interventions are not driven forward by the community, with the active involvement of community members and people with lived experience of drug use, leading to substantial changes in ways of serving and administering these areas, then task forces may differ from place-based initiatives in important ways.

It is also necessary to measure the impact that the task forces have at local level. This represents a significant challenge, as their introduction was not accompanied by a framework for data collection and statistical assessment. This underlines the importance of measuring, monitoring, and evaluating place-based initiatives to ensure accountability. Unfortunately, this cannot be implemented retrospectively, as control groups and baseline measurements are invariably required.

# 6 Conclusions

In the previous chapters of this report, we provided a broad overview of the origins, guiding principles, and characteristics of place-based initiatives, focusing on interventions to reduce drug-related harms. We used a targeted review of reviews and a powerful search strategy to identify relevant publications from the existing literature, including books, academic articles, research reports, official publications, and advocacy documents. We summarised a range of initiatives and presented a thematic analysis of 41 publications in order to respond to the research questions that were originally posed by the HRB.

Place-based initiatives represent both an evolution of earlier programmes and an attempt to address some of their weaknesses. They developed under the influence of long-standing trends in health and social policy, such as the push to democratise services by involving users in their design and delivery, a focus on the role of social determinants, an awareness of the need to address drug-related harms from a holistic and multisectoral perspective, and an interest in the role of the local context in generating risk factors or providing protection from drug-related harms.

Place-based initiatives have attracted a lot of attention from researchers and policymakers in recent years, and they are viewed as an interesting, promising, and innovative framework for developing new strategies. The need to identify new approaches and policies is felt most urgently in countries like the USA where drug-related harms have assumed epidemic proportions. Although the death toll associated with opioids is generally much lower in European countries, there is a perception in many countries that the treatment systems, harm reduction interventions, and prevention programmes put in place during the 1980s and 1990s need to be improved or replaced. This process of questioning existing systems and searching for more effective responses has generated interest in alternative approaches.

The literature on place-based initiatives has grown rapidly over the last two decades. By 2010, a small number of studies relating to initiatives like PROSPER and CTC had been published and academic interest was starting to grow. By about 2020, the literature on these programmes had expanded considerably and articles on other kinds of place-based initiatives had been published. The four review articles that we summarised were all published quite recently – between 2018 and 2022 – but there is little overlap with the 41 studies included in our evidence review. By expanding the scope of our review to include countries other than the USA, and by including a wider range of research designs, we are able to provide a richer account of place-based initiatives than other published studies. By focusing specifically on drug-related harms, we can identify studies which go beyond prevention programmes that are targeted only at schoolchildren and their families.

Interestingly, and despite the adoption of a powerful search strategy, we were not able to find many place-based initiatives which address drug-related harms from the perspective of policing, population health, family well-being, or local development. Most initiatives have been funded, developed, and delivered by organisations which are rooted in the field of drug treatment and prevention services. Moreover, we have not been able to find many documents by advocacy groups, and most of the studies we came across were published in scientific journals. This shows that place-based initiatives are situated firmly in the “major league” of drug policy, where only the largest, richest, and most qualified government organisations and foundations operate. It is unsurprising, therefore, that nearly all of the initiatives we describe were implemented in the USA with federal funding, although there is one notable exception (the IPM).

From a European perspective, it is rather surprising that American place-based initiatives make little attempt to target deprived neighbourhoods. Unless they are implemented universally, place-based initiatives should arguably be targeted, given their focus on the social fabric of local communities and tackling risk factors. Policies to tackle the opioid epidemic in the USA have tended, so far, to ignore how the social and ethnic composition of local communities influence the distribution of risk and protective factors. In most of the place-based initiatives that have been tested, the participating communities have generally been small, independent, rural towns with a mixed socioeconomic composition and an overwhelmingly White population. Curiously, this choice is never discussed, although many other characteristics which could potentially influence these programmes are considered.

Following the Black Lives Matter movement, this approach was called into question, along with the idea that local communities are essentially cohesive and homogeneous entities. During its implementation, the managers and researchers involved with the HCS study have struggled to keep up with the challenges that have been voiced in relation to issues of race, class, and power in community coalitions and in relation to the targeting of interventions.

In Europe, spatial targeting can be problematic for other reasons, some of which emerged in a study of CTC in the Netherlands (Steketee *et al.* 2013). In this case, service providers and practitioners who were involved in the implementation of a place-based initiative in one set of neighbourhoods decided to implement the same interventions in the control areas on the basis of a commitment to universalism and the equal treatment of all neighbourhoods. The IPM capitalises on these values by proposing an intervention which is both place-based and universal, where targeting has no role because all neighbourhoods are included.

We saw in Chapter 5 that it is possible to think about place-based initiatives as involving both a framework and a set of interventions. The framework sets out the rules regarding the funding, governance, design, and management of the initiatives, but merely provides a structure. It comprises a funding body, guidance committee, technical assistance team, research team, a group of coordinators, and a set of community coalitions. This framework could be used to design and implement any kind of intervention, and is potentially relevant to a wide range of services.

In programmes like CTC, HCS, and IPM, researchers, coordinators, and managers guide community coalitions towards specific kinds of interventions. For example, they may define a menu of interventions from which coalitions can choose, or provide standardised survey results which highlight specific features of the local population. It is easy to see that the balance of power between centre and local communities can vary depending on a range of factors, and there is potential for conflict and disagreement. It is also apparent that values are important and have the potential to guide place-based initiatives in specific directions.

There is still not enough research on the kinds of interventions that can be implemented within the context of place-based initiatives. Programmes like PROSPER and CTC adopt a rather conservative approach, emphasising the importance of proven preventive interventions that can be implemented by schools or social workers, focusing on skills. Some of the other initiatives we described in Chapter 4 provide a glimpse of the enormous variety of interventions that could potentially be adopted by place-based initiatives. For example, they could be used to address issues like intimidation, drug dealing, screening for blood-borne infections, addressing the effects of adverse childhood experiences, supporting families in difficulty, creating educational and leisure opportunities, supervising children outside school, providing housing, tackling the legacy of racism, and improving transport, infrastructure, and services at local level. In this sense, it is important to consider how the boundaries of place-based initiatives are defined.

The first wave of large, place-based initiatives – including PROSPER, CTC, and IPM – have been studied in detail and some of the publications cited in previous chapters adopt state-of-the-art methods to quantify their impact at local level. The results of these studies show that these programmes can be effective and cost-efficient within the specific context in which they are delivered, although their population-level impacts on drug use appear to be rather modest and do not appear to endure beyond school.

In order to achieve more significant reductions in drug-related harms, it is evident that interventions will have to be more ambitious, and this is arguably the motivation behind HCS, which aims to shed light on the potential impact of a well-funded place-based initiative that targets adults and local institutions as well as schoolchildren and their families. This is arguably the most promising initiative currently under way, and it will be interesting to see how effective it is in reducing opioid-related deaths in the target areas.

Some of the other initiatives we described in Chapter 4 provide examples of innovative interventions. The Barcelona programme Salut als Barris includes grassroots actions that were developed by engaging with local communities, providing an interesting example of what can be achieved with a relatively limited budget, where practitioners in the public health and social service systems are enthusiastic about involving local communities. TMI is also interesting, to the extent that it makes a serious effort to address the link between trauma and drug use, once again exploiting teachers, social workers, and GPs. It seems clear that the involvement of practitioners and professionals is crucial to the success of place-based initiatives. If they embrace the logic and the values that inspire these programmes, then they are more likely to succeed; however, if they resist them, they seem destined to fail.

There are likely to be debates in the coming years between researchers, policymakers, practitioners, and the wider society regarding the appropriate scope and scale of these initiatives. Although ambitious does not always imply costly, there is an awareness among researchers that interventions which require local people to participate in lengthy training sessions so that they can acquire new skills, “become better parents” or play a greater role in their neighbourhood are unlikely to be effective. Individuals and families – particularly those living in deprived areas – already face considerable burdens in terms of paid work, unpaid care, and meeting obligations to family members and peers. At the same time, research on place-based interventions is in its infancy, and the repertoire of actions that can be undertaken at local level seems destined to expand. It is arguably important to keep pushing forward the innovations, rather than converging on the first design which demonstrates positive impacts.

A key issue in relation to place-based initiatives relates to the level at which they produce effects. While PROSPER, CTC, HCS, and many other American initiatives tend to adopt an individualistic approach that emphasises the importance of reaching people with appropriate forms of training and information, the IPM focuses much more on the social context and ways of achieving collective impact. This is a key issue, and one which has not been explored sufficiently. Policies that shape collective behaviour through the use of rules and sanctions (e.g. curfews for young people, bans on advertising alcohol or drinking in public areas, rules regarding pub opening hours, penalties for selling alcohol or tobacco to young people), as well as vouchers and incentives, have been part of the response to substance use in Iceland since the 1990s. However effective these interventions may be in Iceland, they are sometimes viewed as unacceptably heavy-handed and prescriptive in other countries. Whatever position we may wish to take in relation to these specific interventions, they provide a clear example of how place-based initiatives can generate an impact at the collective level by activating or deactivating specific mechanisms. Together with changing community norms and creating more effective institutional actions, collective impact is at the core of place-based initiatives.

To conclude, it is evident that the empowerment of local communities and their direct and enhanced involvement in decision-making is central to place-based initiatives. Many of the other issues that we have mentioned – such as the risk of placing an excessive burden on community members, overlooking internal divisions, or ignoring values that are important to local people – can be resolved through local involvement and ownership. This is a substantive rather than a formal characteristic, which means that the framework that is adopted must actually enable ordinary community members to have an influence over decisions and feel a sense of involvement and ownership. Community involvement is often treated in isolation from other aspects of policy implementation, as if it merely involved the exchange of information and opinions. By contrast, the research discussed in this report shows that community involvement is a fundamental component of place-based initiatives and one which may be expected to yield more appropriate responses to drug-related harms based in local areas.

# Appendix A: Literature search for review studies

## PubMed search

Searched on 3 January 2023.

**Table A1: Results of search using PubMed**

Search number	Query	Filters	Results
19	#15 AND #18	in the last 10 years	549
18	#16 OR #17	in the last 10 years	1,625,837
17	review[Publication Type] OR systematic review[Publication Type]	in the last 10 years	1,383,238
16	(review[Title] OR reviews[Title] OR overview[Title] OR overviews[Title] OR synthesis[Title] OR syntheses[Title]) OR (review[Other Term] OR reviews[Other Term] OR overview[Other Term] OR overviews[Other Term] OR synthesis[Other Term] OR syntheses[Other Term])	in the last 10 years	601,070
15	#4 AND #14	in the last 10 years	7,244
14	#5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13	in the last 10 years	130,463
13	"phencyclidine abuse"[MeSH Terms] OR "prescription drug diversion"[MeSH Terms] OR "amphetamine related disorders"[MeSH Terms] OR "dependency, psychological"[MeSH Terms] OR "cocaine related disorders"[MeSH Terms] OR "amphetamine related disorders"[MeSH Terms] OR "cocaine related disorders"[MeSH Terms] OR "substance abuse, intravenous"[MeSH Terms] OR "substance related disorders"[mesh:noexp] OR "behavior, addictive"[mesh:noexp] OR "drug misuse"[MeSH Terms] OR "substance related disorders"[mesh:noexp] OR "narcotic related disorders"[MeSH Terms] OR "drug overdose"[MeSH Terms] OR "marijuana abuse"[MeSH Terms] OR "marijuana use"[MeSH Terms] OR "opiate substitution treatment"[MeSH Terms] OR "inhalant abuse"[mesh]	in the last 10 years	68,097
12	"Narcotic*"[Ot] OR "polyabuse*"[Ot] OR "illicit-drug*"[Ot]	in the last 10 years	1,723
11	substance[ot] AND (problem*[Ot] OR use[ot] OR user*[Ot] OR abuse*[Ot] OR misuse*[ot] OR abusing[Ot] OR depend*[Ot] OR addict*[Ot])	in the last 10 years	13,145

10	drug*[ot] AND (problem*[Ot] OR use [ot] OR user*[Ot] OR abuse* [Ot] OR misuse* [ot] or abusing[Ot] OR depend*[Ot] OR addict*[Ot])	in the last 10 years	11,301
9	"mdma"[Ot] OR "opiate*" [Ot] OR "opioid"[Ot] OR "opioids"[Ot] OR "heroin"[Ot] OR "methadone"[Ot] OR "cocaine"[Ot] OR "amphetamine*" [Ot] OR "marijuana"[Ot] OR "cannabis"[Ot] OR "crack"[Ot] OR "phencyclidine"[Ot] OR benzodiazepine*[Ot] OR "methamphetamine*" [Ot]	in the last 10 years	41,980
8	"Narcotic*" [Title] OR "polyabuse*" [Title] OR "illicit-drug*" [Title]	in the last 10 years	1,636
7	substance[title] AND (problem*[Title] OR use[title] OR user*[Title] OR abuse*[Title] OR misuse*[title] OR abusing[Title] OR depend*[Title] OR addict*[Title])	in the last 10 years	12,840
6	drug*[title] AND (problem*[Title] OR use[title] OR user*[Title] OR abuse*[Title] OR misuse*[title] or abusing[Title] OR depend*[Title] OR addict*[Title])	in the last 10 years	15,996
5	"mdma"[Title] OR "opiate*" [Title] OR "opioid"[Title] OR "opioids"[Title] OR "heroin"[Title] OR "methadone"[Title] OR "cocaine"[Title] OR "amphetamine*" [Title] OR "marijuana"[Title] OR "cannabis"[Title] OR "crack"[Title] OR "phencyclidine"[Title] OR benzodiazepine*[Title] OR "methamphetamine*" [Title]	in the last 10 years	57,415
4	#1 OR #2 OR #3	in the last 10 years	425,266
3	COMMUNITY PARTICIPATION [MESH]	in the last 10 years	17,160
2	PLACE[Other Term] OR PBI[Other Term] OR PBIS[Other Term] OR AREA[Other Term] OR COMMUNITY[Other Term] OR SETTLEMENT*[Other Term] OR NEIGHBOURHOOD*[Other Term] OR NEIGHBORHOOD*[Other Term] OR SPATIAL*[Other Term] OR DISTRICT*[Other Term] OR LOCATION[Other Term] OR PARTNER*[Other Term] OR CITIZEN*[Other Term] OR RESIDENT*[Other Term] OR GROUP[Other Term] OR LOCAL[Other Term]	in the last 10 years	158,782
1	PLACE[Title] OR PBI[Title] OR PBIS[Title] OR AREA[Title] OR COMMUNITY[Title] OR SETTLEMENT*[Title] OR NEIGHBOURHOOD*[Title] OR NEIGHBORHOOD*[Title] OR SPATIAL*[Title] OR DISTRICT*[Title] OR LOCATION[Title] OR PARTNER*[Title] OR CITIZEN*[Title] OR RESIDENT*[Title] OR GROUP[Title] OR LOCAL[Title]	in the last 10 years	327,354



## Cochrane Library search

Searched on 9 January 2023.

**Table A2: Results of search using the Cochrane Library**

ID	Search	Hits
#1	PLACE:ti OR PBI:ti OR PBIS:ti OR AREA:ti OR COMMUNITY:ti OR SETTLEMENT*:ti OR NEIGHBOURHOOD*:ti OR NEIGHBORHOOD*:ti OR SPATIAL*:ti OR DISTRICT*:ti OR LOCATION:ti OR PARTNER*:ti OR CITIZEN*:ti OR RESIDENT*:ti OR GROUP:ti OR LOCAL:ti	66,971
#2	(PLACE OR PBI OR PBIS OR AREA OR COMMUNITY OR SETTLEMENT* OR NEIGHBOURHOOD* OR NEIGHBORHOOD* OR SPATIAL* OR DISTRICT* OR LOCATION OR PARTNER* OR CITIZEN* OR RESIDENT* OR GROUP OR LOCAL):kw	91,734
#3	[mh "COMMUNITY PARTICIPATION"]	1,841
#4	#1 OR #2 OR #3 in Cochrane Reviews	418
#5	mdma:ti OR opiate*:ti OR opioid:ti OR opioids:ti OR heroin:ti OR methadone:ti OR cocaine:ti OR amphetamine*:ti OR marijuana:ti OR cannabis:ti OR crack:ti OR phencyclidine:ti OR benzodiazepine*:ti OR methamphetamine*:ti	15,951
#6	drug*:ti AND (problem*:ti OR use:ti OR user*:ti OR abuse*:ti OR misuse*:ti OR abusing:ti OR depend*:ti OR addict*:ti)	3,061
#7	Narcotic*:ti OR polyabuse*:ti OR illicit-drug*:ti	510
#8	substance:ti AND (problem*:ti OR use:ti OR user*:ti OR abuse*:ti OR misuse*:ti OR abusing:ti OR depend*:ti OR addict*:ti)	2739
#9	mdma:kw OR opiate*:kw OR opioid:kw OR opioids:kw OR heroin:kw OR methadone:kw OR cocaine:kw OR amphetamine*:kw OR marijuana:kw OR cannabis:kw OR crack:kw OR phencyclidine:kw OR benzodiazepine*:kw OR methamphetamine*:kw	21,864
#10	drug*:kw AND (problem*:kw OR use:kw OR user*:kw OR abuse*:kw OR misuse*:kw OR abusing:kw OR depend*:kw OR addict*:kw)	209,414
#11	substance:kw AND (problem*:kw OR use:kw OR user*:kw OR abuse*:kw OR misuse*:kw OR abusing:kw OR depend*:kw OR addict*:kw)	5,671
#12	Narcotic*:kw OR polyabuse*:kw OR illicit-drug*:kw	5,152
#13	[mh "phencyclidine abuse"] OR [mh "prescription drug diversion"] OR [mh "amphetamine related disorders"] OR [mh "dependency, psychological"] OR [mh "cocaine related disorders"] OR [mh "amphetamine related disorders"] OR [mh "cocaine related disorders"] OR [mh "substance abuse, intravenous"] OR [mh "substance related disorders"] OR [mh "behavior, addictive"] OR [mh "drug misuse"] OR [mh "substance related disorders"] OR [mh "narcotic related disorders"] OR [mh "drug overdose"] OR [mh "marijuana abuse"] OR [mh "marijuana use"] OR [mh "opiate substitution treatment"] OR [mh "inhalant abuse"]	5,500
#14	#5 OR #6 OR #7 OR #8 OR #9 OR #10 OR #11 OR #12 OR #13	235,392
#15	#4 AND #14 with Cochrane Library publication date Between Jan 2013 and Jan 2023	64

## Campbell Library search

Searched on 9 January 2023.

The following search was conducted in the 'Anywhere' field search option (see Figure A1).

### 70 results for

“(PLACE OR PBI OR PBIS OR AREA OR COMMUNITY OR SETTLEMENT\* OR NEIGHBOURHOOD\* OR NEIGHBORHOOD\* OR SPATIAL\* OR DISTRICT\* OR LOCATION OR PARTNER\* OR CITIZEN\* OR RESIDENT\* OR GROUP OR LOCAL) AND (mdma OR opiate\* OR opioid OR opioids OR heroin OR methadone OR cocaine OR amphetamine\* OR marijuana OR cannabis OR crack OR phencyclidine OR benzodiazepine\* OR methamphetamine\* OR drug\* OR addict\* OR narcotic\* OR polyabuse\* OR illicit OR substance)” anywhere published in “Campbell Systematic Reviews”

Figure A1: Campbell Library search screenshot

The screenshot displays the 'ADVANCED SEARCH' interface. At the top, there are two tabs: 'ADVANCED SEARCH' (selected) and 'CITATION SEARCH'. Below the tabs, the search form is titled 'Advanced search'. It features a table with two columns: 'Context' and 'Term'. The first row has 'Anywhere' in the context and '(PLACE OR PBI OR PBIS OR AREA OR COMMUNITY OR SETTLEMENT)' in the term. The second row has 'Keywords' in the context and 'Enter Search term' in the term. The third row has 'Anywhere' in the context and 'Enter Search term' in the term. The fourth row has 'Anywhere' in the context and 'Enter Search term' in the term. Below the table, there is a 'Published in' field with 'Campbell Systematic Reviews' entered. Underneath, there is a 'PUBLICATION DATE' section with three radio buttons: 'All dates', 'Last', and 'Custom range'. The 'Custom range' option is selected, and it shows a date range from '1' to '2023'.

## Epistemonikos search

Searched on 9 January 2023.

The following search was conducted in the 'Title' field (see Figure A2).

title:(((PLACE OR PBI OR PBIS OR AREA OR COMMUNITY OR SETTLEMENT\* OR NEIGHBOURHOOD\* OR NEIGHBORHOOD\* OR SPATIAL\* OR DISTRICT\* OR LOCATION OR PARTNER\* OR CITIZEN\* OR RESIDENT\* OR GROUP OR LOCAL) AND (mdma OR opiate\* OR opioid OR opioids OR heroin OR methadone OR cocaine OR amphetamine\* OR marijuana OR cannabis OR crack OR phencyclidine OR benzodiazepine\* OR methamphetamine\* OR drug\* OR addict\* OR narcotic\* OR polyabuse\* OR illicit OR substance)))

Figure A2: Epistemonikos search screenshot

The screenshot displays the Epistemonikos search interface. At the top, there are tabs for 'COVID-19 Evidence' and 'COVID-19 News'. The main navigation bar includes the Epistemonikos logo and links for 'About', 'Help', and 'Contact'. The search bar is labeled 'Advanced search' and contains the query: 'title:(((PLACE OR PBI OR PBIS OR AREA OR COMMUNITY ...))'. Below the search bar, there are several filter categories: 'Publication year' (Last 10 years), 'Added to database' (All), 'Publication type' (Systematic Review), 'Cochrane review' (All), 'Pubmed central (PMC)' (All), 'Systematic Review Question' (All), 'Type of meta-analysis' (All), and 'Country or regional focus'. The search results are displayed in a list format, showing 'Showing items 1 - 10' and 'Total: 120'. The first result is a 'Systematic review' titled 'Is there a place for off-label pharmacotherapy in cannabis use disorder? A review on efficacy and safety.' by Laprevote V, Schwan R, Schwitzer T, Rolland B, Thome J, published in 'Current pharmaceutical design' in 2015. The second result is another 'Systematic review' titled 'Recommendations for opioid prescribing after urological surgery: Evidence update from the promoting opioid stewardship in endourology work group' by Koo K, Winoker J, Faisal F, Patel H, Metcalf M, Pierorazio P, Matlaga B, published in 'J. Urol.' in 2020. The third result is partially visible and is the same as the first result.

# Appendix B: Review studies included in full-text screening

Following each record below, we indicate the judgement reached after full-text screening, using the following categories: (1) eligible; (2) does not deal with drug-related threats and harms; (3) does not relate to place-based initiatives; (4) not a systematic review or meta-analysis.

1. Cyril S, Smith BJ, Possamai-Inesedy A, Renzaho AMN (2015). Exploring the role of community engagement in improving the health of disadvantaged populations: a systematic review. *Global Health Action*, 8(1): 29842. <https://doi.org/10.3402/gha.v8.29842> (ineligible – does not deal with drug-related threats and harms)
2. Flanagan SK, Varga SM, Zaff JF, Margolius M, Lin ES (2018). *Comprehensive Community Initiatives: The Impact on Population-Level Children, Youth, and Family Outcomes*. New York: Weiss Institute. (eligible)
3. Hutchison M, Russell BS (2021). Community coalition efforts to prevent adolescent substance use: a systematic review. *Journal of Drug Education*, 50(1-2): 3–30. <https://doi.org/10.1177/00472379211016384> (eligible)
4. Krakouer J, Savaglio M, Taylor K, Skouteris H (2022). Community-based models of alcohol and other drug support for First Nations peoples in Australia: a systematic review. *Drug and Alcohol Review* 41(6): 1418–1427. <https://doi.org/10.1111/dar.13477> (ineligible – does not relate to place-based initiatives)
5. Leece P, Khorasheh T, Paul N, Keller-Olaman S, Massarella S, Caldwell J, Parkinson M, Strike C, Taha S, Penney G, Henderson R, Manson H (2019). ‘Communities are attempting to tackle the crisis’: a scoping review on community plans to prevent and reduce opioid-related harms. *BMJ Open*, 9(9): e028583. <https://doi.org/10.1136/bmjopen-2018-028583> (eligible)
6. Nagorcka-Smith P, Bolton KA, Dam J, Nichols M, Alston L, Johnstone M, Allender S (2022). The impact of coalition characteristics on outcomes in community-based initiatives targeting the social determinants of health: a systematic review. *BMC Public Health*, 22(1): 1358. <https://doi.org/10.1186/s12889-022-13678-9> (eligible)
7. O’Mara-Eves A, Brunton G, Oliver S, Kavanagh J, Jamal F, Thomas J (2015). The effectiveness of community engagement in public health interventions for disadvantaged groups: a meta-analysis. *BMC Public Health*, 15(1): 129. <https://doi.org/10.1186/s12889-015-1352-y> (ineligible – does not relate to place-based initiatives)

8. Porthé V, García-Subirats I, Ariza C, Villalbí JR, Bartroli M, Juárez O, Díez E (2021). Community-based interventions to reduce alcohol consumption and alcohol-related harm in adults. *Journal of Community Health*, 46(3): 565–576. <https://doi.org/10.1007/s10900-020-00898-6> (ineligible – does not deal with drug-related threats and harms)
9. Sigfusdottir ID, Soriano HE, Mann MJ, Kristjansson AL (2020). Prevention is possible: a brief history of the origin and dissemination of the Icelandic Prevention Model. *Health Promotion Practice*, 21(1): 58–61. <https://doi.org/10.1177/1524839919886314> (ineligible – not a systematic review or meta-analysis)
10. Stockings E, Bartlem K, Hall A, Hodder R, Gilligan C, Wiggers J, Sherker S, Wolfenden L (2018). Whole-of-community interventions to reduce population-level harms arising from alcohol and other drug use: a systematic review and meta-analysis. *Addiction*, 113(11): 1984–2018. <https://doi.org/10.1111/add.14277> (eligible)
11. Valdez ES, Skobic I, Valdez L, Garcia DO, Korchmaros J, Stevens S, Sabo S, Carvajal S (2020). Youth participatory action research for youth substance use prevention: a systematic review. *Substance Use & Misuse*, 55(2): 314–328. <https://doi.org/10.1080/10826084.2019.1668014> (ineligible – does not relate to place-based initiatives)

# Appendix C:

## Main literature search

Here we provide detailed information on our database and website searches.

### Embase.com

Searched on 25 January 2023.

Table C1 shows the details of our search, which yielded 8,608 unique records.

**Table C1: Embase search algorithm**

No.	Query	Results
#45	#40 NOT #44	8,608
#44	#41 OR #42 OR #43	2,565,819
#43	'rodent'/de AND 'animal experiment'/de	9,215
#42	'animal experiment'/de NOT ('human experiment'/de OR 'human'/de)	2,499,634
#41	(rat:ti OR rats:ti OR mouse:ti OR mice:ti OR swine:ti OR porcine:ti OR murine:ti OR sheep:ti OR lambs:ti OR pigs:ti OR piglets:ti OR rabbit:ti OR rabbits:ti OR cat:ti OR cats:ti OR dog:ti OR dogs:ti OR cattle:ti OR bovine:ti OR monkey:ti OR monkeys:ti OR trout:ti OR marmoset*:ti) AND 'animal experiment'/de	1,190,697
#40	#37 NOT #38 AND [english]/lim	8,640
#39	#37 NOT #38	8,709
#38	(#1 OR #24 OR #30 OR #35) AND [2013-2023]/py AND ([editorial]/lim OR [letter]/lim OR [note]/lim)	203
#37	(#1 OR #24 OR #30 OR #35) AND [2013-2023]/py	8,912
#36	#1 OR #24 OR #30 OR #35	14,715
#35	(#7 OR #29) AND #34	5,863
#34	#31 OR #32 OR #33	82,983
#33	'family support':ti,ab,kw OR 'family resource':ti,ab,kw	9,813
#32	'harm reduction'/de OR 'crime'/de OR 'criminal behavior'/de OR 'drug traffic'/exp OR 'property crime'/exp OR 'crime prevention'/de OR 'offender'/de	60,000
#31	((harm* OR crime\$ OR criminal) NEAR/5 reduc*):ti,ab,kw	19,694
#30	#23 AND #29	7,157
#29	#25 OR #26 OR #27 OR #28	123,554
#28	'recovery community':ti,ab,kw OR 'recovery communities':ti,ab,kw OR 'recovery capital':ti,ab,kw	291
#27	'community participation'/de OR 'community resource'/de	4,250

No.	Query	Results
#26	'community assets':ti,ab,kw OR ((communit* NEAR/4 partner*):ti,ab,kw) OR 'civil societ* involv*':ti,ab,kw OR 'communit* plan*':ti,ab,kw OR 'social reintegration':ti,ab,kw OR 'community action\$':ti,ab,kw OR 'collaborative action\$':ti,ab,kw OR 'whole community':ti,ab,kw	15,041
#25	'community based':ti,ab,kw OR 'community fora':ti,ab,kw OR 'community forum*':ti,ab,kw OR ((communit* NEAR/3 engag*):ti,ab,kw) OR 'community action':ti,ab,kw OR 'community intervention*':ti,ab,kw OR 'local intervention*':ti,ab,kw OR 'community change agent\$':ti,ab,kw OR communitarian:ti,ab,kw OR 'community organi*':ti,ab,kw OR ((communit* NEAR/5 intermediar*):ti,ab,kw)	111,339
#24	#7 AND #16 AND #23	3,787
#23	#17 OR #18 OR #19 OR #20 OR #21 OR #22	576,406
#22	'intravenous drug abuse'/de OR 'drug dependence'/de OR 'cannabis addiction'/de OR 'addiction'/de OR 'drug misuse'/exp OR 'drug abuse'/de OR 'narcotic dependence'/exp OR 'substance abuse'/exp	271,120
#21	'opiate addiction'/de OR 'heroin dependence'/de OR 'morphine addiction'/de OR 'drug abuse'/de OR 'methadone treatment'/de OR 'injection drug user'/de OR 'drug overdose'/de OR 'drug seeking behavior'/de	132,065
#20	'amphetamine abuse'/de	195
#19	'analgesic agent abuse'/de OR 'illicit drug inhalation'/de OR 'multiple drug abuse'/de OR 'phencyclidine abuse'/de OR 'prescription drug diversion'/de OR 'amphetamine dependence'/de OR 'benzodiazepine dependence'/de OR 'cocaine dependence'/de OR 'methamphetamine dependence'/de OR 'phencyclidine dependence'/de	19,046
#18	((drug OR drugs OR substance\$ OR opiate\$ OR opioid\$ OR morphine OR heroin OR narcotic\$) NEAR/4 (problem\$ OR abuse* OR abusing OR dependen* OR addict* OR misuse OR polyabuse OR use OR uses OR users)):ti,ab,kw	416,391
#17	((mdma OR opiate\$ OR opioid\$ OR opium OR heroin OR methadone OR cocaine OR amphetamine\$ OR marijuana OR cannabis OR crack OR phencyclidine) NEAR/4 (problem OR problems OR abuse* OR abusing OR dependen* OR addict* OR misuse OR polyabuse OR use OR uses OR users)):ti,ab,kw	113,154
#16	#8 OR #9 OR #10 OR #11 OR #12 OR #13 OR #14 OR #15	1,231,539
#15	((drug OR drugs OR substance\$ OR opiate\$ OR opioid\$ OR morphine OR heroin OR narcotic\$) NEAR/4 (treatment\$ OR service\$ OR unit OR units OR center OR centers OR centre OR centres OR facilit*)):ti,ab,kw	256,298
#14	((opioid\$ OR opiate\$ OR agonist\$) NEAR/3 (substitut* OR replace*)):ti,ab,kw	3,634
#13	subutex:ti,ab,kw OR suboxone:ti,ab,kw	593
#12	'community-based rehabilitation'/de	940
#11	'rehabilitation'/de OR 'drug dependence treatment'/exp	125,106
#10	'buprenorphine plus naloxone'/de OR 'naloxone'/de	47,265
#9	overdos*:ti,ab,kw OR 'over dos*':ti,ab,kw OR naloxone:ti,ab,kw OR recovery:ti,ab,kw OR narcan:ti,ab,kw OR buprenorphine:ti,ab,kw OR detox*:ti,ab,kw	846,462
#8	((needle* OR syringe* OR inject*) NEAR/4 (exchange OR suppl* OR access* OR provision OR provid* OR distribut* OR dispens* OR pack\$ OR program* OR service\$ OR center\$ OR centre\$ OR scheme\$ OR facility OR facilities OR pharmacy OR pharmacies OR unit OR units OR room\$)):ti,ab,kw	27,841
#7	#2 OR #3 OR #4 OR #5 OR #6	280,672

No.	Query	Results
#6	'social environment'/de OR 'community'/de OR 'community resilience'/de OR 'community support'/de OR 'neighborhood'/exp OR 'social capital'/de OR 'social connectedness'/exp OR 'social incentive'/de OR 'social isolation'/exp	192,577
#5	(social* NEAR/4 reintegrat*):ti,ab,kw	1,245
#4	'drug project\$:ti,ab,kw	177
#3	((geographic* NEAR/4 based):ti,ab,kw) OR 'place based':ti,ab,kw OR placebased:ti,ab,kw OR 'area based':ti,ab,kw OR areabased:ti,ab,kw	9,393
#2	(('legal space' OR location\$ OR hotspot\$ OR 'hot spot'\$ OR neighbourhoood\$ OR neighborhood\$ OR local OR community OR communities OR stakeholder\$ OR grassroot\$) NEAR/4 (program* OR initiative\$ OR led OR response\$)):ti,ab,kw	84,803
#1	((mersey NEAR/5 model*):ti,ab,kw) OR ((icelandic NEAR/5 model*):ti,ab,kw) OR 'healing communities':ti,ab,kw OR 'drugs task force':ti,ab,kw OR 'drug task force':ti,ab,kw	88

## Cochrane Library

Searched 25 January 2023.

We identified 941 results for trials and 15 results for Cochrane reviews. Some 14 Cochrane reviews and 914 CENTRAL records were downloaded (see Table C2).

**Table C2: Cochrane Library search algorithm**

ID	Search	Hits
#1	(mersey:ti,ab,kw NEAR/4 model*:ti,ab,kw) OR (icelandic:ti,ab,kw NEAR/4 model*:ti,ab,kw) OR "healing communities":ti,ab,kw OR "drugs task force":ti,ab,kw OR "drug task force":ti,ab,kw	9
#2	("Legal space":ti,ab,kw OR location?:ti,ab,kw OR Hotspot?:ti,ab,kw OR ("Hot" NEXT spot?):ti,ab,kw OR Neighbourhood?:ti,ab,kw OR Neighborhood?:ti,ab,kw OR local:ti,ab,kw OR community:ti,ab,kw OR communities:ti,ab,kw OR stakeholder?:ti,ab,kw OR Grassroot?:ti,ab,kw) NEAR/4 (program*:ti,ab,kw OR initiative?:ti,ab,kw OR led:ti,ab,kw OR response?:ti,ab,kw)	6,919
#3	((Geographic*:ti,ab,kw NEAR/4 based:ti,ab,kw) OR place-based:ti,ab,kw OR placebased:ti,ab,kw OR area-based:ti,ab,kw OR areabased:ti,ab,kw)	292
#4	("drug" NEXT project?):ti,ab,kw	41
#5	(social*:ti,ab,kw NEAR/4 reintegrat*:ti,ab,kw)	78
#6	[mh "social environment"]	4,513
#7	[mh ^"community networks"] OR [mh ^"social capital"] OR [mh ^"social inclusion"] OR [mh ^"social planning"] OR [mh "social isolation"] OR [mh "social change"]	593
#8	[mh "community participation"]	1,841
#9	{OR #2-#8}	13,722
#10	((needle*:ti,ab,kw OR syringe*:ti,ab,kw OR inject*:ti,ab,kw) NEAR/4 (exchange:ti,ab,kw OR suppl*:ti,ab,kw OR access*:ti,ab,kw OR provision:ti,ab,kw OR provid*:ti,ab,kw OR distribut*:ti,ab,kw OR dispens*:ti,ab,kw OR pack*:ti,ab,kw OR program*:ti,ab,kw OR service*:ti,ab,kw OR center*:ti,ab,kw OR centre*:ti,ab,kw OR scheme*:ti,ab,kw OR facility:ti,ab,kw OR facilities:ti,ab,kw OR pharmacy:ti,ab,kw OR pharmacies:ti,ab,kw OR unit:ti,ab,kw OR units:ti,ab,kw OR room?:ti,ab,kw))	3,627



ID	Search	Hits
#11	(overdos*:ti,ab,kw OR over-dos*:ti,ab,kw OR naloxone:ti,ab,kw OR recovery:ti,ab,kw OR narcan:ti,ab,kw OR buprenorphine:ti,ab,kw OR detox*:ti,ab,kw)	78,653
#12	[mh "buprenorphine"] OR [mh "naloxone"] OR [mh ^"rehabilitation"] OR [mh ^"opiate substitution treatment"] OR [mh "substance abuse treatment centers"] OR [mh ^"rehabilitation centers"]	4,769
#13	(subutex:ti,ab,kw OR suboxone:ti,ab,kw)	95
#14	((opiod?:ti,ab,kw OR opiate?:ti,ab,kw OR agonist?:ti,ab,kw) NEAR/3 (substitut*:ti,ab,kw OR replace*:ti,ab,kw))	680
#15	((drug:ti,ab,kw OR drugs:ti,ab,kw OR substance?:ti,ab,kw OR opiate?:ti,ab,kw OR opiod?:ti,ab,kw OR morphine:ti,ab,kw OR heroin:ti,ab,kw OR narcotic?:ti,ab,kw) NEAR/4 (treatment?:ti,ab,kw OR service?:ti,ab,kw OR unit:ti,ab,kw OR units:ti,ab,kw OR center:ti,ab,kw OR centers:ti,ab,kw OR centre:ti,ab,kw OR centres:ti,ab,kw OR facilit*:ti,ab,kw))	49,344
#16	{OR #10-#15}	128,953
#17	((mdma:ti,ab,kw OR opiate?:ti,ab,kw OR opiod?:ti,ab,kw OR opium:ti,ab,kw OR heroin:ti,ab,kw OR methadone:ti,ab,kw OR cocaine:ti,ab,kw OR amphetamine?:ti,ab,kw OR marijuana:ti,ab,kw OR cannabis:ti,ab,kw OR crack:ti,ab,kw OR phencyclidine:ti,ab,kw) NEAR/4 (problem:ti,ab,kw OR problems:ti,ab,kw OR abuse*:ti,ab,kw OR abusing:ti,ab,kw OR dependen*:ti,ab,kw OR addict*:ti,ab,kw OR misuse:ti,ab,kw OR polyabuse:ti,ab,kw OR use:ti,ab,kw OR uses:ti,ab,kw OR users:ti,ab,kw))	17,313
#18	((drug:ti,ab,kw OR drugs:ti,ab,kw OR substance?:ti,ab,kw OR morphine:ti,ab,kw OR narcotic?:ti,ab,kw) NEAR/4 (problem?:ti,ab,kw OR abuse*:ti,ab,kw OR abusing:ti,ab,kw OR dependen*:ti,ab,kw OR addict*:ti,ab,kw OR misuse:ti,ab,kw OR polyabuse:ti,ab,kw OR use:ti,ab,kw OR uses:ti,ab,kw OR users:ti,ab,kw))	48,776
#19	[mh "narcotics"] OR [mh "illicit drugs"] OR [mh ^"substance-related disorders"] OR [mh ^"phencyclidine abuse"] OR [mh ^"amphetamine-related disorders"] OR [mh "cocaine-related disorders"] OR [mh ^"inhalant abuse"] OR [mh ^"marijuana abuse"] OR [mh ^"narcotic-related disorders"] OR [mh "opiod-related disorders"] OR [mh ^"phencyclidine abuse"] OR [mh ^"substance abuse, intravenous"] OR [mh ^"substance abuse, oral"] OR [mh ^"prescription drug diversion"] OR [mh ^"drug users"] OR [mh "drug overdose"] OR [mh ^"drug seeking behavior"] OR [mh "drug misuse"]	14,869
#20	{OR #17-#19}	63,891
#21	(community-based:ti,ab,kw OR "community fora":ti,ab,kw OR ("community" NEXT forum?):ti,ab,kw OR (communit*:ti,ab,kw NEAR/3 engag*:ti,ab,kw) OR "community action":ti,ab,kw OR ("community" NEXT intervention?):ti,ab,kw OR ("local" NEXT intervention?):ti,ab,kw OR ("community change" NEXT agent?):ti,ab,kw OR communitarian:ti,ab,kw OR ("community" NEXT organi?):ti,ab,kw OR (communit*:ti,ab,kw NEAR/5 intermediar*:ti,ab,kw))	11,715
#22	("community assets":ti,ab,kw OR (communit*:ti,ab,kw NEAR/4 partner*:ti,ab,kw) OR ("civil" NEXT societ? NEXT involv?):ti,ab,kw OR (communit? NEXT plan?):ti,ab,kw OR "social reintegration":ti,ab,kw OR ("community" NEXT action?):ti,ab,kw OR ("collaborative" NEXT action?):ti,ab,kw OR "whole community":ti,ab,kw)	1,042
#23	[mh ^"community participation"] OR [mh "community integration"] OR [mh "community networks"]	488
#24	("recovery community":ti,ab,kw OR "recovery communities":ti,ab,kw OR "recovery capital":ti,ab,kw)	17
#25	{OR #21-#24}	12,550
#26	((harm?:ti,ab,kw OR crime?:ti,ab,kw OR criminal:ti,ab,kw) NEAR/5 reduc*:ti,ab,kw)	1,275

ID	Search	Hits
#27	[mh ^"Harm reduction"] OR [mh ^"crime"] OR [mh ^"theft"] OR [mh "fraud"] OR [mh "sex offenses"] OR [mh "homicide"] OR [mh "violence"] OR [mh "prescription drug diversion"] OR [mh "drug trafficking"] OR [mh "needle sharing"] OR [mh "sex work"] OR [mh "criminals"] OR [mh ^"criminal behavior"] OR [mh ^offender]	2686
#28	("family support":ti,ab,kw OR "family resource":ti,ab,kw)	702
#29	{OR #26-#28}	4452
#30	#9 AND #16 AND #20	411
#31	#20 AND #25	944
#32	(#9 OR #25) AND #29	581
#33	#1 OR #30 OR #31 OR #32 with Publication Year from 2013 to 2023, with Cochrane Library publication date Between Jan 2013 and Jan 2023, in Trials	

## Social Care Online Database

Searched on 25 January 2023.

Some 1,468 records were downloaded.

The search interface does not allow complex searching, so a number of search strings were used, as shown in Table C3.

**Table C3: Social Care Online Database search algorithm**

Search strings	Number of records downloaded
"Mersey model" OR "icelandic model" OR "healing communities" OR "drugs task force" OR "drug task force"	1
"Legal space" OR location OR Hotspot OR "Hot spot" OR Neighbourhood OR Neighborhood OR local OR community OR communities OR stakeholder OR Grassroot OR Geographic OR "place based" OR placebased OR area-based OR areabased OR "drug project" OR "drug projects" OR reintegration or reintegrate AND needle OR syringe OR inject OR overdose or overdosing or "over dose" or "over-dosed" OR "over-dosing" OR naloxone OR recovery OR narkan OR buprenorphine OR detoxify OR detoxification OR rehabilitation OR subutex OR suboxone OR substitution OR replacement OR treatment OR service OR unit OR units OR center OR centre OR facility OR facilities AND mdma OR opiate OR opioid OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine OR illegal OR illicit OR "drug abuse" OR "drug abusers" OR "drug misuse" OR "drug misusers" OR "drug users" OR "drug user" OR "drug use" OR "substance abuse" OR "substance abusers" OR "substance misuse" OR "substance misusers" OR "substance users" OR "substance user" OR "substance use" OR morphine OR narcotic OR narcotics	397

Search strings	Number of records downloaded
<p>mdma OR opiate OR opioid OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine OR illegal OR illicit OR "drug abuse" OR "drug abusers" OR "drug misuse" OR "drug misusers" OR "drug users" OR "drug user" OR "drug use" OR "substance abuse" OR "substance abusers" OR "substance misuse" OR "substance misusers" OR "substance users" OR "substance user" OR "substance use" OR morphine OR narcotic OR narcotics</p> <p>AND</p> <p>"community-based" OR "community fora" OR "community forum" OR "community engagement" OR "community action" OR "community intervention" OR "community interventions" OR "local intervention" OR "local interventions" OR "change agent" OR "change agents" OR communitarian OR "community organisation" OR "community organization" OR "community organisations" OR "community organizations"</p>	146
<p>mdma OR opiate OR opioid OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine OR illegal OR illicit OR "drug abuse" OR "drug abusers" OR "drug misuse" OR "drug misusers" OR "drug users" OR "drug user" OR "drug use" OR "substance abuse" OR "substance abusers" OR "substance misuse" OR "substance misusers" OR "substance users" OR "substance user" OR "substance use" OR morphine OR narcotic OR narcotics</p> <p>AND</p> <p>intermediary OR intermediaries OR "community assets" OR "community partnership" OR "community partnerships" OR "civil society" OR community planning" OR "social reintegration"</p>	0
<p>mdma OR opiate OR opioid OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine OR illegal OR illicit OR "drug abuse" OR "drug abusers" OR "drug misuse" OR "drug misusers" OR "drug users" OR "drug user" OR "drug use" OR "substance abuse" OR "substance abusers" OR "substance misuse" OR "substance misusers" OR "substance users" OR "substance user" OR "substance use" OR morphine OR narcotic OR narcotics</p> <p>AND</p> <p>"community action" OR "community actions" OR "collaborative action" OR "collaborative actions" OR "whole community" OR "recovery community" OR "recovery communities" OR "recovery capital"</p>	12
<p>"Legal space" OR location OR Hotspot OR "Hot spot" OR Neighbourhood OR Neighborhood OR local OR community OR communities OR stakeholder OR Grassroot OR Geographic OR "place based" OR placebased OR area-based OR areabased OR "drug project" OR "drug projects" OR reintegration or reintregate</p> <p>AND</p> <p>harm OR crime OR criminal OR theft OR fraud</p> <p>AND 2013-2023</p>	297
<p>"Legal space" OR location OR Hotspot OR "Hot spot" OR Neighbourhood OR Neighborhood OR local OR community OR communities OR stakeholder OR Grassroot OR Geographic OR "place based" OR placebased OR area-based OR areabased OR "drug project" OR "drug projects" OR reintegration or reintregate</p> <p>AND</p> <p>"sex offenses" OR homicide OR violence OR "drug diversion" OR "drug trafficking" OR "needle sharing" OR "sex work" OR offenders OR "family support" OR "family resource"</p> <p>AND 2013 to 2023</p>	436

Search strings	Number of records downloaded
<p>“community-based” OR “community fora” OR “community forum” OR “community engagement” OR “community action” OR “community intervention” OR “community interventions” OR “local intervention” OR “local interventions” OR “change agent” OR “change agents” OR communitarian OR “community organisation”</p> <p>AND</p> <p>harm OR crime OR criminal OR theft OR fraud</p> <p>AND 2013 to 2023</p>	49
<p>“community organization” OR “community organisations” OR “community organizations” OR intermediary OR intermediaries</p> <p>AND</p> <p>harm OR crime OR criminal OR theft OR fraud</p> <p>AND 2013 to 2023</p>	5
<p>“community assets” OR “community partnership” OR “community partnerships” OR “civil society” OR “community planning” OR “social reintegration”</p> <p>AND</p> <p>harm OR crime OR criminal OR theft OR fraud</p> <p>AND 2013 to 2023</p>	2
<p>“community action” OR “community actions” OR “collaborative action” OR “collaborative actions” OR “whole community” OR “recovery community” OR “recovery communities” OR “recovery capital”</p> <p>AND</p> <p>harm OR crime OR criminal OR theft OR fraud</p> <p>AND 2013 to 2023</p>	2
<p>“sex offenses” OR homicide OR violence OR “drug diversion” OR “drug trafficking” OR “needle sharing” OR “sex work” OR offenders OR “family support” OR “family resource”</p> <p>AND</p> <p>“community-based” OR “community fora” OR “community forum” OR “community engagement” OR “community action” OR “community intervention” OR “community interventions” OR “local intervention” OR “local interventions” OR “change agent” OR “change agents” OR communitarian OR “community organisation”</p> <p>AND 2013-2023</p>	117
<p>“sex offenses” OR homicide OR violence OR “drug diversion” OR “drug trafficking” OR “needle sharing” OR “sex work” OR offenders OR “family support” OR “family resource”</p> <p>AND</p> <p>“community organization” OR “community organisations” OR “community organizations” OR intermediary OR intermediaries OR “community assets”</p> <p>AND 2013-2023</p>	3
<p>“sex offenses” OR homicide OR violence OR “drug diversion” OR “drug trafficking” OR “needle sharing” OR “sex work” OR offenders OR “family support” OR “family resource”</p> <p>AND</p> <p>“community partnership” OR “community partnerships” OR “civil society” OR “community planning” OR “social reintegration” OR “community action” OR “community actions” OR “collaborative action” OR “collaborative actions” OR “whole community” OR “recovery community” OR “recovery communities” OR “recovery capital”</p> <p>AND 2013-2023</p>	1

## Social Sciences Citation Index

Searched on 30 January 2023.

Some 16,137 results were downloaded in 17 files. The following searches were used:

# Web of Science Search Strategy (v0.1)

- WOS.SSCI: 1985 to 2023

### # Searches

1. TS=((mersey NEAR/2 model\$) OR (icelandic NEAR/2 model\$) OR (healing NEAR/2 communities) OR "drugs task force" OR "drug task force")

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:05:16 GMT+0000 (Greenwich Mean Time)

Results: 254

2. TS=((Legal NEAR/2 space) OR location OR Hotspot OR "Hot spot" OR Neighbourhood OR Neighborhood OR local OR community OR communities OR stakeholder\$ OR Grassroot\$ OR Geographic OR "place based" OR placebased OR area-based OR areabased OR "drug project" OR "drug projects" OR reintegration or reintegrate)

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:07:45 GMT+0000 (Greenwich Mean Time)

Results: 879377

3. TS=(needle OR needles OR syringe OR syringes OR injecting OR inject OR overdos\* OR "over dose" or "over-dosed" OR "over-dosing" OR naloxone OR recovery OR narkan OR buprenorphine OR detoxify OR detoxification OR rehabilitation OR subutex OR suboxone OR substitution OR replacement OR treatment OR service OR unit OR units OR center OR centre OR facility OR facilities)

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:10:02 GMT+0000 (Greenwich Mean Time)

Results: 1370169

4. TS=(mdma OR opiate OR opioid OR opium OR heroin OR methadone OR cocaine OR amphetamine\$ OR marijuana OR cannabis OR crack OR phencyclidine OR illegal OR illicit OR "drug abuse" OR "drug abusers" OR "drug misuse" OR "drug misusers" OR "drug users" OR "drug user" OR "drug use" OR "substance abuse" OR "substance abusers" OR "substance misuse" OR "substance misusers" OR "substance users" OR "substance user" OR "substance use" OR morphine OR narcotic OR narcotics)

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:11:00 GMT+0000 (Greenwich Mean Time)

Results: 191039

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5. #4 AND #3 AND #2

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:11:31 GMT+0000 (Greenwich Mean Time)

Results: 18765

---

6. TS=((community NEAR/3 (based OR fora OR forum OR engagement OR action OR intervention)) OR (local NEAR/3 intervention) OR (change NEAR/3 agent) OR communitarian OR "community organisation" OR "community organization" OR "community organisations" OR "community organizations" )

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:13:19 GMT+0000 (Greenwich Mean Time)

Results: 79090

---

7. #6 AND #4

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:13:37 GMT+0000 (Greenwich Mean Time)

Results: 5318

---

8. TS=(intermediary OR (community NEAR/3 (assets OR partnership OR planning OR action OR recovery OR whole)) OR "civil society" OR "social reintegration" OR (collaborative NEAR/3 action) OR "recovery capital")

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:17:42 GMT+0000 (Greenwich Mean Time)

Results: 40412

---

9. #4 AND #8

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:17:58 GMT+0000 (Greenwich Mean Time)

Results: 1155

---

10. TS=((harm OR crime OR criminal OR theft OR fraud OR "sex offenses" OR homicide OR violence OR "drug diversion" OR "drug trafficking" OR "needle sharing" OR "sex work" OR offenders OR "family support" OR "family resource") NEAR/4 (reduce OR reduction OR prevent OR prevention OR preventing))

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:20:33 GMT+0000 (Greenwich Mean Time)

Results: 26091

---

11. (#2 OR #6) AND #10

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:21:14 GMT+0000 (Greenwich Mean Time)

Results: 8019

---

12. #1 OR #5 OR #7 OR #9 OR #11

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:22:15 GMT+0000 (Greenwich Mean Time)

Results: 27310

13. #12

Editions: WOS.SSCI

Timespan: 2013-01-01 to 2023-01-30

Date Run: Mon Jan 30 2023 11:23:40 GMT+0000 (Greenwich Mean Time)

Results: 16540

14. DT=(Art Exhibit Review OR Bibliography OR Biographical-Item OR Book Review OR Chronology OR Dance Performance Review OR Database Review OR Discussion OR Editorial Material OR Fiction, Creative Prose OR Film Review OR Hardware Review OR Item About an Individual OR Letter OR Music Performance Review OR Music Score OR Music Score Review OR News Item OR Note OR Poetry OR Record Review OR Script OR Software Review OR Theater Review OR TV Review, Radio Review OR TV Review, Radio Review Video)

Editions: WOS.SSCI

Timespan: 2013-01-01 to 2023-01-30

Date Run: Mon Jan 30 2023 11:33:34 GMT+0000 (Greenwich Mean Time)

Results: 518659

15. #13 NOT #14

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:33:58 GMT+0000 (Greenwich Mean Time)

Results: 16280

16. LA=(English)

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:38:11 GMT+0000 (Greenwich Mean Time)

Results: 7641769

17. #15 AND #16

Editions: WOS.SSCI

Date Run: Mon Jan 30 2023 11:38:34 GMT+0000 (Greenwich Mean Time)

Results: 16137

## Sociological Abstracts (ProQuest)

Searched on 1 February 2023.

The search interface would not combine the four result sets, so each search was conducted separately, as shown below. A total of 2,931 records were downloaded.

## Search 1

Figure C1: Sociological Abstracts (ProQuest) Search 1

Set *	Search	Databases	Results	Save search/alert	Other actions
<input type="checkbox"/> S1	@ Title("mersey model" OR "icelandic model" OR "healing communities" OR "drugs task force" OR "drug task force") OR summary("mersey model" OR "icelandic model" OR "healing communities" OR "drugs task force" OR "drug task force") Limits applied Database: Sociological Abstracts Limited by: Date: After 2013 Language: English	Sociological Abstracts	5	Save search/alert	Other actions *

## Search 2

((Title(("Legal space" OR location? OR Hotspot? OR Hot-spot? OR Neighbourhood? OR Neighborhood? OR local OR community OR communities OR stakeholder? OR Grassroot? NEAR/4 (program\* OR initiative? OR led OR response?)) OR summary(("Legal space" OR location? OR Hotspot? OR Hot-spot? OR Neighbourhood? OR Neighborhood? OR local OR community OR communities OR stakeholder? OR Grassroot? NEAR/4 (program\* OR initiative? OR led OR response?))) OR (title((Geographic NEAR/4 based) OR "place based" OR placebased OR "area based" OR areabased) OR summary((Geographic NEAR/4 based) OR "place based" OR placebased OR "area based" OR areabased)) OR (Title("drug project") OR summary("drug project")) OR (Title(social NEAR/4 reintegration) OR summary(social NEAR/4 reintegration)) OR (Title("social capital") OR summary("social capital")) OR (MAINSUBJECT.EXACT.EXPLODE("Community Change") OR MAINSUBJECT.EXACT.EXPLODE("Community Organizations") OR MAINSUBJECT.EXACT.EXPLODE("Communities"))) AND ((TITLE((needle? OR syringe? OR inject\*) NEAR/4 (exchange? OR supply OR access\* OR provision OR provid\* OR distribut\* OR dispens\* OR pack? OR program\* OR service OR services OR center OR centers OR centre OR centres OR scheme OR schemes OR facility OR facilities OR pharmacy OR pharmacies OR unit OR units OR room OR rooms)) OR SUMMARY((needle? OR syringe? OR inject\*) NEAR/4 (exchange? OR supply OR access\* OR provision OR provid\* OR distribut\* OR dispens\* OR pack? OR program\* OR service OR services OR center OR centers OR centre OR centres OR scheme OR schemes OR facility OR facilities OR pharmacy OR pharmacies OR unit OR units OR room OR rooms))) OR (TITLE(overdos\* OR "over dose" OR over-dosing OR over-dosed OR naloxone OR recovery OR nalcarn OR buprenorphine OR detoxif\*) OR summary(overdos\* OR "over dose" OR over-dosing OR over-dosed OR naloxone OR recovery OR nalcarn OR buprenorphine OR detoxif\*)) OR (title(subutex OR suboxone) OR summary(subutex OR suboxone)) OR (title((opioid OR opioids OR opiate OR opiates OR agonist\*) NEAR/3 (substitute? OR replac\*)) OR summary((opioid OR opioids OR opiate OR opiates OR agonist\*) NEAR/3 (substitute? OR replac\*))) OR (title((drug OR drugs OR substance OR opiate OR opiates OR opioid OR opioids OR morphine OR heroin OR narcotic OR narcotics) NEAR/4 (treatment OR service OR services OR unit OR units OR center OR centers OR centre OR centres OR facilit\*)) OR summary((drug OR drugs OR substance OR opiate OR opiates OR opioid OR opioids OR morphine OR heroin OR narcotic OR narcotics) NEAR/4 (treatment OR service OR services OR unit OR units OR center OR centers OR centre OR centres OR facilit\*))) OR (MAINSUBJECT.EXACT("Needle Sharing") OR MAINSUBJECT.EXACT("Methadone Maintenance") OR MAINSUBJECT.EXACT("Detoxification") OR MAINSUBJECT.EXACT("Needle Exchange Programs"))) AND ((TITLE((mdma OR opiate OR opiates OR opioid OR opioids OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine) NEAR/4 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users)) OR SUMMARY((mdma OR opiate OR opiates OR opioid OR opioids OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine) NEAR/4 (problem?



OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users))) OR (TITLE((drug OR drugs OR substance OR morphine OR narcotic OR narcotics) NEAR/4 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users)) OR SUMMARY((drug OR drugs OR substance OR morphine OR narcotic OR narcotics) NEAR/4 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users))) OR ((MAINSUBJECT.EXACT("Drugs") OR MAINSUBJECT.EXACT("Psychedelic Drugs") OR MAINSUBJECT.EXACT("Tranquilizing Drugs") OR MAINSUBJECT.EXACT("Drug Abuse") OR MAINSUBJECT.EXACT("Narcotic Drugs") OR MAINSUBJECT.EXACT("Cocaine") OR MAINSUBJECT.EXACT("Marijuana") OR MAINSUBJECT.EXACT("Substance Abuse")) OR (MAINSUBJECT.EXACT("Lysergic Acid Diethylamide") OR MAINSUBJECT.EXACT("Opiates"))))Limits applied

### Databases:

1.1. Sociological Abstracts

### Limited by:

Date: After 2012

### Source type:

7 types searched Hide list

Books, Conference Papers & Proceedings, Dissertations & Theses, Other Sources, Reports, Scholarly Journals, Working Papers

### Language:

English

## Search 3

((TITLE((mdma OR opiate OR opiates OR opioid OR opioids OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine) NEAR/4 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users)) OR SUMMARY((mdma OR opiate OR opiates OR opioid OR opioids OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine) NEAR/4 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users))) OR (TITLE((drug OR drugs OR substance OR morphine OR narcotic OR narcotics) NEAR/4 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users)) OR SUMMARY((drug OR drugs OR substance OR morphine OR narcotic OR narcotics) NEAR/4 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users))) OR ((MAINSUBJECT.EXACT("Drugs") OR MAINSUBJECT.EXACT("Psychedelic Drugs") OR MAINSUBJECT.EXACT("Tranquilizing Drugs") OR MAINSUBJECT.EXACT("Drug Abuse") OR MAINSUBJECT.EXACT("Narcotic Drugs") OR MAINSUBJECT.EXACT("Cocaine") OR MAINSUBJECT.EXACT("Marijuana") OR MAINSUBJECT.EXACT("Substance Abuse")) OR (MAINSUBJECT.EXACT("Lysergic Acid Diethylamide") OR MAINSUBJECT.EXACT("Opiates")))) AND ((TITLE("community based" OR "community fora" OR "community forum" OR (communit\* NEAR/3 engag\*) OR "community action" OR "community intervention" OR "local intervention" OR "change agent?" OR communitarian OR (community NEAR/3 organi\* OR (communit NEAR/5 intermediar\*)) OR SUMMARY("community based" OR "community

fora" OR "community forum" OR (communit\* NEAR/3 engag\*) OR "community action" OR "community intervention" OR "local intervention" OR "change agent?" OR communitarian OR (community NEAR/3 organi\*) OR (communit NEAR/5 intermediar\*)) OR (TITLE("community assets" OR (communit\* NEAR/4 partner\*) OR "civil society" OR "community plan\*" OR "social reintegration" OR "community action" OR "collaborative action" OR "whole community") OR SUMMARY("community assets" OR (communit\* NEAR/4 partner\*) OR "civil society" OR "community plan\*" OR "social reintegration" OR "community action" OR "collaborative action" OR "whole community")) OR (TITLE("recovery community" OR "recovery communities" OR "recovery capital") OR SUMMARY("recovery community" OR "recovery communities" OR "recovery capital")) OR (MAINSUBJECT.EXACT("Community Involvement") OR MAINSUBJECT.EXACT("Citizen Participation") OR MAINSUBJECT.EXACT("Change Agents") OR MAINSUBJECT.EXACT("Communitarianism") OR MAINSUBJECT.EXACT("Community Organizations") OR MAINSUBJECT.EXACT("Local Planning") OR MAINSUBJECT.EXACT("Civil Society") OR MAINSUBJECT.EXACT("Cultural Capital"))))Limits applied

**Databases:** 1. Sociological Abstracts

**Limited by:**

Date: After 2012

**Source type:**

7 types searched [Hide list](#)

Books, Conference Papers & Proceedings, Dissertations & Theses, Other Sources, Reports, Scholarly Journals, Working Papers

**Document type:**

14 types searched [Hide list](#)

Annual Report, Article, Book, Book Chapter, Case Study, Conference Paper, Conference Proceeding, Correction/Retraction, Dissertation/Thesis, Evidence Based Healthcare, Literature Review, Report, Review, Working Paper/Pre-Print

**Language:**

English

**Search 4 – excludes Search 3**

(((((Title(("Legal space" OR location? OR Hotspot? OR Hot-spot? OR Neighbourhood? OR Neighborhood? OR local OR community OR communities OR stakeholder? OR Grassroot?) NEAR/4 (program\* OR initiative? OR led OR response?)) OR summary(("Legal space" OR location? OR Hotspot? OR Hot-spot? OR Neighbourhood? OR Neighborhood? OR local OR community OR communities OR stakeholder? OR Grassroot?) NEAR/4 (program\* OR initiative? OR led OR response?))) OR (title((Geographic NEAR/4 based) OR "place based" OR placebased OR "area based" OR areabased) OR summary((Geographic NEAR/4 based) OR "place based" OR placebased OR "area based" OR areabased)) OR (Title("drug project") OR summary("drug project")) OR (Title(social NEAR/4 reintegration) OR summary(social NEAR/4 reintegration)) OR (Title("social capital") OR summary("social capital")) OR (MAINSUBJECT.EXACT.EXPLODE("Community Change") OR MAINSUBJECT.EXACT.EXPLODE("Community Organizations") OR MAINSUBJECT.EXACT.EXPLODE("Communities"))) OR ((TITLE("community based" OR "community fora" OR "community forum" OR (communit\* NEAR/3 engag\*) OR

"community action" OR "community intervention" OR "local intervention" OR "change agent?"  
 OR communitarian OR (community NEAR/3 organi\*) OR (communit NEAR/5 intermediar\*) OR  
 SUMMARY("community based" OR "community fora" OR "community forum" OR (communit\*  
 NEAR/3 engag\*) OR "community action" OR "community intervention" OR "local intervention"  
 OR "change agent?" OR communitarian OR (community NEAR/3 organi\*) OR (communit  
 NEAR/5 intermediar\*)) OR (TITLE("community assets" OR (communit\* NEAR/4 partner\*)  
 OR "civil society" OR "community plan\*" OR "social reintegration" OR "community action"  
 OR "collaborative action" OR "whole community") OR SUMMARY("community assets" OR  
 (communit\* NEAR/4 partner\*) OR "civil society" OR "community plan\*" OR "social reintegration"  
 OR "community action" OR "collaborative action" OR "whole community")) OR (TITLE("recovery  
 community" OR "recovery communities" OR "recovery capital") OR SUMMARY("recovery  
 community" OR "recovery communities" OR "recovery capital")) OR (MAINSUBJECT.  
 EXACT("Community Involvement") OR MAINSUBJECT.EXACT("Citizen Participation") OR  
 MAINSUBJECT.EXACT("Change Agents") OR MAINSUBJECT.EXACT("Communitarianism") OR  
 MAINSUBJECT.EXACT("Community Organizations") OR MAINSUBJECT.EXACT("Local Planning")  
 OR MAINSUBJECT.EXACT("Civil Society") OR MAINSUBJECT.EXACT("Cultural Capital")) AND  
 (TITLE((harm OR crime OR criminal OR theft OR fraud OR "sex offenses" OR homicide OR  
 violence OR "drug diversion" OR "drug trafficking" OR "needle sharing" OR "sex work" OR  
 offenders OR offending) NEAR/4 (reduce OR reducing OR reduction OR prevent OR prevention  
 OR preventing)) OR SUMMARY((harm OR crime OR criminal OR theft OR fraud OR "sex offenses"  
 OR homicide OR violence OR "drug diversion" OR "drug trafficking" OR "needle sharing"  
 OR "sex work" OR offenders OR offending) NEAR/4 (reduce OR reducing OR reduction OR  
 prevent OR prevention OR preventing)) OR TITLE("family support" OR "family resource") OR  
 SUMMARY("family support" OR "family resource") OR (MAINSUBJECT.EXACT.EXPLODE("Harm  
 Reduction") OR MAINSUBJECT.EXACT.EXPLODE("Crime Prevention") OR MAINSUBJECT.  
 EXACT("Deterrence")) OR ((MAINSUBJECT.EXACT.EXPLODE("Crime") OR MAINSUBJECT.  
 EXACT.EXPLODE("Offenses") OR MAINSUBJECT.EXACT.EXPLODE("Female Offenders") OR  
 MAINSUBJECT.EXACT.EXPLODE("Offenders") OR MAINSUBJECT.EXACT.EXPLODE("Drug  
 Offenders") OR MAINSUBJECT.EXACT.EXPLODE("Juvenile Offenders")) AND (MAINSUBJECT.  
 EXACT("Prevention") OR MAINSUBJECT.EXACT.EXPLODE("Harm Reduction") OR MAINSUBJECT.  
 EXACT.EXPLODE("Crime Prevention") OR MAINSUBJECT.EXACT("Deterrence")))) NOT  
 (((TITLE((mdma OR opiate OR opiates OR opioid OR opioids OR opium OR heroin OR methadone  
 OR cocaine OR amphetamine? OR marijuana OR cannabis OR crack OR phencyclidine) NEAR/4  
 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR  
 use OR uses OR user OR users)) OR SUMMARY((mdma OR opiate OR opiates OR opioid OR  
 opioids OR opium OR heroin OR methadone OR cocaine OR amphetamine? OR marijuana OR  
 cannabis OR crack OR phencyclidine) NEAR/4 (problem? OR abuse\* OR abusing OR dependen\*  
 OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users))) OR (TITLE((drug OR  
 drugs OR substance OR morphine OR narcotic OR narcotics) NEAR/4 (problem? OR abuse\*  
 OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR  
 users)) OR SUMMARY((drug OR drugs OR substance OR morphine OR narcotic OR narcotics)  
 NEAR/4 (problem? OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse  
 OR use OR uses OR user OR users))) OR ((MAINSUBJECT.EXACT("Drugs") OR MAINSUBJECT.  
 EXACT("Psychedelic Drugs") OR MAINSUBJECT.EXACT("Tranquilizing Drugs") OR MAINSUBJECT.  
 EXACT("Drug Abuse") OR MAINSUBJECT.EXACT("Narcotic Drugs") OR MAINSUBJECT.  
 EXACT("Cocaine") OR MAINSUBJECT.EXACT("Marijuana") OR MAINSUBJECT.EXACT("Substance  
 Abuse")) OR (MAINSUBJECT.EXACT("Lysergic Acid Diethylamide") OR MAINSUBJECT.  
 EXACT("Opiates")))) AND ((TITLE("community based" OR "community fora" OR "community  
 forum" OR (communit\* NEAR/3 engag\*) OR "community action" OR "community intervention"  
 OR "local intervention" OR "change agent?" OR communitarian OR (community NEAR/3 organi\*)

OR (communit NEAR/5 intermediar\*) OR SUMMARY("community based" OR "community fora" OR "community forum" OR (communit\* NEAR/3 engag\*) OR "community action" OR "community intervention" OR "local intervention" OR "change agent?" OR communitarian OR (community NEAR/3 organi\*) OR (communit NEAR/5 intermediar\*)) OR (TITLE("community assets" OR (communit\* NEAR/4 partner\*) OR "civil society" OR "community plan\*" OR "social reintegration" OR "community action" OR "collaborative action" OR "whole community") OR SUMMARY("community assets" OR (communit\* NEAR/4 partner\*) OR "civil society" OR "community plan\*" OR "social reintegration" OR "community action" OR "collaborative action" OR "whole community")) OR (TITLE("recovery community" OR "recovery communities" OR "recovery capital") OR SUMMARY("recovery community" OR "recovery communities" OR "recovery capital")) OR (MAINSUBJECT.EXACT("Community Involvement") OR MAINSUBJECT.EXACT("Citizen Participation") OR MAINSUBJECT.EXACT("Change Agents") OR MAINSUBJECT.EXACT("Communitarianism") OR MAINSUBJECT.EXACT("Community Organizations") OR MAINSUBJECT.EXACT("Local Planning") OR MAINSUBJECT.EXACT("Civil Society") OR MAINSUBJECT.EXACT("Cultural Capital"))))Limits applied

**Databases:** Sociological Abstracts

**Limited by:**

Date: After 2012

**Source type:**

7 types searched Hide list

Books, Conference Papers & Proceedings, Dissertations & Theses, Other Sources, Reports, Scholarly Journals, Working Papers

**Document type:**

14 types searched Hide list

Annual Report, Article, Book, Book Chapter, Case Study, Conference Paper, Conference Proceeding, Correction/Retraction, Dissertation/Thesis, Evidence Based Healthcare, Literature Review, Report, Review, Working Paper/Pre-Print

**Language:**

English

## Scopus Database

Searched on 31 January 2023.

The following search algorithm was used, and 7,086 records were downloaded.

```
( TITLE-ABS-KEY ( {mersey model} OR {icelandic model} OR "healing communities" OR "drugs task force" OR "drug task force" ) ) OR ( ( ( TITLE-ABS-KEY ( "SOCIAL CAPITAL" ) ) OR ( TITLE-ABS-KEY ( social W/4 integration ) ) OR ( TITLE-ABS-KEY ( {DRUG PROJECT} ) ) OR ( TITLE-ABS-KEY ( ( ( geographic W/4 based ) OR {place based} OR placebased OR {area based} OR areabased ) ) ) OR ( TITLE-ABS-KEY ( ( "Legal space" OR location OR hotspot OR "Hot spot" OR neighbourhood OR neighborhood OR local OR community OR communities OR stakeholder OR grassroot ) W/4 ( program OR initiative OR led OR response ) ) ) ) AND ( (
```

TITLE-ABS-KEY ( ( ( needle\* OR syringe\* OR inject\* ) W/4 ( exchange\* OR supply OR access\* OR provision OR provid\* OR distribut\* OR dispens\* OR pack OR program\* OR service OR center OR centre OR scheme OR facility OR facilities OR pharmacy OR pharmacies OR unit OR units OR room ) ) ) ) OR ( TITLE-ABS-KEY ( ( overdose OR {over dose} OR overdosing OR overdosed OR {over dosing} OR {over dosed} OR naloxone OR recovery OR naran OR buprenorphine OR detox\* ) ) ) ) OR ( TITLE-ABS-KEY ( ( subutex OR suboxone ) ) ) ) OR ( TITLE-ABS-KEY ( ( ( opioid OR opiate OR agonist ) W/3 ( substitute\* OR replac\* ) ) ) ) ) OR ( TITLE-ABS-KEY ( ( ( drug OR drugs OR substance OR opiate OR opioid OR morphine OR heroin OR narcotic\* ) W/4 ( treatment OR service OR unit OR center OR centre OR facility\* ) ) ) ) ) AND ( ( TITLE-ABS-KEY ( ( ( mdma OR opiate OR opioid OR opium OR heroin OR methadone OR cocaine OR amphetamine OR marijuana OR cannabis OR crack OR phencyclidine ) W/4 ( problem OR abuse OR abusing OR dependen\* OR addict\* OR misuse OR polyabuse OR use OR uses OR user ) ) ) ) ) OR ( TITLE-ABS-KEY ( ( ( drug OR drugs OR substance OR morphine OR narcotic\* ) W/4 ( problem OR abuse OR abusing OR dependen\* OR addict\* OR misuse OR polyabuse OR use OR uses OR user ) ) ) ) ) ) OR ( ( ( TITLE-ABS-KEY ( ( ( mdma OR opiate OR opioid OR opium OR heroin OR methadone OR cocaine OR amphetamine OR marijuana OR cannabis OR crack OR phencyclidine ) W/4 ( problem OR abuse OR abusing OR dependen\* OR addict\* OR misuse OR polyabuse OR use OR uses OR user ) ) ) ) ) ) OR ( TITLE-ABS-KEY ( ( ( drug OR drugs OR substance OR morphine OR narcotic\* ) W/4 ( problem OR abuse OR abusing OR dependen\* OR addict\* OR misuse OR polyabuse OR use OR uses OR user ) ) ) ) ) ) AND ( ( TITLE-ABS-KEY ( ( "recovery community" OR "recovery communities" OR "recovery capital" ) ) ) ) OR ( TITLE-ABS-KEY ( ( "community assets" OR ( community W/4 partnership ) OR "civil society" OR "community plan" OR "social reintegration" OR "community action" OR "collaborative action" OR "whole community" ) ) ) ) OR ( TITLE-ABS-KEY ( ( "community based" OR "community fora" OR "community forum" OR ( communit\* W/3 engag\* ) OR "community action" OR "community intervention" OR "local intervention" OR "change agent" OR communitarian OR ( community W/3 organi\* ) OR ( communit W/5 intermediar\* ) ) ) ) ) ) OR ( ( ( TITLE-ABS-KEY ( "SOCIAL CAPITAL" ) ) ) OR ( TITLE-ABS-KEY ( social W/4 integration ) ) ) OR ( TITLE-ABS-KEY ( {DRUG PROJECT} ) ) ) OR ( TITLE-ABS-KEY ( ( ( geographic W/4 based ) OR {place based} OR placebased OR {area based} OR areabased ) ) ) ) OR ( TITLE-ABS-KEY ( ( "Legal space" OR location OR hotspot OR "Hot spot" OR neighbourhood OR neighborhood OR local OR community OR communities OR stakeholder OR grassroot ) W/4 ( program OR initiative OR led OR response ) ) ) ) ) OR ( ( TITLE-ABS-KEY ( ( "recovery community" OR "recovery communities" OR "recovery capital" ) ) ) ) OR ( TITLE-ABS-KEY ( ( "community assets" OR ( community W/4 partnership ) OR "civil society" OR "community plan" OR "social reintegration" OR "community action" OR "collaborative action" OR "whole community" ) ) ) ) OR ( TITLE-ABS-KEY ( ( "community based" OR "community fora" OR "community forum" OR ( communit\* W/3 engag\* ) OR "community action" OR "community intervention" OR "local intervention" OR "change agent" OR communitarian OR ( community W/3 organi\* ) OR ( communit W/5 intermediar\* ) ) ) ) ) ) AND ( ( TITLE-ABS-KEY ( ( "family support" OR "family resource" ) ) ) ) OR ( TITLE-ABS-KEY ( ( ( harm OR crime OR criminal OR theft OR fraud OR "sex offenses" OR homicide OR violence OR "drug diversion" OR "drug trafficking" OR "needle sharing" OR "sex work" OR offenders OR offending ) W/4 ( reduce OR reducing OR reduction OR prevent OR prevention OR preventing ) ) ) ) ) ) ) AND ( LIMIT-TO ( LANGUAGE , "English" ) ) AND ( LIMIT-TO ( PUBYEAR , 2023 ) OR LIMIT-TO ( PUBYEAR , 2022 ) OR LIMIT-TO ( PUBYEAR , 2021 ) OR LIMIT-TO ( PUBYEAR , 2020 ) OR LIMIT-TO ( PUBYEAR , 2019 ) OR LIMIT-TO ( PUBYEAR , 2018 ) OR LIMIT-TO ( PUBYEAR , 2017 ) OR LIMIT-TO ( PUBYEAR , 2016 ) OR LIMIT-TO ( PUBYEAR , 2015 ) OR LIMIT-TO ( PUBYEAR , 2014 ) OR LIMIT-TO ( PUBYEAR , 2013 ) )

## Criminal Justice Abstracts

---

Searched on 2 February 2023.

A total of 1,152 records were downloaded, using the following search algorithm.

---

“mersey model” OR “icelandic model” OR “healing communities” OR “drugs task force” OR “drug task force”

(“Legal space” OR location\* OR Hotspot\* OR Hot-spot\* OR Neighbourhood\* OR Neighborhood\* OR local OR community OR communities OR stakeholder\* OR Grassroot\*) N4 (program\* OR initiative\* OR led OR response\*)

((Geographic N4 based) OR “place based” OR placebased OR “area based” OR areabased)

“drug project”

social N4 reintegration

“social capital”

---

### 2 OR 3 OR 4 OR 5 OR 6

((needle\* OR syringe\* OR inject\*) N4 (exchange\* OR supply OR access\* OR provision OR provid\* OR distribut\* OR dispens\* OR pack OR packs OR program\* OR service OR services OR center OR centers OR centre OR centres OR scheme OR schemes OR facility OR facilities OR pharmacy OR pharmacies OR unit OR units OR room OR rooms))

(overdose OR “over dose” OR overdosing OR overdosed OR over-dose OR over-dosing OR overdosed OR naloxone OR recovery OR narcan OR buprenorphine OR detox\*)

(subutex OR suboxone)

((opioid OR opioids OR opiate OR opiates OR agonist\*) N3 (substitute\* OR replac\*))

((drug OR drugs OR substance OR opiate OR opiates OR opioid OR opioid OR morphine OR heroin OR narcotic OR narcotics) N4 (treatment OR service OR services OR unit OR units OR center OR centers OR centre OR centres OR facility\*))

---

### 8 OR 9 OR 10 OR 11 OR 12

((mdma OR opiate OR opiates OR opioid OR opioids OR opium OR heroin OR methadone OR cocaine OR amphetamine\* OR marijuana OR cannabis OR crack OR phencyclidine) N4 (problem OR problems OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users))

((drug OR drugs OR substance OR morphine OR narcotic OR narcotics) N4 (problem OR problems OR abuse\* OR abusing OR dependen\* OR addict\* OR misuse\* OR polyabuse OR use OR uses OR user OR users))

---

### 14 OR 15

(“community based” OR “community fora” OR “community forum” OR (communit\* N3 engag\*) OR “community action” OR “community intervention” OR “local intervention” OR “change agent” OR communitarian OR (community N3 organi\*) OR (communit N5 intermediar\*))

(“community assets” OR (communit\* N4 partner\*) OR “civil society” OR “community plan\*” OR “social reintegration” OR “community action” OR “collaborative action” OR “whole community” (“recovery community” OR “recovery communities” OR “recovery capital”))

---

### 17 OR 18 OR 19

((harm OR crime OR criminal OR theft OR fraud OR “sex offenses” OR homicide OR violence OR “drug diversion” OR “drug trafficking” OR “needle sharing” OR “sex work” OR offenders OR offending) N4 (reduce OR reducing OR reduction OR prevent OR prevention OR preventing))

---

("family support" OR "family resource")

21 OR 22

7 AND 13 AND 16

16 AND 20

(7 OR 20) and 23

1 OR 24 OR 25 OR 26

DATE LIMIT

ENGLISH

## HRB National Drugs Library

Searched on 31 January 2023.

A series of searches were conducted with the following terms in the title, subject, and abstract fields.

Place-based

Placebased

Area-based

Areabased

Mersey model

Icelandic model

Healing communities

Drug task force

Hotspots

Grassroots

Drugs task force

Drug project

Recovery community

Recovery communities

Recovery capital

Community assets

Local initiative

Local intervention

A total of 642 records were downloaded.

**Figure C2: HRB National Drugs Library search screenshot**

HRB Health Research Board

## HRB National Drugs Library

Home Key Irish Data Practitioner Portal Research Evidence Course Directory Search

Home > Advanced Search

Browse the repository by subject, author or perform a simple search.

Search Reset the form

Title:	all of	drug project	
Subject:	all of	drug project	+
All fields:	all of		
Author:	all of		
Abstract:	all of	drug project	
Geographical area:	all of		
Publisher:	all of		
Year/Date Range:			

## LitSense

Searched on 29–30 April 2023.

LitSense returns relevant sentences from the biomedical literature that best match the query sentence provided by the user. It only displays sentences that share at least 60% of similar terms with the query sentence. To make parts of the query mandatory, they must be surrounded by double quotes. We searched the following fields: title, abstract, introduction, methods, results, discussion, conclusion.

Our search phrases were built up by combining one element from each of the following categories: (1) place-based/community; (2) intervention/programme/coalition; and (3) substance/drugs.



We found that inclusion of any additional terms (e.g. relating to harms or problems) added little to the searches as they could not be fixed using quotation marks. The term “community” typically yields more records than other place-related terms. The term “place-based” is rarely used in the American literature and “substance” use returns more results than “drug” use. However, the latter term yields many results relating to drug testing, drug resistance, etc. Of the three terms that identify interventions, coalition seems to be the most effective, particularly in the American context. We identified 21 potentially relevant publications, which fell to seven after deduplicating against the main database containing the results of other searches.

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**1) Search phrase: place-based intervention for substance use**

2,479 sentences found

None of the first 50 records were relevant.

---

**2) Search phrase: “place-based” intervention for substance use**

1,172 sentences found

None of the first 50 records were relevant.

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**3) Search phrase: “place-based” “intervention” for substance use**

763 sentences found

None of the first 50 records were relevant.

---

**4) Search phrase: “place-based” “programme” for substance use**

57 sentences found

None of the first records were relevant. Most results related to health, as ‘substance’ could not be fixed as a required term (if we put this term in quotation marks, no sentences are identified).

---

**5) Search phrase: “community” “intervention” for “substance” use**

1,990 sentences found

5 potentially relevant records in the first 50 results.

---

**6) Search phrase: “community” “programme” for substance use**

2,686 sentences found

2 potentially relevant records in the first 50 results.

---

**7) Search phrase: “community” “coalition” for “substance” use**

185 sentences found

9 potentially relevant records in first 70 results.

---

**8) Search phrase: “place-based” “intervention” for “drug” use**

11 sentences found

No relevant records in first 50 results.

---

**9) Search phrase: “place-based” “programme” for “drug” use**

1 sentence found

Not relevant.

---

**10) Search phrase: “place-based” “coalition” for “drug” use**

0 sentences found.

---

**11) Search phrase: “community” “intervention” for “drug” use**

2,402 sentences found

1 relevant record in first 50 results.

---

**12) Search phrase: “community” “programme” for “drug” use**

706 sentences found

No relevant records in first 50 results.

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**13) Search phrase: “community” “coalition” for “drug” use**

145 sentences found

5 potentially relevant in the first 80 records.

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## Semantic Scholar

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Searched on 26–27 July 2023.

Semantic Scholar provides a set of tools for searching and summarising scientific papers, based on artificial intelligence. It was developed at the Allen Institute for AI and exploits natural language processing to search bibliographical databases. Since 2017, it includes biomedical articles and currently covers more than 200 million publications across most fields of scientific research.

As in the case of LitSense, our search phrases were built up by combining one element from each of the following categories: (1) place-based/community; (2) intervention/programme/coalition; and (3) substance/drugs. As the search results are ordered by relevance, we confined our attention to the first 100 records for each search string. The results are shown below. Overall, this resource identified nine potentially eligible records, which we had already found using other databases.

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### 1) Search phrase: place-based intervention for substance use

31 records found

No eligible records.

---

### 2) Search phrase: place-based programme for substance use

4 records found

No eligible records.

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### 3) Search phrase: community intervention for substance use

5,750 records found

2 eligible records in the first 100 results (duplicates of existing documents in our database).

Kuklinski *et al.* (2015)

Oesterle *et al.* (2018)

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### 4) Search phrase: “place-based” “programme” for substance use

57 sentences found

None of the first records were relevant. Most results related to health, as ‘substance’ could not be fixed as a required term (if we put this term in quotation marks, no sentences are identified).

---

### 5) Search phrase: “community” “intervention” for “substance” use

1,990 sentences found

5 potentially relevant records in the first 50 results.

---

### 6) Search phrase: community programme for substance use

873 records found

No eligible records in the first 100 results.

---

### 7) Search phrase: community coalition for substance use

213 records found

5 eligible records in the first 100 results (duplicates of existing documents in our database).

Hutchison & Russell (2021)

Fagan & Hawkins (2013)

Röding *et al.* (2021)

Hawkins *et al.* (2014)

Eschbach *et al.* (2022)

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**8) Search phrase: place-based intervention for drug use**

78 records found

No eligible records.

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**9) Search phrase: place-based programme for drug use**

24 records found

No eligible records.

---

**10) Search phrase: place-based coalition for drug use**

No records found.

---

**11) Search phrase: community intervention for drug use**

11,700 records found

3 eligible records in the first 100 results (duplicates of existing documents in our database).

Stockings *et al.* (2018)

Rhew *et al.* (2016)

Oesterle *et al.* (2018)

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**12) Search phrase: community programme for drug use**

3,160 records found

No eligible records in the first 100 results.

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**13) Search phrase: community coalition for drug use**

291 records found

One potentially relevant records in the first 100 results (duplicate of a document in our database).

Hutchison & Russell (2021)

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# Appendix D: Potentially eligible studies retained after title and abstract screening

For each record, we indicate the judgement reached after full-text screening, using the following categories: (1) eligible; (2) does not deal with illicit drug-related threats; (3) does not relate to existing place-based initiatives; (4) does not meet the formal criteria (carried out in a developing country, refers to a poster or commentary, etc.).

1. Adams N (2020). Using community engagement to map pathways of opioid use and recovery. *Journal of Community Health Nursing*, 37(1): 1–8. <https://doi.org/10.1080/07370016.2020.1693089> (exclude – does not relate to existing place-based initiatives)
2. Aldridge AP, Barbosa C, Barocas JA, Bush JL, Chhatwal J, Harlow KJ, Hyder A, Linas BP, McCollister KE, Morgan JR, Murphy SM, Savitzky C, Schackman BR, Seiber EE, Starbird LE, Villani J, Zarkin GA (2020). Health economic design for cost, cost-effectiveness and simulation analyses in the HEALing Communities Study. *Drug and Alcohol Dependence*, 217: 108336. <https://doi.org/10.1016/j.drugalcdep.2020.108336> (include)
3. Alexandridis AA, Dasgupta N, McCort AD, Ringwalt CL, Rosamond WD, Chelminski PR, Marshall SW (2019). Associations between implementation of Project Lazarus and opioid analgesic dispensing and buprenorphine utilization in North Carolina, 2009–2014. *Injury Epidemiology*, 6: 2. <https://doi.org/10.1186/s40621-018-0179-2> (exclude – does not deal with illicit drug-related threats)
4. Alexandridis AA, Dasgupta N, Ringwalt C, Sanford C, McCort A (2017). Effect of local health department leadership on community overdose prevention coalitions. *Drug and Alcohol Dependence*, 171: e5–e6. <https://doi.org/10.1016/j.drugalcdep.2016.08.031> (exclude – does not meet the formal criteria – conference abstract)
5. Allen M, Ghaffar H, Rosas-Lee M, Svetaz MV, Davey C, Palma DM (2013). Collaboration process evaluation of Padres Informados/Jovenes Preparados. *Journal of Adolescent Health*, 52(2): S72. <https://doi.org/10.1016/j.jadohealth.2012.10.168> (exclude – does not meet the formal criteria – poster)
6. Ashford RD, Brown AM, Ryding R, Curtis B (2020). Building recovery ready communities: the recovery ready ecosystem model and community framework. *Addiction Research & Theory*, 28(1): 1–11. <https://doi.org/10.1080/16066359.2019.1571191> (exclude – does not relate to existing place-based initiatives)

7. Bašić J (2015). Community mobilization and readiness: planning flaws which challenge effective implementation of 'Communities That Care' (CTC) prevention system. *Substance Use & Misuse*, 50(8–9): 1083–1088. <https://doi.org/10.3109/10826084.2015.1007655> (include)
8. Brown EC, Hawkins JD, Rhew IC, Shapiro VB, Abbott RD, Oesterle S, Arthur MW, Briney JS, Catalano RF (2014). Prevention system mediation of Communities That Care effects on youth outcomes. *Prevention Science*, 15(5): 623–632. <https://doi.org/10.1007/s1121-013-0413-7> (exclude – does not deal with illicit drug-related threats)
9. Brown LD, Chilenski SM, Wells R, Jones EC, Welsh JA, Gayles JG, Fernandez ME, Jones DE, Mallett KA, Feinberg ME (2021). Protocol for a hybrid type 3 cluster randomized trial of a technical assistance system supporting coalitions and evidence-based drug prevention programs. *Implementation Science*, 16(1): 64. <https://doi.org/10.1186/s13012-021-01133-z> (exclude – does not relate to existing place-based initiatives)
10. Callejas LM, Henry M, Yanez R, Sandoval F (2021). Promotores de Bienestar: a culturally responsive approach for reducing opioid deaths in New Mexico's Latino communities. *Social Work in Mental Health*, 19(6): 526–533. <https://doi.org/10.1080/15332985.2021.1929662> (exclude – does not relate to existing place-based initiatives)
11. Calvert WJ, Allen KR, Brockman–Jankowski S (2014). Interim evaluation of a university–community collaboration to address methamphetamine use in a rural Missouri community. *Progress in Community Health Partnerships: Research, Education, and Action*, 8(2): 207–213. <https://doi.org/10.1353/cpr.2014.0029> (exclude – does not relate to existing place-based initiatives)
12. Cantu R, Fields–Johnson D, Savannah S (2023). Applying a social determinants of health approach to the opioid epidemic. *Health Promotion Practice*, 24(1): 16–19. <https://doi.org/10.1177/1524839920943207> (include)
13. Carter JG, Mohler G, Rajc R, Chowdhury N, Pandey S (2021). The Indianapolis harmspot policing experiment. *Journal of Criminal Justice*, 74: 101814. <https://doi.org/10.1016/j.jcrimjus.2021.101814> (exclude – does not relate to existing place-based initiatives)
14. Chandler RK, Villani J, Clarke T, McCance–Katz EF, Volkow ND (2020). Addressing opioid overdose deaths: the vision for the HEALing Communities Study. *Drug and Alcohol Dependence*, 217: 108329. <https://doi.org/10.1016/j.drugalcdep.2020.108329> (include)
15. Chatterjee A, Glasgow L, Bullard M (2022). Placing racial equity at the center of substance use research: lessons from the HEALing Communities Study. *American Journal of Public Health*, 112(2): 204–208. <https://doi.org/10.2105/AJPH.2021.306572e> (exclude – does not deal with illicit drug-related threats)
16. Chilenski SM, Perkins DF, Olson J, Hoffman L, Feinberg ME, Greenberg M, Welsh J, Crowley DM, Spoth R (2016a). The power of a collaborative relationship between technical assistance providers and community prevention teams: a correlational and longitudinal study. *Evaluation and Program Planning*, 54: 19–29. <https://doi.org/10.1016/j.evalprogplan.2015.10.002> (exclude – does not deal with illicit drug-related threats)

17. Chilenski SM, Welsh JA, Perkins DF, Feinberg ME, Greenberg MT (2016b). Universal prevention exposure as a moderator of the community context: findings from the PROSPER Project. *American Journal of Community Psychology*, 57(1-2): 8-19. <https://doi.org/10.1002/ajcp.12032> (exclude – does not deal with illicit drug-related threats)
18. Christens BD, Byrd K, Hartigan LA, Speer PW (2021). Participatory roles in community coalitions: associations with perceptions of influence on decision-making. *Community Development*, 52(3): 365-381. <https://doi.org/10.1080/15575330.2021.1874455> (exclude – does not deal with illicit drug-related threats)
19. Clondalkin Drug and Alcohol Task Force (2018). *Reclaiming Community Development as an Effective Response to Drug Harms, Policy Harms, Poverty and Inequality*. Dublin: Clondalkin Drug and Alcohol Task Force. (exclude – does not relate to existing place-based initiatives)
20. Collura JJ, Raffle H, Collins AL, Kennedy H (2019). Creating spaces for young people to collaborate to create community change: Ohio's youth-led initiative. *Health Education & Behavior*, 46(S1), 44S-52S. <https://doi.org/10.1177/1090198119853571> (exclude – does not relate to existing place-based initiatives)
21. Corsaro N, Brunson RK (2013). Are suppression and deterrence mechanisms enough? Examining the 'pulling levers' drug market intervention strategy in Peoria, Illinois, USA. *International Journal of Drug Policy*, 24(2): 115-121. <https://doi.org/10.1016/j.drugpo.2012.12.006> (include)
22. Crowley DM, Jones DE, Coffman DL, Greenberg MT (2014). Can we build an efficient response to the prescription drug abuse epidemic? Assessing the cost effectiveness of universal prevention in the PROSPER trial. *Preventive Medicine*, 62: 71-77. <https://doi.org/10.1016/j.ypmed.2014.01.029> (include)
23. Department of Health (2017). *Reducing Harm, Supporting Recovery: a health-led response to drug and alcohol use in Ireland 2017-2025*. Dublin: Department of Health. <https://www.drugsandalcohol.ie/27603/1/Reducing-Harm-Supporting-Recovery-2017-2025.pdf> (exclude – does not relate to existing place-based initiatives)
24. Dobash G, Panting-Crespo J, Plavin D (2021). Rural FM residency drives substance use disorder response through community training. *Journal of Addiction Medicine*, 15(5): e52-e53. <https://doi.org/10.1097/ADM.0000000000000902> (exclude – does not meet the formal criteria – poster)
25. Domínguez M, Montolio D (2021). Bolstering community ties as a mean of reducing crime. *Journal of Economic Behavior & Organization*, 191: 916-945. <https://doi.org/10.1016/j.jebo.2021.09.022> (include)
26. Donohue RH Jr (2018). Changing police roles in response to the opioid epidemic: Massachusetts departments as a model for the country. *Law Enforcement Executive Forum*, 18(4): 26-37. <https://doi.org/10.19151/leef.2018.1804.d> (exclude – does not meet the formal criteria –abstract)
27. Dorton HE, Semien DS (2016). 'Collaborative investment' instead of community policing: an examination of an innovative drug market intervention program in Southern Alabama. *Race, Gender & Class*, 23(1): 99-107. (include)

28. Drainoni ML, Knudsen HK, Adams K, Andrews-Higgins SA, Auritt V, Back S, Barkowski LK, Batty EJ, Behrooz MR, Bell S, Chen S, Christopher MC, Coovert N, Crable EL, Dasgupta A, Goetz M, Goddard-Eckrich D, Hartman JL, Heffer H, ... McAlearney AS (2022). Community coalition and key stakeholder perceptions of the community opioid epidemic before an intensive community-level intervention. *Journal of Substance Abuse Treatment*, 138: 108731. <https://doi.org/10.1016/j.jsat.2022.108731> (include)
29. Eschbach CL, Contreras DA, Kennedy LE (2022). Three cooperative extension initiatives funded to address Michigan's opioid crisis. *Frontiers in Public Health*, 10: 921919. <https://doi.org/10.3389/fpubh.2022.921919> (exclude – does not relate to existing place-based initiatives)
30. Fagan AA, Hawkins JD (2013). Preventing substance use, delinquency, violence, and other problem behaviors over the life-course using the Communities That Care system. In CL Gibson and MD Krohn (eds), *Handbook of Life-Course Criminology: Emerging Trends and Directions for Future Research*. New York: Springer. 277–296. (exclude – does not meet the formal criteria – summary of previous research)
31. Glasgow Centre For Population Health (2015). *Positive Conversations, Meaningful Change: Learning from Animating Assets*. Glasgow: Glasgow Centre for Population Health. (exclude – does not deal with illicit drug-related threats)
32. Gloppen KM, Brown EC, Wagenaar BH, Hawkins JD, Rhew IC, Oesterle S (2016). Sustaining adoption of science-based prevention through Communities That Care. *Journal of Community Psychology*, 44(1): 78–89. <https://doi.org/10.1002/jcop.21743> (include)
33. Gurganus KM, Butt AL, Kirchenbauer CM, Melvik C, Piatt J, Hawkins J, U'Ren S, Onuorah Y (2015). Implementing the Regional Epidemiological Outcomes Workgroup (REOW) in the state of Oklahoma for substance abuse prevention: an ODMHSAS Project. *Community Mental Health Journal*, 51(5): 535–539. <https://doi.org/10.1007/s10597-014-9821-9> (exclude – does not relate to existing place-based initiatives)
34. Haggerty KP, Shapiro VB (2013). Science-based prevention through Communities That Care: a model of social work practice for public health. *Social Work in Public Health*, 28(3–4): 349–365. <https://doi.org/10.1080/19371918.2013.774812> (exclude – does not meet the formal criteria – summary of previous research)
35. Haggerty KP, Barton VJ, Catalano RF, Spearmon ML, Elion EC, Reese RC, Uehara ES (2017). Translating grand challenges from concept to community: the 'Communities in Action' experience. *Journal of the Society for Social Work and Research*, 8(1): 137–159. <https://doi.org/10.1086/690561> (exclude – does not meet the formal criteria – summary of previous research)
36. Halsall T, Lachance L, Kristjansson AL (2020). Examining the implementation of the Icelandic model for primary prevention of substance use in a rural Canadian community: a study protocol. *BMC Public Health*, 20(1): 1235. <https://doi.org/10.1186/s12889-020-09288-y> (include)
37. Halsall T, Mahmoud K, Iyer SN, Orpana H, Zeni M, Matheson K (2023). Implications of time and space factors related with youth substance use prevention: a conceptual review and case study of the Icelandic Prevention Model being implemented in the context of the COVID-19 pandemic. *International Journal of Qualitative Studies on Health and Well-Being*, 18(1): 2149097. <https://doi.org/10.1080/17482631.2022.2149097> (exclude – does not deal with illicit drug-related threats)

38. Halsall T, Mahmoud K, Pouliot A, Iyer SN (2022). Building engagement to support adoption of community-based substance use prevention initiatives. *BMC Public Health*, 22(1): 2213. <https://doi.org/10.1186/s12889-022-14496-9> (include)
39. Hawkins JD, Oesterle S, Brown EC, Abbott RD, Catalano RF (2014). Youth problem behaviors 8 years after implementing the Communities That Care prevention system: a community-randomized trial. *JAMA Pediatrics*, 168(2): 122–129. <https://doi.org/10.1001/jamapediatrics.2013.4009> (include)
40. Helm S, Davis K, Haumana AYP (2017). Challenges and lessons learned in implementing a community-academic partnership for drug prevention in a native Hawaiian community. *Puerto Rico Health Sciences Journal*, 36(2): 101–106. (exclude – does not relate to existing place-based initiatives)
41. Henderson JL, Chiodo D, Varatharasan N, Andari S, Luce J, Wolfe J (2022). Youth Wellness Hubs Ontario: development and initial implementation of integrated youth services in Ontario, Canada. *Early Intervention in Psychiatry*, 17(1): 107–114. <https://doi.org/10.1111/eip.13315> (exclude – does not relate to existing place-based initiatives)
42. Johnson CA, Hansen WB, Pentz MA (2013 [1986]). Comprehensive community programs for drug abuse prevention. In KL Kumpfer, S Griswold-Ezekoye and M Frank (eds), *Childhood and Chemical Abuse: Prevention and Intervention* [e-book]. New York: Routledge. 181–200. <https://doi.org/10.4324/9781315826172> (exclude – does not meet the formal criteria – originally published in 1986)
43. Johnson K, Collins D, Shamblen S, Kenworthy T, Wandersman A (2017). Long-term sustainability of evidence-based prevention interventions and community coalitions survival: a five and one-half year follow-up study. *Prevention Science*, 18(5): 610–621. <https://doi.org/10.1007/s11121-017-0784-2> (exclude – does not relate to existing place-based initiatives)
44. Kim BK (2015). *Understanding strengths: developmental changes and effects of protective factors in a community prevention trial*. Unpublished PhD dissertation. University of Washington. (exclude – does not deal with illicit drug-related threats)
45. Kim BKE, Gilman AB, Hawkins JD (2015a). 28 school- and community-based preventive interventions during adolescence: preventing delinquency through science-guided collective action. In J Morizot and L Kazemian (eds), *The Development of Criminal and Antisocial Behavior: Theory, Research and Practical Applications*. New York: Springer. 447–460. (exclude – does not meet the formal criteria – summary of previous research)
46. Kim BKE, Oesterle S, Hawkins JD, Shapiro VB (2015b). Assessing sustained effects of Communities That Care on youth protective factors. *Journal of the Society for Social Work and Research*, 6(4): 565–589. <https://doi.org/10.1086/684163> (exclude – does not deal with illicit drug-related threats)
47. Knudsen HK, Drainoni ML, Gilbert L, Huerta TR, Oser CB, Aldrich AM, Campbell ANC, Crable EL, Garner BR, Glasgow LM, Goddard-Eckrich D, Marks KR, McAlearney AS, Oga EA, Scalise AL, Walker DM (2020). Model and approach for assessing implementation context and fidelity in the HEALing Communities Study. *Drug and Alcohol Dependence*, 217: 108330. <https://doi.org/10.1016/j.drugalcdep.2020.108330> (exclude – does not deal with illicit drug-related threats)



48. Komro KA, Kominsky TK, Skinner JR, Livingston MD, Livingston BJ, Avance K, Lincoln AN, Barry CM, Walker AL, Pettigrew DW, Merlo LJ, Cooper HLF, Wagenaar AC (2022). Study protocol for a cluster randomized trial of a school, family, and community intervention for preventing drug misuse among older adolescents in the Cherokee Nation. *Trials*, 23(1): 175. <https://doi.org/10.1186/s13063-022-06096-0> (include)
49. Koning IM, De Kock C, van der Kreeft P, Percy A, Sanchez ZM, Burkhart G (2021). Implementation of the Icelandic Prevention Model: a critical discussion of its worldwide transferability. *Drugs: Education, Prevention and Policy*, 28(4): 367–378. <https://doi.org/10.1080/09687637.2020.1863916> (exclude – does not meet the formal criteria – commentary)
50. Kristjansson AL, Lilly CL, Thorisdottir IE, Allegrante JP, Mann MJ, Sigfusson J, Soriano HE, Sigfusdottir ID (2021). Testing risk and protective factor assumptions in the Icelandic model of adolescent substance use prevention. *Health Education Research*, 36(3): 309–318. <https://doi.org/10.1093/her/cyaa052> (exclude – does not deal with illicit drug-related threats)
51. Kristjansson AL, Mann MJ, Sigfusson J, Thorisdottir IE, Allegrante JP, Sigfusdottir ID (2020a). Development and guiding principles of the Icelandic model for preventing adolescent substance use. *Health Promotion Practice*, 21(1): 62–69. <https://doi.org/10.1177/1524839919849032> (include)
52. Kristjansson AL, Mann MJ, Sigfusson J, Thorisdottir IE, Allegrante JP, Sigfusdottir ID (2020b). Implementing the Icelandic model for preventing adolescent substance use. *Health Promotion Practice*, 21(1): 70–79. <https://doi.org/10.1177/1524839919849033> (include)
53. Kuklinski MR, Fagan AA, Hawkins JD, Briney JS, Catalano RF (2015). Benefit–cost analysis of a randomized evaluation of Communities That Care: monetizing intervention effects on the initiation of delinquency and substance use through grade 12. *Journal of Experimental Criminology*, 11(2): 165–192. <https://doi.org/10.1007/s11292-014-9226-3> (exclude – does not deal with illicit drug-related threats)
54. Kuklinski MR, Hawkins JD, Plotnick RD, Abbott RD, Reid CK (2013). How has the economic downturn affected communities and implementation of science-based prevention in the randomized trial of Communities That Care? *American Journal of Community Psychology*, 51(3): 370–384. <https://doi.org/10.1007/s10464-012-9557-z> (exclude – does not deal with illicit drug-related threats)
55. Kuklinski MR, Oesterle S, Briney JS, Hawkins JD (2021). Long-term impacts and benefit–cost analysis of the Communities That Care prevention system at age 23, 12 years after baseline. *Prevention Science*, 22(4): 452–463. <https://doi.org/10.1007/s1121-021-01218-7> (include)
56. Lardier DT, Bermea AM, Brown TL, Garcia-Reid P, Reid RJ (2020). ‘You gotta be strong minded’: substances use and individualism among urban minority youth. *Urban Social Work*, 4(2): 173–200. <https://doi.org/10.1891/USW-D-19-00015> (exclude – does not relate to existing place-based initiatives)

57. Lefebvre RC, Chandler RK, Helme DW, Kerner R, Mann S, Stein MD, Reynolds J, Slater MD, Anakaraonye AR, Beard D, Burrus O, Frkovich J, Hedrick H, Lewis N, Rodgers E (2020). Health communication campaigns to drive demand for evidence-based practices and reduce stigma in the HEALing Communities Study. *Drug and Alcohol Dependence*, 217: 108338. <https://doi.org/10.1016/j.drugalcdep.2020.108338> (exclude – does not relate to existing place-based initiatives)
58. MacArthur S, Wray P, Warnick C, Keady TC, Jensen C, Sorenson M, Narine L (2022). Implementing substance use prevention programming in rural Utah during COVID-19. *Journal of Addiction Medicine*, 16(5): e296. (exclude – does not meet the formal criteria – poster)
59. Manchak SM, Gosney ME, Haberman C, Firesheets KC (2022). A data-driven response to the addiction crisis in Hamilton County, Ohio. *Journal of Public Health Management and Practice*, 28: S320–S325. <https://doi.org/10.1097/PHH.0000000000001566> (exclude – does not relate to existing place-based initiatives)
60. Minnick D, Place JM, Thaller J (2022). Creating a community-academic partnership: an innovative approach to increasing local community capacities to address substance misuse. *Journal of Higher Education Outreach and Engagement*, 26(3): 117–128. (exclude – does not relate to existing place-based initiatives)
61. Moore SK, Saunders EC, McLeman B, Metcalf SA, Walsh O, Bell K, Meier A, Marsch LA (2021). Implementation of a New Hampshire community-initiated response to the opioid crisis: a mixed-methods process evaluation of Safe Station. *International Journal of Drug Policy*, 95: 103259. <https://doi.org/10.1016/j.drugpo.2021.103259> (exclude – does not relate to existing place-based initiatives)
62. Morrissey S, Nyrop K, Lee T (2019). Landscapes of loss and recovery: the anthropology of police-community relations and harm reduction. *Human Organization*, 78(1): 28–42. <https://doi.org/10.17730/0018-7259.78.1.28> (exclude – does not relate to existing place-based initiatives)
63. Community Wise (2016). Optimization Trial. <https://clinicaltrials.gov/show/NCT02951455> (exclude – does not meet the formal criteria – only a registered trial)
64. Oesterle S, Hawkins JD, Kuklinski MR, Fagan AA, Fleming C, Rhew IC, Brown EC, Abbott RD, Catalano RF (2015). Effects of Communities That Care on males' and females' drug use and delinquency 9 years after baseline in a community-randomized trial. *American Journal of Community Psychology*, 56(3–4): 217–228. <https://doi.org/10.1007/s10464-015-9749-4> (include)
65. Oesterle S, Kuklinski MR, Hawkins JD, Guttmanova K, Rhew IC, Skinner ML (2018). Long-term effects of the Communities That Care trial on substance use, antisocial behavior, and violence through age 21 years. *American Journal of Public Health*, 108(5): 659–665. <https://doi.org/10.2105/AJPH.2018.304320> (include)
66. Oldeide O, Fosse E, Holsen I (2021). Local drug prevention strategies through the eyes of policymakers and outreach social workers in Norway. *Health & Social Care in the Community*, 29(2): 376–384. <https://doi.org/10.1111/hsc.13096> (exclude – does not relate to existing place-based initiatives)

67. Orjiakor CT, Eze J, Chinweoke M, Ezenwa M, Orjiakor I, Onwujekwe O, Palamar J (2023). A systematic review of actors, actions, and outcomes of community-based efforts to prevent or reduce methamphetamine use. *Addiction Research and Theory*, 31(5): 335–344. <https://doi.org/10.1080/16066359.2023.2167982> (exclude – does not relate to existing place-based initiatives)
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102. Young AM, Brown JL, Hunt T, Sprague Martinez LS, Chandler R, Oga E, Winhusen TJ, Baker T, Battaglia T, Bowers-Sword R, Button A, Fallin-Bennett A, Fanucchi L, Freeman P, Glasgow LM, Gulley J, Kendell C, Lofwall M, Lyons MS, ... Walsh SL (2022). Protocol for community-driven selection of strategies to implement evidence-based practices to reduce opioid overdoses in the HEALing Communities Study: a trial to evaluate a community-engaged intervention in Kentucky, Massachusetts, New York and Ohio. *BMJ Open*, 12(9): e059328. <https://doi.org/10.1136/bmjopen-2021-059328> (exclude – does not deal with illicit drug-related threats)

# Appendix E: Potentially eligible studies identified using citation search

The outcome of the full-text screening process is indicated for each record generated by the citation search, using the following categories: (1) eligible; (2) does not deal with illicit drug-related threats; (3) does not relate to existing place-based initiatives; (4) does not meet the formal criteria (carried out in a developing country, refers to a poster or commentary, etc.).

1. Asgeirsdottir BB, Kristjansson AL, Sigfusson J, Allegrante JP, Sigfusdottir ID (2021). Trends in substance use and primary prevention variables among adolescents in Lithuania, 2006–19. *European Journal of Public Health*, 31(1): 7–12. <https://doi.org/10.1093/eurpub/ckaa097> (include)
2. Brown LD, Feinberg ME, Shapiro VB, Greenberg MT (2015). Reciprocal relations between coalition functioning and the provision of implementation support. *Prevention Science*, 16(1): 101–109. <https://doi.org/10.1007/s1121-013-0447-x> (include)
3. Chandler R, Nunes EV, Tan S, Freeman PR, Walley AY, Lofwall M, Oga E, Glasgow L, Brown JL, Fanucchi L, Beers D, Hunt T, Bowers-Sword R, Roeber C, Baker T, Winhusen TJ (2023). Community selected strategies to reduce opioid-related overdose deaths in the HEALing (Helping to End Addiction Long-term<sup>SM</sup>) Communities Study. *Drug and Alcohol Dependence*, 245: 109804. <https://doi.org/10.1016/j.drugalcdep.2023.109804> (include)
4. Chen S, Walt G, Aldrich A, McAlearney AS, Linas B, Amuchi B, Freedman DA, Goddard-Eckrich D, Gibson E, Hartman J, Bosak J, Lunze K, Jones L, Christopher M, Salsberry P, Jackson R, Back S, Drainoni ML, Walker DM (2023). A qualitative study of health equity's role in community coalition development. *Health Education & Behavior*. <https://doi.org/10.1177/10901981231179755> (include)
5. Chilenski SM, Frank J, Summers N, Lew D (2019). Public health benefits 16 years after a statewide policy change: Communities That Care in Pennsylvania. *Prevention Science*, 20(6): 947–958. <https://doi.org/10.1007/s1121-019-01028-y> (include)
6. Dunlap LJ, Kuklinski MR, Cowell A, McCollister KE, Bowser DM, Campbell M, Fernandes CSF, Kemburu P, Livingston BJ, Prosser LA, Rao V, Smart R, Yilmazer T (2022). Economic evaluation design within the HEAL Prevention Cooperative. *Prevention Science*. <https://doi.org/10.1007/s1121-022-01400-5> (exclude – does not relate to existing place-based initiatives)
7. Feinberg ME, Fang S, Fosco GM, Sloan CJ, Mogle J, Spoth RL (2022). Long-term effects of adolescent substance use prevention on participants, partners, and their children: resiliency and outcomes 15 years later during the COVID-19 pandemic. *Prevention Science*, 23(7): 1264–1275. <https://doi.org/10.1007/s1121-022-01384-2> (include)

8. Meyers CCA, Mann MJ, Thorisdottir IE, Ros Garcia P, Sigfusson J, Sigfusdottir ID, Kristjansson AL (2023). Preliminary impact of the adoption of the Icelandic Prevention Model in Tarragona City, 2015–2019: a repeated cross-sectional study. *Frontiers in Public Health*, 11: 1117857. <https://doi.org/10.3389/fpubh.2023.1117857> (include)
9. Osgood DW, Feinberg ME, Gest SD, Moody J, Ragan DT, Spoth R, Greenberg MT, Redmond C (2013). Effects of PROSPER on the influence potential of prosocial versus antisocial youth in adolescent friendship networks. *Journal of Adolescent Health*, 53(2): 174–179. <https://doi.org/10.1016/j.jadohealth.2013.02.013> (include)
10. Spoth R, Redmond C, Shin C, Trudeau L, Greenberg MT, Feinberg ME, Welsh J (2022). Applying the PROSPER prevention delivery system with middle schools: emerging adulthood effects on substance misuse and conduct problem behaviors through 14 years past baseline. *Child Development*, 93(4): 925–940. <https://doi.org/10.1111/cdev.13746> (include)



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